6-13-2025

A Clinical Practice Guideline for Enhanced Rehabilitation Assessment in Poststroke Patients

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Walden University
2025

Executive Summary: Clinical Practice Guideline

A Clinical Practice Guideline for Enhanced Rehabilitation Assessment in Poststroke Patients

by

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Executive Summary Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

July 2025

Summary

This doctoral project aimed to develop clinical practice guidelines (CPG) to strengthen the assessment of poststroke patients for rehabilitation. The project sought to adopt an evidence-based approach to develop standardized recommendations that can help in the timely and appropriate rehabilitation of stroke survivors, thereby reducing the risk of long-term disability and readmissions. Stroke is a significant cause of disability and poor functional recovery, increased healthcare costs, and lower quality of life for patients occur because of poor rehabilitation assessment. While rehabilitation protocols already exist, discrepancies in patient evaluations result in intervention delays and ineffective uptake of rehabilitation programs, limiting the chances of recovery for patients. Standardizing rehabilitation assessment criteria can help in timely and targeted interventions that can maximize patient outcomes while at the same time promoting efficient use of healthcare resources.

The CPG contains evidence-based criteria for assessment of poststroke rehabilitation to ensure that all eligible patients receive timely and appropriate rehabilitation interventions. This project utilized the AGREE II instrument to evaluate the quality and rigor of the guideline and ascertain that it met established standards of reliability and applicability. Overall, experts strongly agreed that the guideline was valid and applicable, particularly in terms of its scope, involvement of stakeholders, and recommendations. Nevertheless, methodology transparency and implementation strategies were minor concerns. The CPG has significant implications for nursing practice, including standardization of poststroke rehabilitation assessment, better

collaboration between the interdisciplinary team, timely referral for rehabilitation and reduction in hospital readmissions, healthcare cost savings, and better patient outcomes.

Background

Stroke is considered one of the leading sources of long-term disability globally. It is associated with high readmission rates and poor rehabilitation results (Tay, 2021). The ineffective rehabilitation programs result from a lack of consistent and standardized assessment guidelines that ensure proper follow-up and consistent monitoring of patients' improvement and adjustment to interventions. Ineffective assessment arises from the restricted integration of multidisciplinary perspectives, delayed evaluation, and lack of standardized protocols (Deepradit et al., 2023; Ju et al., 2022). Conversely, this has led to delayed, inadequate, or intermittent assessment processes, poor patient outcomes, disability risk, morbidity, and hospital readmission (Hsieh et al., 2019; Ju et al., 2022). Research has indicated the readmission rate can reach 25% within 90 days post-discharge (Hsieh et al., 2019). The practice problem was the lack of a standardized workflow for the interdisciplinary team to reassess stroke patients' progress and subsequent needs after discharge from the acute setting. The project's purpose was to create an evidence-based CPG to direct the workflow of the interdisciplinary team.

A literature search was performed using major medical and academic databases, including PubMed, CINAHL, EBSCOhost, and Google Scholar, to identify scholarly articles related to poststroke rehabilitation and its assessment methods. The keywords used were *stroke rehabilitation*, *poststroke assessment, rehabilitation follow-up*, and *clinical practice guidelines for stroke*. Boolean operators and filters were applied to achieve greater precision in the search, which targeted studies published within the past

decade. The initial search retrieved a total of 472 articles from the selected databases. These were screened for relevance based on titles and abstracts to give 135 articles. A second-stage screening was conducted using a set of inclusion criteria, including methodological rigor, study sample size, and the article's relevance to the CPG objectives. Articles were excluded if they had poor study designs, were not peer-reviewed, or did not focus on stroke rehabilitation. Of these, 27 were finally selected after a detailed review to underpin the development of the CPG.

The structured review of the literature backs up that early, multidisciplinary, and continuous rehabilitation assessments increase the chances of improving the stroke outcome (see Ju et al., 2022; Langhorne et al., 2018). Further, early rehabilitation (occurring between 24 to 48 hours) is related to better functional independence and fewer complications (Bernhardt et al., 2019; Langhorne et al., 2018). Moreover, multidisciplinary assessments (physical, cognitive, emotional, etc.) enhance long-term outcomes (Teasell et al., 2020). Routine follow-up and re-assessment at scheduled intervals prevent functional regressing and readmissions (Hoffmann et al., 2020; Morris et al., 2020). Additionally, evidence has suggested that increasing the frequency of therapy improves the patients' results significantly and that including psychological therapy demonstrated distinct improvement in mood and active participation in rehabilitative procedures (Langhorne et al., 2020; Mitchell et al., 2022). Moreover, community-based rehabilitation also promotes the autonomy and self-management of the patient (Langhorne et al., 2021). Furthermore, according to the Stroke Foundation (2021), survivors should continue rehabilitation and periodical assessment at key recovery

intervals during the chronic phase to address evolving needs, prevent secondary complications, improve physiological endurance, and maintain functional gains.

