

Patient & Family Education and Support of Stroke and Heart Failure Survivors

HCR•ManorCare

Home Safety Education:

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Stroke Support Group:

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Heart Failure Education:

Laura Wilson

Business Development – East Side

Home Safety Education

Ginny Krisanda, Director of Rehab

Rehab's patient/family involvement in
Discharge Planning from the skilled
nursing facility

Successful Discharge Dependent Upon...

- Patient is able to safely perform necessary functional activities
- Safe environment
- Patient and Family Awareness

Initial Assessment Includes:

- Previous level of function
- Previous living environment
- This information helps the therapist develop the plan of care

Home Floor Plan Questionnaire

- Type of home
- Entry-ways
- Stairs/elevators
- Bathroom arrangement
- Bedroom –including type of bed
- Phones-emergency alert systems

Why Assess Environment?

- Most accidents do occur in the home
- Accidents/falls can lead to re-hospitalization/Nursing home placement or even death!
- Simple, common sense steps can prevent such catastrophes

Home Assessment

- Done by PT or OT
- Patient must be present
- Family members should be present
- Done early on in discharge planning to allow for necessary modifications to home

Discharge Hazards

- Intrinsic-specific to the patient
example: low vision
- Extrinsic-environmental
example: poor lighting

Discharge Hazards

The home assessment identifies extrinsic hazards that put a patient with specific intrinsic problems at risk.

Stairs

- Rails on both sides-extend complete length of stairway
- Well-lit
- Stairs visible to client

Clutter

- Pathways are clear
- Pull up throw rugs
- Watch for changes in floor surfaces

Bathroom

- Grab bars
- Sliding bench seat facilitates tub transfers
- Bath bench in shower or tub
- Mats or non-skid strips on slippery surfaces

Kitchen

- Frequently used items accessible
- Don't store heavy objects too low or too high
- Flammable objects away from stove
- Set water heater to 120 degrees

Furniture

- In good repair
- Chairs sturdy with arms
- Correct height

Lighting

- Natural light best
- Avoid glare
- Use night lights/rocker switches

Entrance/Exit

- Pathways clear
- Steps and walkways in good repair
- Inclines not too steep
- Effective lighting
- Door width adequate
- Emergency exit plan

Maintenance/Prevention

- Patient knowledgeable about safety and exit plan
- Home program in place to address intrinsic factors

Strength-Balance-Flexibility

Medication Schedule

Healthy Diet

Safety Websites

- www.hcr-manorcare.com To to "resources" and then "in-home safety tips"
- www.nihseniorhealth.gov
- www.aota.org
- www.homesafetycouncil.org check out the home safety video!
- www.aarp.com

Patient/Family Support Group

Barbara Schirhart, Director Social Services
ManorCare – North Olmsted

The Dream is Gone

LIVING WITH A HEART
ATTACK OR CVA

Realization of changes

➤ Age and Financial position

Life Goals

Life Style

Realization of changes

➤ Physical changes

Responsibility changes

Relationship changes

Spouse

Children

Personality Changes

Dependency on others

Realization of changes

➤ Financial

Income

Savings

Insurance

Medicare

Medicaid

Forced retirement

Home adequate for needs

Floating with Indecisiveness

➤ The Survivor

Therapy

Medical and Professional support

Will they still be “who they were?”

Depression

Floating with Indecisiveness

➤ The Spouse and Family

Who gives support to them?

May have to get a job to supplement income

Health, sleep, and depression

Will they be able to provide for their needs?

Joining a Support Group

- Benefits
- ManorCare-North Olmsted Meetings
- Resources for other existing support groups

Heat Failure Education

Laura Wilson, Business Development –
East Side
ManorCare-Willoughby

Program Goals

- To provide area hospitals with a post-acute “partner” to assist in managing their length of stay, reinforce patient education started in the hospital and return patient to hospital outpatient services
- To decrease the frequency of emergency room visits and hospital inpatient admissions for patients with heart failure

Criteria for Participation

- Any patient with a primary or secondary diagnosis of Heart Failure
- Have had an exacerbation of the condition
- Have community discharge goals
- Have been participating in a hospital-based Heart Failure program.

Educational Services:

- Staff with specialized training in heart failure
- Physical, Occupational and Speech Therapies as required
- Education (disease process, medication, exercise, nutrition, community resources) for patients and caregivers, in individual and group settings

Educational Services (cont'd):

- Medical Nutrition Therapy
- Evaluation of home bathroom scales and replacement as needed
- Smoking cessation
- Services after discharge including referrals to participating home health agencies and hospital-based outpatient clinic

Discharge Goals:

Upon discharge, patients and / or their caregivers will be able to:

- *Effectively manage self-care to the highest practical level*
- *Recognize signs and symptoms of heart failure exacerbations and response needed*

Discharge Goals (con't):

- Appropriately manage medication regimen and recognize side effects
- Understand physical limitations and energy conservation practices
- Properly express good nutrition patterns
- Report lessened edema, clear lung sounds and stabilized weight record upon clinical evaluation

Community Resources

- www.heartfailure.org
- www.hfsa.org
- www.successwithchf.com
- www.heartinfo.org