Box One: Transitions of Care Checklist

This checklist is provided as a guide to help ensure evidence- and consensus- based recommendations are applied to develop a collaborative action plan for each person as they transition to different settings and phases of care.

This checklist is applicable to primary care, the emergency department, acute care, rehabilitation settings, complex care/transitional bed settings, long-term care and community settings. The transitions of care checklist should enable the health care team member to work with the person with stroke and their family to have meaningful dialogues regarding necessary information and services to ensure positive and successful care transitions.

Support for people with stroke, families and caregivers may include:

- ☐ Shared decision making/participation regarding transitions across stages of care.
- ☐ Accurate and up to date information about the next care setting, what can be expected, and how to prepare.
- ☐ Access to restorative care and active rehabilitation to improve and/or maintain function based on the individualized care plan.
- ☐ Advance care planning, palliative care and end-of-life care as applicable.
- ☐ Counseling, preparation and ongoing assessment for adjustment to change of: living setting; abilities; social roles and relationships; participation, leisure and vocational activities; and, home environment. Also consider impact on family (e.g., spouse or partner, children); potential resource issues (financial), and independence (e.g., driving).
- ☐ Written discharge instructions and recommendations should be included in collaborative action plans, and include goals and follow-up care.
- ☐ Access to a designated contact person in the hospital or community for continuity of care and questions.
- ☐ Access to and advice from health and social service organizations appropriate to needs and stage of transition and recovery.
- ☐ Links to and information about local community agencies such as stroke groups, peer visiting programs, meal provider agencies, and other services and agencies.
- ☐ Where possible, access to peer supports who have had a stroke and experienced transitions following the acute phase.
- ☐ All communications should be available in aphasia-friendly formats as required and appropriate to the health literacy of people with stroke, their families and caregivers.