# Organisation of teams

This infographic represents the core components of community rehabilitation for survivors of stroke with severe disability. These have been agreed by expert consensus, including those with lived experiences. This is a lay summary, produced in collaboration with the Nottingham Stroke Research Partnership Group. Full details can be found at: https://bit.ly/StrokeHoRSSe


**Core team**

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


**Service eligibility criteria**

Referrals not restricted to health professionals, time since stroke, where patient lives or their level of disability.

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


**Service structure**

**7** day working.

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

**Integrated** stroke services

Flexible working.


**Working across organisations**

Teams communicate with acute colleagues to support:
- 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 team member should be available.


**Audit**

Teams should participate in **national audit programmes** such as Sentinel Stroke National Audit Programme or Scottish Stroke Care Audit


**Research**

Teams should:
- Encourage involvement in research
- Share examples of good practice
- Share and use research in practice

# Multidisciplinary interventions

## Specific interventions and team skills

The team should have the expertise to offer the following specialist assessments and treatment.

- Skin and continence
- Carer burden
- Postural support and seating
- Environment including adaptation & equipment
- Communication
- Cognition
- Sexual activity & relationships
- Mood disorders
- Activities of daily living
- Tight muscles and Pain
- Mobility transfers, including vehicle access
- Upper limb problems
- Financial guidance
- End of life care
- Medication management
- Fatigue and sleep

## Goal setting

**Goal setting**

Patients (and carers) should be supported to set goals jointly with the team.

Goals should be:

- Meaningful to the patient
- Aspirational
- Realistic
- Based on a full assessment

## Outcome measures

**Outcome measures**

Use recognised measures to assess an individual's progress.

Ensure measures are accessible for those with communication difficulties.

Recorded within **2 weeks** of discharge from the hospital and reviewed regularly.

## Education

**Education**

- The team should be involved in educating others about the rehabilitation of stroke survivors with severe disability.
- This should include, stroke survivors, their family and carers as well as commissioners, care home staff and other health care professionals.