This evidence is strong as it contains Level I evidence comprised of six articles in the form of meta-analyses and systematic reviews that ensure that the evidence presented consolidates results across diverse studies and that the outcomes reflect the broader scientific evidence. In addition, Level II evidence included 10 randomized controlled trials (RCTs) informing intensive therapy and frequent and interval assessment (see Juckett et al., 2020; Langhorne et al., 2020). This makes the findings credible as RCTs are recognized for their rigorous research design, efficacy in establishing causal relationships, and bias management. Level III evidence included information from nine cohorts and quasi-experimental studies, further enhancing the importance of continuous surveillance and reevaluation (see Ju et al., 2022). Furthermore, two qualitative studies—Level IV and V evidence—contributed to contextualizing and patient-centered viewpoints of the obstacles to rehabilitation adherence and emotional recovery following a stroke. Thus, the CPG integrates the best available evidence, and its implementation can close the practice gap, decrease hospital readmissions, and improve patient functional outcomes.

Consequently, the lack of standardized and consistent guidelines in the stroke rehabilitation assessment across facilities leads to delayed therapy initiation, inconsistent monitoring, and missing follow-up care (Deepradit et al., 2023; Ju et al., 2022). Moreover, studies have pointed out that many stroke survivors fail to adhere to their discharge and rehabilitation plans, leading to preventable depletions in function (Morris et al., 2020) and considering the occurrence of these gaps. The proposed CPG attempts to

establish an evidence-based, structured assessment framework to provide stroke patients with timely, consistent, individualized, and multidisciplinary rehabilitation interventions.

This doctoral project aimed to design and validate a structured, evidence-based CPG that improves poststroke rehabilitation assessment, follow-up strategies, and interdiscipline coordination. This CPG aims to

- standardize assessment criteria for poststroke rehabilitation eligibility.
- ensure timely rehabilitation referrals to improve functional recovery.
- enhance follow-up care by implementing structured reassessments at 30-, 60-, and 90 days post-discharge.
- integrate multidisciplinary approaches to address the physical, cognitive, and emotional needs of stroke survivors.

Clinical Practice Guideline Development

A CPG is a structured framework that guides care providers and patients to make informed decisions about appropriate healthcare for various clinical conditions. A CPG is based on the best available evidence and is created through rigorous methodological processes, often involving expert consensus, reviewing current literature, and considering patient values and clinical judgment. For this project, the CPG focused on assessing poststroke patients for rehabilitation. The objective for the development of this CPG was to provide clear, structured guidance to healthcare providers in identifying patients who could benefit from early rehabilitation interventions. Additionally, it can support timely and appropriate referrals, ensuring that all eligible stroke survivors receive consistent, high-quality care. The CPG, in Appendix A and B, was developed based on an extensive literature review to ensure it is grounded in current, high-quality evidence.

After its development, an expert panel comprising four professionals with clinical and academic experience in stroke care and rehabilitation was identified. This panel evaluated the CPG's quality and rigor using the AGREE II (Appraisal of Guidelines for Research and Evaluation II) tool. The experts were determined by their expertise in previous CPG development, stroke rehabilitation, and clinical experience. The panel included a family nurse practitioner and clinic owner specializing in stroke management and poststroke recovery. The second expert was a rehabilitation nurse practitioner (DNP, CRRN) who had patient-centered rehabilitation planning experience. The third expert was a physical therapist (NCS) with neurological rehabilitation and mobility expertise. The last expert was a board-certified pharmacist who previously managed an inpatient long-term rehabilitation facility with an emphasis on stroke compliance and medication management, specializing in developing clinical guidelines and implementation science. A formal request was made to these experts, who were invited based on their qualifications, professional experience, and prior involvement in stroke rehabilitation and guideline assessment. Each panelist had at least 5 years' experience in their field and was competent in evidence-based clinical practice and quality improvement initiatives.

