Organisation of teams

HoRSSe
Home-Based Rehabilitation for Severe Stroke

Core MDT

The core MDT should include:
- Occupational therapist
- Physiotherapist
- Speech and Language Therapist
- Psychologist
- Nurse
- Support worker
- Doctor
- Dietician
- Social care worker
- Admin

Service eligibility criteria

Modified Rankin Score **over 3.**

Referrals not restricted to health professionals, time since stroke or patient's residence.

Focus on:
- Rehabilitation
- Maximising quality of life
- Disability management
- Secondary complication prevention
- Reducing carer burden

Service structure

7 day working.

Holistic assessment completed within **1** week of discharge.

Integrated stroke services* with ESD.

Flexible working.

Working across organisations

Seamless transitions through in-reach into acute teams for:
- Joint home visits
- Discharge planning meetings

Collaboration with:
- Care homes
- Specialist teams
- Social care
- Community matron

Support access to:
- Exercise groups
- Accessible transport
- Voluntary groups*

Communication

Contact should be made with patient or carer/family within **1** working day from discharge.

Communication should be clear, accessible and co-ordinated.

Contact details for a key member should be available.

Audit

Teams should participate in **national audit programmes*** such as SSNAP or SSCA

Other data could include:
- Unmet needs
- 90-day mortality
- Hospital readmission 30 days
- Social care requirements

Research

Teams should:
- Encourage active involvement in research, both patients and staff.
- Share good practice through case studies
- Disseminate and implement research findings within practice.

MDT = Multidisciplinary Team
ESD = Early Supported Discharge
SSNAP = Sentinel Stroke National Audit Programme
SSCA = Scottish Stroke Care Audit

Version 1, 2021

Multidisciplinary interventions

HoRSSe
Home-Based Rehabilitation for Severe Stroke

Skin integrity^ and continence

Carer burden^

Postural support and seating^

Environment^ including adaptation & equipment

Communication^

Cognition^ including apraxia

Sexual activity & relationships

Mood disorders

Activities of daily living including basic self-care tasks

Spasticity and Pain^

Specific interventions and MDT skills

The MDT should have the knowledge and expertise to offer the following specialist assessments and interventions.

Mobility transfers, including vehicle access

Upper limb^ impairments

End of life care

Financial guidance

Medication management

Fatigue and sleep hygiene

Goal setting

Patients (and carers) should be supported to engage in **joint** goal setting with the MDT.

Goals should be:

- Meaningful to the patient
- Aspirational
- Realistic
- Based on holistic MDT assessments

Outcome measures

Use validated outcome measures which are sensitive to change for both impairment and global function, e.g. quality of life.

Ensure measures are accessible for those with communication difficulties.

Recorded within **2 weeks** of discharge from the hospital and reviewed at agreed timepoints.

Education

- The team should be involved in raising the awareness of meaningful outcomes amongst commissioners and other healthcare professionals.
- Education should include self-management and reducing secondary complications amongst patients, families and carers (especially those in care homes).

* Areas which have been identified in the long-term plan https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

^ Areas which have been identified by the James Lind Alliance and Stroke Association as priorities for further investment in research priorities_in_stroke_rehabilitation_and_lon-term_care.pdf

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