



CANADIAN STROKE BEST PRACTICE RECOMMENDATIONS

**Rehabilitation, Recovery and Community Participation
Following Stroke
Part One: Stroke Rehabilitation Planning for Optimal Care
Delivery
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Box 8: Supporting Successful Transitions of Care Checklist

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Box 8: Supporting Successful Transitions of Care Checklist

This checklist is provided as a guide to help ensure evidence- and consensus- based recommendations are applied to develop an action plan for each individual as they transition to different settings and phases of care. This checklist is applicable to all care settings and should enable the healthcare team member to work with the individual with stroke, their family and caregivers to have meaningful conversations regarding appropriate supports and services to ensure positive and successful care transitions.

Support for individuals with stroke, their families, and caregivers should be based on shared decision-making and tailored to the individual's cognitive, sensory, and communication abilities. It may include:

- Shared decision making and participation regarding transitions across stages of care.
- Accurate and up to date information about the next care setting, what can be expected, and how to prepare.
- Access to restorative care and active rehabilitation to improve and/or maintain function based on the individualized care plan.
- Counseling, preparation and ongoing assessment for adjustment to change of: living setting; abilities; social roles and relationships; participation, leisure and vocational activities; and home environment. Also consider impact on family (e.g., spouse or partner, children); potential resource issues (financial), and independence (e.g., driving).
- Written discharge instructions and recommendations should be included in collaborative action plans and include goals and follow-up care.
- Access to a designated contact person in the hospital and community for continuity of care and questions.
- Access to and advice from health and social service organizations appropriate to needs and stage of transition and recovery.
- Links to and information about local community agencies such as stroke groups, peer visiting programs, meal provider agencies, and other services and agencies.
- Information and guidance on advance care planning, palliative care, and end-of-life care as appropriate.
- Where possible, access to peer supports who have had a stroke and experienced transitions following the acute phase.
- All communication should be tailored to the individual's cognitive, sensory, and communication abilities (such as aphasia-friendly formats) as required and appropriate to the health literacy of individuals with stroke, their families and caregivers.