The panel assessed the CPG using the AGREE II validation tool. The AGREE II tool is widely recognized for the appraisal of guidelines for research and evaluation and for assessing the quality and methodological rigor of clinical guidelines (Lilova et al., 2023). AGREE II is made up of 23 items that are divided into six domains: scope and purpose, stakeholder involvement, rigor of development, clarity of presentation, applicability, and editorial independence (Bargeri et al., 2021). Each panel member was provided with the AGREE II tool checklist and independently assessed the guideline

across the six domains on a 7-point Likert scale from 1 (*strongly disagree*) to 7 (*strongly agree*). The data collection occurred over 2 weeks, during which each panelist completed the standardized scoring. Once all appraisals were submitted, the results were analyzed by calculating domain scores according to AGREE II protocols, scaling each as a percentage of the maximum possible score using the formula:

$$\text{Domain Score} = \frac{\text{Obtained Score} - \text{Minimum Score}}{\text{Maximum Score} - \text{Minimum Score}} \times 100$$

Where:

- **Obtained Score** = Sum of ratings in that domain
- **Minimum Score** = $1\times$ (number of items in the domain)
- **Maximum Score** = $7\times$ (number of items in the domain)

Results

The CPG in Appendix A underwent a structured evaluation by an expert panel using the AGREE II instrument. The results were calculated per domain for each expert. Table 1 describes the outcomes for Expert 1.

Table 1

Expert 1-- AGREE II Review Results

Domain	Ratings	Obtained score	Percentage score
Scope and purpose	6, 5, 7	18	83.33%
Stakeholder involvement	6, 5, 7	18	83.33%
Rigor of development	6, 5, 7, 6, 5, 7, 6, 5	47	81.25%
Clarity of presentation	7, 6, 5	18	83.33%
Applicability	6, 5, 7, 6	24	83.33%
Editorial independence	5, 7	12	83.33%

Table 2 depicts the scores for Expert 2.

Table 2

Expert 2-- AGREE II Review Results

Domain	Ratings	Obtained score	Percentage score
Scope and purpose	7, 6, 5	18	83.33%
Stakeholder involvement	7, 6, 5	18	83.33%
Rigor of development	7, 6, 5, 7, 6, 5, 7, 6	49	80.95%
Clarity of presentation	7, 6, 5	18	83.33%
Applicability	6, 5, 7, 6	24	83.33%
Editorial independence	5, 7	12	83.33%

Table 3 shows the scores for Expert 3.

Table 3

Expert 3 -- AGREE II Review Results

Domain	Ratings	Obtained score	Percentage score
Scope and purpose	5, 7, 6	18	83.33%
Stakeholder involvement	5, 7, 6	18	83.33%
Rigor of development	5, 7, 6, 5, 7, 6, 5, 7	48	79.17%
Clarity of presentation	5, 7, 6	18	83.33%
Applicability	5, 7, 6, 5	23	79.17%
Editorial independence	7, 5	12	83.33%

Table 4 depicts the outcomes for Expert 4.

Table 4

Expert 4-- AGREE II Review Results

Domain	Ratings	Obtained score	Percentage score
Scope and purpose	6, 5, 7	18	83.33%
Stakeholder involvement	6, 5, 7	18	83.33%
Rigor of development	6, 5, 7, 6, 5, 7, 6, 5	47	81.25%
Clarity of presentation	7, 6, 5	18	83.33%
Applicability	6, 7, 5, 6	24	83.33%
Editorial independence	7, 6	13	87.50%

Table 5 compiles the score for the four experts.

