Department: Rehabilitation Services: Persons with a Stroke

Scope of Service

The Physical Rehabilitation Unit offers specific services for persons experiencing a stroke or other brain injury. The physical rehabilitation department is part of the individual’s continuum of care that culminates with a re-entry program into the community or discharge to a community facility for safety, care, and/or continued therapy services.

The persons with a stroke served in this program include:

- Ischemic
- Hemorrhagic
- Tumors

Admission criteria include physical impairments that limit functional activity and potential to benefit from individualized and interdisciplinary rehabilitative services. All persons served must be neurologically and medically stable, alert, and able to tolerate three hours of combined therapies per day. The unique needs of each individual are considered including the level of medical complexity, psychosocial needs, prior level of function, prognosis for functional improvements and discharge plan. Individuals with developmental delays or anyone who has been diagnosed with a mental health disorder is eligible for our rehabilitation program if they can participate and demonstrate the potential for functional progress. A physician order and referral is required for admission.

Inpatient services include 24 hour nursing care, six days/week Physical and Occupational Therapy, Speech Language Pathology, and Recreational Therapy. Additional services include; Social Services, Nutritional Services, Spiritual Services, Psychological Support, and acute medical management. All services are overseen by a board certified Physiatrist who provides direction related to medical and rehabilitative care and design of each patient’s individualized treatment plan.

For the person with a stroke, the inpatient rehabilitation plan of care focuses on injury mechanics, strengthening, spasticity management, cognitive retraining, swallow and voice training, bowel and bladder training, pulmonary function, skin and wound care, pain management, nutrition, psychological and social services support, patient and family education along with comprehensive discharge planning including community support and re-entry. When possible and appropriate, community activities are encouraged to promote the return to, or introduce, activities in the community. A variety of support groups are accessible which include movement disorders, brain tumor and stroke.

As a part of the rehabilitation process, everyone is encouraged to socialize and interact with other rehab persons and their families as part of their recovery process. Most individuals and their families have the opportunity to attend the monthly stroke support group during their rehabilitation stay. The support group provides speakers who address topics designed to educate and support each person and their family. The support group includes not only current patients but individuals and their families from the community who have experienced the effect of a stroke.

Functional intervention includes activities of daily living (ADLs), equipment and environment modifications, neuromuscular re-training, assisted weight bearing, ambulation and use of software and technology. When the person served requires special equipment that is beyond the scope of the team, such as seating or orthotic needs, services are coordinated with external vendors. These vendors will provide services on site or immediately post-discharge. Supportive services for the person served and their families includes but are not limited to; spiritual care, financial counseling, behavioral health intervention, peer group(s) support and comprehensive discharge planning. Follow-up care may be coordinated by the physiatrist in collaboration with the other physicians involved in the ongoing management of the patient’s medical needs.
Medicare, Medicaid and most private insurance carriers are accepted. All private insurances are pre-certified prior to admission. Persons with limited to no healthcare funding are referred to Patient Financial Services to establish a payment plan or be considered for charity care. Patient Financial Services provides to each patient a written letter reviewing their carrier coverage as well as a contact person who can further assist them with insurance or financial questions.

Mission Statement

The Physical Rehabilitation Center at Rush-Copley Medical Center is dedicated to meet the needs of our community, patients, staff and physicians by providing the highest quality healthcare in an efficient, resourceful manner. This is demonstrated through our commitment to quality outcomes and extraordinary care.

Leadership/Staffing

The Physical Rehabilitation Unit leadership team includes the Director of Therapy Services and Therapy Service Manager. A lead therapist and nursing clinical coordinator help to facilitate care for the patients on a daily basis. Additional members of the team include the Admission Coordinator who supports the intake and screening of all new admissions and the Prospective Payment System (PPS) Coordinator who ensures accurate documentation and transfer of information required by regulatory agencies.

The nursing team includes registered nurses and support staff specially trained to support the restoration and rehabilitation of the patient population. The nursing staffing matrix is reviewed by the unit charge nurse every eight hours and adjusted according to patient census and acuity. The Therapy and Nursing matrices are available upon request.

Other core members of the team include Physical, Occupational, and Speech-Language Therapists. In addition, a Recreational Therapist is a key member of the team focused on community reintegration and fostering interests which help to enhance the patient’s sense of well-being and purpose. The Therapy staffing matrix is adjusted daily based upon the volume of new admissions and discharges.

