Table 2: Patient Education across the Continuum

Stroke Awareness and Action	Hyperacute Care	Acute Inpatient Care	Stroke Rehabilitation	Stroke Prevention	Transitions	Community Integration
Review and reinforce all information previously provided that is relevant to the patient and their unique situation						

• **Signs of Stroke**
  • **F**ace
  • **A**rms
  • **S**peech
  • **T**ime
• **Call 911** immediately if signs of stroke observed
• **Never drive self** or someone with stroke to hospital on your own
• **Risk factors** for stroke
  • High Blood Pressure
  • Obesity
  • High Sodium Diet
  • Diabetes
  • High Cholesterol
  • Lack of Exercise
  • Smoking
  • Sleep Apnea
  • Family History
• Risk of stroke for all age groups from newborns to children, young adults and older adults
	• Types of Stroke
	• Cause of stroke for individual patient
	• Diagnostic tests
	  • CT Scan
	  • MRI
	  • Carotid imaging
	  • ECG for AFib detection
	• Acute thrombolysis
	• Endovascular interventions
	• Involvement of neurosurgery if applicable
	• Potential outcomes – expectation management
	• For patients discharged directly from the ED:
	  • Need for follow-up with primary care and stroke specialists (refer to prevention education)
	  • Risk of recurrence and review of stroke signs and symptoms
	• Accessing resources and stroke support following
		• Current deficits – what areas may be involved
		• Patient safety
		• Family and caregiver safety
		• Tests and interventions
		• Initiate discharge planning
		• Potential for home modifications prior to discharge
		• Discuss potential pathway for care and likely next setting of care
		• Focus on self-management and involvement of family and informal caregivers in daily activities
		• Medications: purpose, schedule, interactions, compliance
		• Activities to prevent complications
		• Accessing resources and stroke support following discharge from acute care
		• Expectations for
			• Educate patients about goal-setting so they can actively participate in goal setting and care planning
			• Information regarding specific individualized rehabilitation needs
			• Roles of each of the rehabilitation team members involved in care
			• The types or rehabilitation exercises and activities that could and should be done between scheduled sessions with therapists
			• Patient, family caregiver safety while participating rehabilitation
			• Self-management skills for mobility and activities of daily living
			• Discharge planning, type of care needed after discharge, and required modifications to
				• **Signs of Stroke**
				  • **F**ace
				  • **A**rms
				  • **S**peech
				  • **T**ime
				• Importance of calling 911 if any stroke signs and symptoms appear again after initial stroke
				• **Risk factors** for stroke
				  • High Blood Pressure
				  • Obesity
				  • High Sodium Diet
				  • Diabetes
				  • High Cholesterol
				  • Lack of Exercise
				  • Smoking
				  • Sleep Apnea
				  • Family History
				• Effects of stroke in months following index event – risk for depression, cognitive changes, sleep apnea, post-stroke fatigue; and provide strategies and self-management skills so patients, families and caregivers can
					• Self-management skills for activities of daily living
					• Types of services and primary contact for health care professionals at the next stage and/or setting
					• Appropriate expectations for recovery of deficits, time frames and likely transition points appropriate to the individual
					• Physical adjustments including medication compliance, post-stroke fatigue, strategies to prevent complications and recurrent stroke
					• Address functional issues – ongoing rehabilitation and physical activity recommendations, personalized plan of care and goal setting
					• Address
						• Self-management skills for mobility, symptom management, medication compliance and activities of daily living
						• Types of services available in the community and how to access them – e.g., mobility assistance, meal delivery, communication support
						• Need for follow-up with primary health care providers for ongoing monitoring and management
						• Appropriate expectations for recovery of deficits, time frames as appropriate to individual situations
						• Physical adjustments including medication compliance, post-stroke fatigue, preventing

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	discharge	recovery following discharge, addressing issues including depression, post-stroke fatigue, rehabilitation needs and access, and issues for social reintegration • Access to community resources and stroke support groups • Re-access to healthcare system • Advance care planning and personal health directives	living setting prior to discharge from inpatient rehabilitation • Information regarding resuming vocational, educational and driving activities • Access to therapists and programs for ongoing rehabilitation in out-patient and community settings • Access to community resources and stroke support groups • Re-access to healthcare system	manage in community and home settings • Medication management • Atrial fibrillation risks and management as appropriate • Adherence to drug therapy • Access to community resources and stroke support groups • Re-access to healthcare system • Advance care planning and personal health directives	psychosocial issues, i.e., depression, family support, referrals to community resources • Self-management preparation for the next phase of care • Timeframes for transitions • Importance of information transfer and provision of written core information about previous stroke related episodes of care to share with stroke experts and recovery team members in next phase of care • Advance care planning and personal health directives	complications, preventing recurrent stroke • Addressing functional issues – ongoing rehabilitation and physical activity recommendations, personalized plan of care and goal setting • Social and leisure activity review and importance of resuming social interactions • Information regarding resuming vocational, educational and driving activities • Information on sexuality following stroke • Advance care planning and personal health directives