Table 5

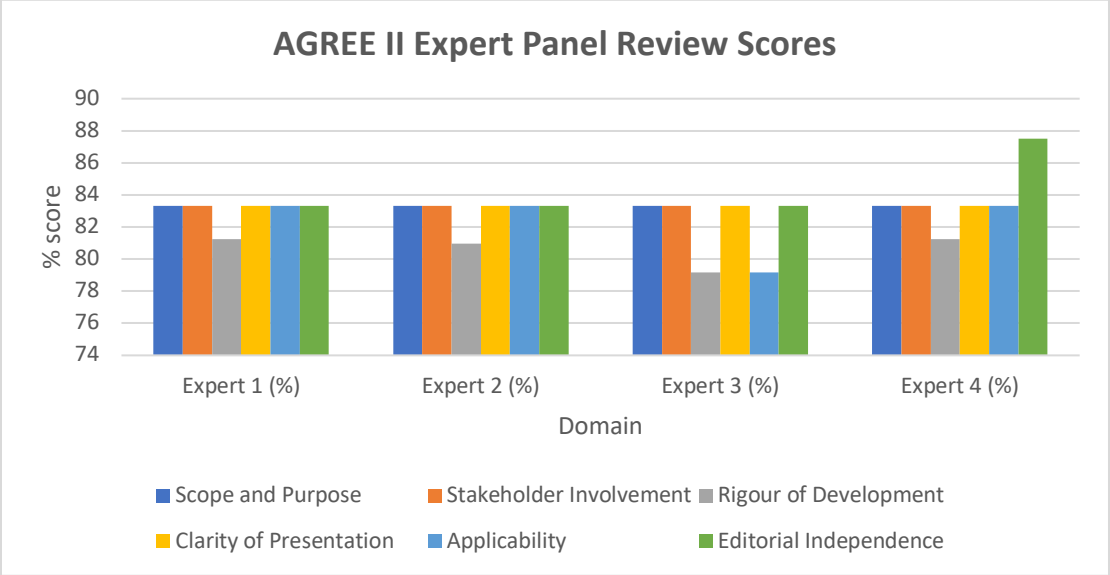
Final Summary of Expert Scores

Domain	Expert 1	Expert 2	Expert 3	Expert 4
Scope and purpose	83.33%	83.33%	83.33%	83.33%
Stakeholder involvement	83.33%	83.33%	83.33%	83.33%
Rigor of development	81.25%	80.95%	79.17%	81.25%
Clarity of presentation	83.33%	83.33%	83.33%	83.33%
Applicability	83.33%	83.33%	79.17%	83.33%
Editorial independence	83.33%	83.33%	83.33%	87.50%

Figure 1 represents a graph that illustrates the AGREE II expert panel review scores for the CPG across six domains. All domain scores exceed the 70% baseline, indicating substantial agreement on the guideline's validity and potential for implementation.

Figure 1

AGREE II Expert Panel Review Scores: Evaluation of Clinical Practice Guideline



Overall, the AGREE II expert panel review scores are strong, with all domain scores greater than 70%, which is the baseline. The highest-rated domains were scope and purpose (83.33%), which demonstrated that the CPG has well-defined objectives and target population, and stakeholder involvement (83.33%), which shows that relevant perspectives were considered in developing the guideline. Secondly, clarity of presentation (83.33%) received consistently high ratings, ensuring that the recommendations were unambiguous. Editorial independence achieved the highest individual score of 87.50%, which gives confidence about the integrity of the guideline and assurance of noncompromise by external influences. The rigor of development (79.17%–81.25%) was slightly lower, with the experts recommending minor improvements in terms of methodology transparency to enhance the CPG's credibility. Furthermore, applicability (79.17%–83.33%) was rated highly, yet some experts

emphasized the need for implementation tools to induce real-world adoption. While these areas for improvement exist, the consistently high ratings indicate that the CPG meets established quality standards, is ready for clinical implementation, and has a strong potential to improve poststroke rehabilitation practices.

The evidence base was judged to be strong and particularly so in supporting early poststroke rehabilitation assessment and structured follow up strategies. A few experts suggested more detailed definitions of rehabilitation intensity threshold and staff training modules. The methodological issues were not significant, but minor improvements were suggested to allow better usability of the guidelines.

This CPG has the potential to greatly improve the organization's poststroke care delivery. The guideline offers a systematic technique of assessing rehabilitation requirements so that all patients who are eligible receive the appropriate rehabilitation referral in a timely manner. Conversely, the CPG could decrease hospital readmissions as rehabilitation interventions provided early and structurally. It could also promote better interdisciplinary teamwork between neurologists, nurses, and rehabilitation specialists. It also ensures better resource allocation as structured assessment process can eliminate unnecessary delays, therapy optimization, and lower costs associated with readmissions, ensuring optimal use of therapy resources. The CPG can also result in better patient outcomes with better functional recovery, leading to better quality of life. From a wider healthcare perspective, the implementation of this guideline helps in value-based care models, which are patient centric and focus on minimizing costs and improving patient outcomes. Organizations that use structured rehabilitation assessments in routine practice have improved performance on quality metrics associated with poststroke recovery.

