Enhancement of Discharge Planning Process for Stroke Patients from Patients’ & Carers’ Perspectives through a Clinical Audit Review

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Introduction
Stroke rehabilitation is one of the core services in the Physiotherapy Department of Tuen Mun Hospital. Appropriate discharge planning can respond to the particular needs of patients and their carers and facilitate patients’ community re-integration. Therefore, understanding the demographic features of our stroke patients and identify areas of patients’ and carers’ needs are the first step in service planning process.

Objectives
To study the demographic features and rehabilitation outcomes of stroke patients and identify areas to enhance discharge planning process.

Methodology
A retrospective clinical audit was conducted for patients discharged from Rehabilitation Stroke Unit (RSU) of Tuen Mun Hospital between December 2013 and December 2014. Mobility status was assessed by Modified Functional Ambulation Category (MFAC) and Elderly Mobility Scale (EMS). Outcome measures included length of stay (LOS), active or maintenance training types in RSU, discharge destination, MFAC and EMS at the days of admission to RSU and discharge as well as post-discharge community rehabilitation be offered.

Result
307 patients (130 males (42.3%) and 177 females (57.7%), mean age of 71.8±12.9 years old) discharged from RSU were recruited for analysis. The mean LOS was 20.3±16.2 days. 276 patients (90%) were on active rehabilitation and 31 patients
(10%) received maintenance exercise. The mobility status was improved in stroke patients as shown in MFAC and EMS. The proportion of walkers (MFAC 3-7) increased from 60.8% (n=187) to 74.3% (n=228) whereas EMS improved from 6.2±5.6 on admission to 9.0±6.9 upon discharge. Concerning discharge destination, 221 patients (72%) were discharged with home care and 86 patients (28%) to institutional care. Majority of post-discharge stroke patients (n=203, 67.9%) required community rehabilitation. 97 patients (32.4%) received rehabilitation in the Geriatric Day Hospital. 32 patients (10.7%) were trained in the Community Rehabilitation Day Centre and 14 patients (4.7%) attended out-patient training in the Physiotherapy Department. 43 patients (14.4%) received out-reach rehabilitation by physiotherapists under Integrated Care- Model and 17 patients (5.7%) by Community Geriatrics Assessment Team. Conclusion Our results showed that majority of patients could ambulate with different levels of assistance upon discharge. Fall prevention education is important to patients and their carers so that patients could ambulate safely in community. Besides, as majority of patients discharged with home care, carers should be involved early and actively in the rehabilitation process. Furthermore, timely and easily accessible community rehabilitation is vital as most stroke patients need to continue rehabilitation after hospital discharge. Through the clinical audit review, discharge planning could be enhanced and stroke patients could be facilitated in community re-integration.