Stroke coordinator's work guide

*During the hospitalisation period, the patient or their relative(s) will be contacted by a **stroke coordinator** once the care team determines that the coordinator service is necessary based on the patient's condition.*

The role of the stroke coordinator is to support the patient and their family members in planning the post-hospitalisation period, which includes supporting and coordinating the implementation of the treatment plan and identifying and planning appropriate support and additional services.

Eligibility criteria

The service is provided to a patient **who has had an ischaemic stroke and who may need additional services (health, social, and community services) within one year of having a stroke.** The need is determined by a nurse in the stroke unit or the patient's attending physician during the consultation prior to discharge from the stroke unit. Patients will usually need additional services in the first three months after becoming ill. To provide the service, the patient's consent is registered in a free text field in the patient's medical record, with the decision also reflected in their medical history.

The coordinator service is available to patients who have at least one of the following conditions and/or circumstances that may complicate their recovery:

1) several concomitant diseases;
2) weak support network;
3) memory and mood problems;
4) a history of poor adherence to treatment.

Contact with the patient or their family members

Information about the patient in need of the service reaches the coordinator through the other members of the care team and is resolved through a working arrangement.

Once the assessment by the stroke nurse or attending physician has shown the patient's suitability and need for the service, the initial contact of the coordinator with the patient and/or their family member will take place during the period of hospitalisation.

- At the first meeting, the coordinator provides information on the content of the service and the coordinator's role and confirms the patient's or family member's consent to the use of the service and (where applicable) to the processing of health data.

- If the patient or the patient's family member is interested in the service, the patient will be admitted to the service, i.e. the statistical code '9425' is entered on the patient's medical invoice. The code is used to analyse the volume of services provided by the coordinator.

When the patient is ready to leave the stroke unit, the coordinator will help to plan additional services or transitioning to home:

- If possible, an appointment with a stroke nurse is booked for the patient as part of secondary prevention even before they leave the stroke unit, and the coordinator is informed about this by the treatment team. The coordinator checks that **a stroke nurse appointment has been booked for the patient and that the patient or their family member is aware of the time of the appointment.**
    - If the patient is referred for additional inpatient treatment, **the coordinator will book an appointment with a stroke nurse for the patient at the end of active inpatient treatment** in accordance with the organisational agreements of the treatment team.
- **If necessary, the coordinator informs the social worker of the local government to arrange a home visit before the patient is discharged.** The need may arise from deficiencies in the home environment (such as access to food), lack of a support network, or the requirement for assistive devices, as identified during the initial interview.
- When planning additional services, the coordinator helps the patient find appointment times at institutions close to home and, if necessary, consults with the local government regarding transportation assistance.
- **The coordinator will inform the patient's family physician by phone once the active treatment phase has concluded** and, if possible, **will schedule a follow-up appointment with the family physician**, typically within 30 days of the patient's return home from the hospital, **as per the standard**.

If the patient is discharged home, the coordinator will contact the patient or their relative within 2 weeks of discharge at the latest.

- If the patient moves to a care facility (not home) at the end of active treatment, the coordinator will report back to the care team dealing with the patient in the care facility on the activities coordinated so far.

The coordinator will remain the primary contact for the patient in assessing post-hospital needs, coordinating services and support, and providing motivational support **for the duration of the entire treatment course** (365 days). If the information needs of the patient or their family members exceed the coordinator's expertise or scope of responsibilities, the coordinator will refer the inquiry to other members of the treatment team or relevant parties involved with the patient and/or their family. If referral is not possible or necessary, the

coordinator will provide the patient or their family member with the contact information.

- Upon discharge from the hospital, further communication is agreed with the patient or their family member, including the frequency and method of contact.

Activities of the coordinator

The service provided by the coordinator includes the following activities:

1) assessment of needs;
2) developing a personalised treatment plan;
3) supporting and monitoring the implementation of the treatment plan;
4) coordination of services (including health, social, and community services);
5) teaching coping skills;
6) providing motivational support and advice.

The stroke coordinator is obliged to handle the patient's personal and sensitive health data in compliance with the established legal protocols. The stroke coordinator handles data in accordance with the healthcare provider's internal policies and established data protection regulations.