Although the CPG showed strong alignment with evidence-based practice, the CPG was limited by several factors during the review and the outcomes. The first is that the expert panel consisted only of four experts. While the team was multidisciplinary, the limited number of the experts may not be able to comprehensively capture the viewpoints of all the viable end-users. Secondly, the AGREE II review process did not include direct patient or caregiver input. As a result, formalizing the guideline's applicability in the real world from the patient or caregiver perspective was not performed. Moreover, some stakeholders also mentioned the challenge of feasibility, especially in situations where the rehabilitation resources or staffing are constrained. However, these limitations indicate that the guideline should continue to be evaluated and updated as implemented.

This project has potential implications that extend beyond the implementation site. Stroke is a major cause of individual disability worldwide, and access to rehabilitation remains unequal. This CPG has the potential to aid the development of rehabilitation practices using standardized assessment criteria within varied healthcare settings, especially within the settings of inconsistent poststroke care protocols. Moreover, the structured way of practice in multidisciplinary assessment and follow-up is in compliance with national and international stroke recovery guidelines, allowing it to be applied in diverse healthcare settings. Structured rehabilitation assessment implementation achieved from a public health perspective can assist in the reduction of disability rates and promote permanent functional independence for stroke survivors, improving the quality of life for stroke patients. In addition, by having all stroke patients, despite their socioeconomic position, receive evidence-based rehabilitation assessment

and targeted rehabilitation services, the CPG can ensure healthcare equity whilst eliminating disparities in care outcomes.

Conclusions

This CPG is expected to improve poststroke rehabilitation by providing the organization with a standardized rehabilitation assessment criterion. The CPG can ensure that stroke survivors receive consistent, relevant, and timely rehabilitation interventions, thus reducing hospital readmission and promoting faster recovery. Moreover, the CPG can promote effective collaboration among healthcare teams involved in stroke care, leading to holistic care and improved patient outcomes. Furthermore, embedded structured reassessments post discharge can optimize patient long-term outcomes.

Additional recommendations to build upon the strengths of this guideline are to further expand stakeholder engagement by including patient and caregiver perspectives to make the guideline more applicable in the real world. Implementation tools such as decision-making flow charts, clinical checklists, and training modules can help in the adoption of the CPG by the health care providers. Feasibility, potential barriers and refinement of the CPG can be assessed through pilot studies conducted within the organization. In addition, electronic decision support tools and telehealth-based rehabilitation follow up would improve access and continuity of care.

This guideline has significant implications for nursing practice and reaffirms the nurse's important role in poststroke recovery. Nurses can evaluate patient triage, lobby to initiate early rehabilitation interventions, and disseminate information regarding recovery expectations to patients by using a standardized assessment process. The CPG also supports nursing-led interdisciplinary collaboration across rehabilitation teams so that

rehabilitation teams can work together to provide patient-centered care. The guideline goes beyond the organization in encouraging positive social change by addressing disparities in poststroke rehabilitation access. Standardized assessment criteria eliminate variability in care delivery, and all stroke survivors from all races, socioeconomic classes, and from all geographic locations have the same opportunity for rehabilitation. This initiative supports principles of diversity, equity, and inclusion (DEI) in that historically underserved populations have structured pathways to poststroke recovery and decrease healthcare disparities.

A multifold approach to assessing the effectiveness of the guideline will be a pre- and post-implementation audit comparing patient rehabilitation referral rates, functional outcomes, and hospital readmission rates. Nursing and provider feedback surveys will assess utility and satisfaction with the guideline. Standardized rehabilitation scales will be used to track the patient outcome at regular intervals over time, and data analysis will assess compliance with the guideline recommendations and the areas for continuous improvement. The organization can use these evaluation methods to maintain quality improvements in poststroke rehabilitation assessment and refine the CPG based on real-world applications. Ultimately, this initiative has the potential to enhance nursing practice, enhance patient outcomes, and improve healthcare equity in poststroke recovery.

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Appendix A: Clinical Practice Guideline (CPG) for Effective Assessment of Stroke Survivors for Rehabilitation

This clinical practice guideline outlines a standardized approach to evaluating stroke survivors' rehabilitation needs to promote timely interventions. This CPG aims to reduce readmission rates and complications, comply with rehabilitation programs, and enhance patient recovery outcomes.

