

Module 3: Admission to Acute Care

This module identifies best practices for acute inpatient admissions (as described in recommendation 2.4.2 for the specific group of TIA patients who should be admitted). Module 3a provides recommendations for acute inpatient treatment, and module 3b provides recommendations for the prevention of secondary complications, which should be initiated in the acute care setting but also be considered as ongoing activities. All patients should be given appropriate cross-continuum prevention assessment and therapies (Modules 5 and 10). The Ontario Stroke Network revised the definition of a stroke unit “A geographical unit with identifiable co-located beds (eg 5A -7, 5A-8, 5A-9, 5A-10, 5A-11) that are occupied by stroke patients 75% of the time and has a dedicated interprofessional team with expertise in stroke care with the following professionals at a minimum nursing, physiotherapy, occupational therapy, speech language pathologist”.) Ontario Stroke Network 2015

Module 3a: Acute Care Treatment

Module 3a Recommended Practices	Contributing Sources of Evidence
3.1 Stroke units	
3.1.1 Patients should be admitted to a specialized, geographically defined hospital unit dedicated to the management of stroke patients A geographical unit with identifiable co-located beds (eg 5A -7, 5A-8, 5A-9, 5A-10, 5A-11) that are occupied by stroke patients 75% of the time and has a dedicated inter-professional team with expertise in stroke care with the following professionals at a minimum nursing, physiotherapy, occupational therapy, speech language pathologist”.	Based on an HQO special report (53) (moderate quality evidence); consistent with CSBPR (level A evidence), SIGN (level A recommendation), and Australia (level C evidence) Ontario Stroke Network
• This recommendation is in accordance with the HQO Effectiveness of Stroke Unit Care: A Special Report, which concluded (61): Moderate quality evidence showed that persons admitted to a stroke unit had a significant reduction in death and the combined outcome of death or institutionalization, and a nonsignificant reduction in institutionalization. Low quality evidence showed that patients admitted to a stroke unit had a significant reduction in the combined outcome of death or dependency and length of hospital stay and a nonsignificant reduction in the outcome of dependency	
3.1.2 The core stroke unit team should consist of health care professionals with stroke expertise in medicine, nursing, occupational therapy, physiotherapy, speech-language pathology, social work, and clinical nutrition (a dietitian)	Based on CSBPR (level A evidence); consistent with Australia (level A evidence)
3.1.3 To have the necessary stroke expertise, the health care professionals on the core stroke unit team should be individuals who spend the vast majority of their time treating stroke patients and regularly complete education about stroke care	Based on CSBPR (no level of evidence provided); consistent with expert advisory panel consensus
3.1.4 Patients should have access to a specialized interprofessional team 7 days a week	Based on expert advisory panel consensus
3.1.5 Physiotherapy, speech-language pathology, and occupational therapy team members should assess stroke patients within 48 hours of admission to hospital and formulate a management plan	Based on CSBPR (level B evidence); modified by expert advisory panel consensus
3.2 Early mobilization	
3.2.1 All stroke patients admitted to hospital with acute stroke should be mobilized early (between 24 hours and 48 hours of stroke onset), unless contraindicated Frequent out-of-bed activity in the very early time frame (within 24 hours of stroke onset) is not recommended Mobilization may be reasonable for some patients with acute stroke in the very early time frame and clinical judgement should be used.	Based on CSBPR (level B evidence); consistent with SIGN (level A recommendation) and Australia (level B evidence)

Module 3a Recommended Practices	Contributing Sources of Evidence
3.3 Assessment	
3.3.1 Clinicians should use standardized, valid assessment tools to evaluate patients' stroke-related impairments and functional status	Based on CSBPR (level of evidence B); consistent with SIGN (level C recommendation)
3.3.2 AlphaFIM should be completed on or by day 3 after admission(target day 3, admission day is day 1)	Based on expert advisory panel consensus in reference to the OSN Stroke Reference Group
3.3.3 All stroke patients should be assessed for risk of developing venous thromboembolism	Based on CSBPR (level of evidence not provided)
3.3.4 Early mobilization and adequate hydration should be encouraged for all acute stroke patients to help prevent venous thromboembolism	Based on CSBPR (level C evidence)
3.3.5 The nutrition and hydration status of stroke patients should be assessed within the first 48 hours of admission using a valid screening tool. Stroke patients with nutritional concerns, hydration deficits, dysphagia, or other comorbidities should be referred to a dietitian. Referral to a dietitian should be made within 7 days of admission for recommendations and for consideration of enteral nutrition support for patients who are unable to meet nutritional and fluid requirements	Based on CSBPR (level B evidence); consistent with SIGN (levels A-C recommendations) and AHA/ASA (class III, level B evidence)
3.4 Recommendations are not applicable to TIA or minor (nondisabling) stroke	
3.5 Cross-continuum prevention assessment and therapies	
3.5.1 All patients, whether admitted to in-hospital rehabilitation or discharged, should be given appropriate cross-continuum secondary prevention assessments and therapies (Modules 5 and 10)	Based on expert advisory panel consensus

Abbreviations: AHA/ASA, American Heart Association/American Stroke Association; Australia, Australian Clinical Guidelines for Stroke Management; CSBPR, Canadian Best Practices Recommendations; FIM, Functional Independence Measure; HQO, Health Quality Ontario; OSN, Ontario Stroke Network; SIGN, Scottish Intercollegiate Guidelines Network; TIA, transient ischemic attack.

The following implementation considerations were noted by members of the expert advisory panel.

Module 3a Implementation Considerations
General considerations
<ul style="list-style-type: none"> • All hospitals providing stroke/TIA care should ensure that the interprofessional stroke team uses standardized, validated assessment tools; where possible, these tools should be in electronic format linked to the EHR • Patients should be screened/assessed for diabetes, dental issues, cognitive impairment, and depression upon presentation to the ED, and the results should be forwarded to the TIA clinic for follow-up • Hospitals should ensure adequate staffing 7 days per week

Abbreviations: ED, emergency department; EHR, electronic health record; TIA, transient ischemic attack.