A dedicated social worker/care manager and psychologist are also vital members of the team. The social worker is responsible for collaborating with the patient and family to ensure a smooth transition to the community. This role helps to identify concerns that may be of psychological or socio-economic focus. Our clinical psychologist is available to support patients and families who may need additional mental health support or assistance in developing coping strategies while adjusting to the physical and psychological demands of rehabilitation.
Qualifications of Staff

Educational opportunities are provided in a variety of methods: See Rehabilitation Center Scope of Services for details.

Additional learning needs may be determined through process improvement measures, patient and family feedback and implementation of new treatments. Education is always provided for any new skill, new equipment, or new patient population.

Examples of education related to persons who suffered a stroke may include:
- Pathophysiology of the stroke, areas of impairment
- Comorbidities impact on outcome
- Wound care, skin assessment,
- Bowel/Bladder Management,
- Spasticity Management,
- Swallow and Voice Therapy,
- Pain Management,
- Wheelchair or adaptive equipment selection and safety,
- Community resources and how to access,
- Wellness and participation in physical sports and leisure activities,
- Psychosocial needs
- Sexuality

An environment of continued learning is encouraged among all team members. Staff is encouraged to pursue advanced degrees and certifications in their field and is financially supported by the institution. The number of specialty certifications held by staff, including Certified Rehabilitation Registered Nurses (CRRN) and Certified Stroke Rehabilitation Specialists, can be provided upon request.

Description of Communication/Collaboration/Functional Relationship with Other Departments and Services

The interdisciplinary team that cares for each patient meets for a daily huddle to communicate any pertinent information about the patient and to serve as the formal team coordination of care for the day. Team staffings are held for an in-depth review of the patient’s plan of care on a weekly, or as needed basis. Attendees at the team staffings may include nurses, therapists, psychologist, pharmacist, chaplain, care manager, dietitian, social worker, and medical staff. Results from the staffings are communicated with the person served, family and support systems at least weekly for collaboration as well as review of progress and anticipated length of stay.

The inpatient rehabilitation leadership team communicates to all team members through regularly scheduled department meetings. Other avenues of communication include weekly and daily communication via email as needed. Morning huddles are also used to communicate key safety as well as general information to all members. This method is utilized to ensure all staff members are aware of critical information in a timely manner.
Additional medical specialists for the person served will be consulted by the Physiatrist as needed. All service specialty providers are considered part of the patient care team and are encouraged to participate in the daily staffing huddles and patient conferences. If attendance is not possible, the provider is expected to communicate with the Physiatrist or unit nursing/therapy staff. Contracted services may also be used for patient/family needs such as prosthetics, orthotics, seating modifications, or assistive technology.

When emergent medical care is necessary and is beyond the scope of the rehabilitation unit staff the services are provided using the acute hospital’s Rapid Response Team (RRT). This team can be activated by the unit staff, physicians, patients, or family members.

Persons served that require a higher level of medical care are transferred to the appropriate care level within the Rush-Copley Medical Center. The person served is discharged from the rehab unit with the ability to return, pending bed availability, once medically stable and able to meet the rehab unit admissions criteria.

**Goals of Department/Service**

Our commitment is to continuously improve the health of our community, by identifying needs of our populations with respect to individual cultures. While collaborating with our interdisciplinary team in order to improve the quality of life and well being of our patients we will provide leadership and talent to achieve the vision of making our physical rehabilitation program the best place in which to live, work, grow, heal and enjoy life. Turning disabilities into possibilities is our main goal.

**Plan to Improve Quality of Care**

There is an organizational commitment to improve quality of care through the Shared Governance structure. Please See Rehabilitation Center Scope of Services for details.

**Any Additional Standards of Practice Adopted/Adapted by Department/Service**

We will provide our patients with:

- A healing and supportive environment
- Utilization of alternative therapies to support the patient and families with special needs
- Continuity of care by utilizing a consistent team of caregivers
- Comprehensive and individualized plan of care
- Collaboration with the healthcare providers to optimize care
- Comprehensive approach to pain management
- Hourly rounding to ensure patient needs are met in a proactive manner.
- Emphasis on providing care within an environment that is in alignment with the persons served cultural and spiritual preferences.

Outpatient therapy services, psychological support, medical and surgical care, emergency services are examples of ongoing services that may be provided within this health system.