Stages of Rehabilitation

Initial Assessment

- **Personnel responsible**: Licensed healthcare provider: a physician or specialized nurse.
- **Timing**: Initiate within 24–48 hours post-stroke, contingent on patient stability.
- **Assessment Criteria**: Monitor vital signs (e.g., blood pressure, heart rate, oxygen levels), consciousness levels, and absence of complicating conditions that could interfere with safe mobilization.
- **Frequency of Reassessment**: Every 12 hours during the initial 48 hours post-stabilization.
- **Documentation**: Record all findings in the patient's medical chart. Use these data points to determine safe rehabilitation initiation.

Comprehensive Multidisciplinary Team Evaluation

- Conduct a comprehensive assessment of motor, cognitive, speech, and functional abilities. Identifying which stroke type and deficits are present during assessment is vitally important. Most discharge planning starts on admission.

- **Team Composition**: Physical therapists, occupational therapists, speech therapists, neuropsychologists, and social workers.
- **Initial Evaluation Timing**: Conduct within 48 hours of stabilization.
- **Assessment Tools**: Utilize the *Functional Independence Measure (FIM)*, *Modified Rankin Scale (mRS)*, and *Montreal Cognitive Assessment (MoCA)* to assess motor, cognitive, and emotional status.
- Develop individualized rehabilitation plan based on assessment results.
- **Follow-Up Frequency**: Weekly interdisciplinary team meetings to review and adjust the care plan based on progress.
- **Documentation**: Document all individual assessments and rehabilitation goals, then integrate them into a unified care plan.

Cognitive and Psychological Support Screening

- **Responsible Personnel**: Neuropsychologist or trained provider.
- **Assessment Timing**: Initial screening within one week of stabilization.
- **Screening Tools**: Use *MoCA* for cognitive assessment and *Patient Health Questionnaire-9 (PHQ-9)* for depressive symptoms.
- **Frequency of Follow-Up**: Monthly cognitive and psychological reassessment.

Referral Process: Refer patients for cognitive-behavioral therapy (CBT) or other interventions within 24 hours if mental health needs are identified.

Documentation: Record assessment results and intervention needs in the patient record, with updates after each reassessment.

Implementation of Rehabilitation Plan

- Physical therapy
- Occupational Therapy
- Speech-Language Therapy
- Cognitive Therapy

Rehab therapy should be performed per patient after assessment and a rehabilitation plan is established.

Early Supported Discharge (ESD) Program

- **Responsible Personnel**: The discharge planning team includes clinicians and therapists.
- **Eligibility Criteria**: Suitable for patients with mild to moderate stroke severity.
- **Home Environment Assessment**: Evaluate the home environment for safety, caregiver availability, and community services readiness.
- **Discharge Planning Timing**: Schedule discharge planning within two weeks of stabilization for patients eligible for ESD.
- **Follow-Up Protocol**: Conduct weekly follow-up evaluations for the first month, then biweekly for the next two months to monitor ESD progress.
- **Documentation**: Track discharge readiness, home setup, and follow-up results in the patient's chart.

Community-Based Rehabilitation Readiness Evaluation

- **Responsible Personnel**: Social workers and therapists.
- **Evaluation Timing**: Conduct initial assessment within one month post-stroke.

- **Assessment Scope**: Evaluate caregiver support, transportation options, and access to community resources.
- **Reevaluation Intervals**: Repeat assessments 60- and 90 days post-stroke to ensure continuity in community-based needs.
- **Referral**: Make necessary referrals to community services (e.g., vocational programs, social reintegration) based on findings.
- **Documentation**: Document findings, referrals, and community support level in patient records.

Continuous Reassessment and Long-Term Monitoring

- **Responsible Personnel**: Interdisciplinary team (Physical therapists, occupational therapists, speech therapists, neuropsychologists, social workers).
- **Follow-Up Intervals**: Conduct formal reassessments at 30-, 60-, and 90-days post-stroke.
- **Outcome Monitoring**: Evaluate physical, cognitive, psychological, and social progress at each interval, adjusting rehabilitation goals and protocols based on the patient's evolving needs, progress, and feedback. Involve patients and caregivers throughout the rehabilitation journey.

  Documentation: Record each reassessment, modifications to the care plan, and any therapy intensity or frequency changes.

Appendix B: CPG Decision Tree