Implementing Stroke Best Practices in Long Term Care Homes

The risk of stroke increases considerably with age[1–3] and 19 per cent of long term care home residents have a diagnosis of recent or previous stroke.[4] The number of stroke patients discharged from acute care facilities directly to long term care homes has increased from 13.9 per cent in 2003 to 18.9 per cent in 2005.[4] The increasing number of strokes in the older segment of the population—with 38 per cent of strokes occurring in those aged 80 years and over—combined with a need for supportive living arrangements emphasizes the necessity of incorporating best practices in long term care to address stroke prevention, recognition and management.

To this end, Central South Long Term Care Homes have developed and trialled a strategic process for implementing stroke best practices. The Promoting Action on Research Implementation in Health Services (PARIHS) framework by Rycroft-Malone[5] was used to develop and guide the implementation of stroke best practices in this long term care setting. The PARIHS framework demonstrates the interplay and relationship between three concepts: evidence, context and facilitation. Using this framework to guide the planning, implementation and evaluation of the project, eight steps were identified and adopted.

Step 1. Identification of resources and forming of teams

The project received funding from Ontario Stoke System. An advisory and evaluation committee was formed to guide the project. Five stroke best practice modules were developed and piloted. The modules were:

- signs and symptoms of stroke;
- falls and stroke;
- continence and stroke;
- dementia and stroke; and
- pain and stroke.

The modules can be viewed in full on the Regional Geriatric Program website at www.rgpc.ca/best/subjects/stroke.cfm.

Step 2. Identification of participating stakeholders

The following seven homes were identified for participation:

- St. Joseph's Health Care Centre, Guelph
- Creekway Village, Burlington
- St. Luke's Place, Cambridge
- Trinity Village, Kitchener
- St. Joseph's Villa, Dundas
- John Noble Home, Brantford
- Westmount, Kitchener

Step 3. A call for facilitator pairs

Mentors exist within all care environments, regardless of formal training. Administrators at each long term care home were asked to identify two such individuals (one regulated and one unregulated health care provider) who were respected by team members, showed leadership skills and demonstrated openness to learning and change. For the mixed-discipline facilitator pair concept to be effective, both individuals had to work on the same schedule for the purposes of communication and coordination. Fourteen facilitators participated in this research project.

Step 4. Identification of external supports

In addition to organizational support, it was felt that external supports could provide guidance to the facilitator pair. The external mentors were required to have expertise in the best practices identified for implementation and to be able to provide additional information and resources for team members to enhance learning and resident care. In addition, they needed to have expertise in adult learning techniques as well as familiarity with the care area intended for the implementation of best practices.

In this case, two members of the Central South Regional Stroke team were identified as external supports: the regional education and research coordinator and the regional stroke community and long term care coordinator.

Step 5. Design, implementation and evaluation of a facilitator workshop

The facilitator pairs attended a workshop, which had the following objectives:

TABLE 1

Development area	Mean rating (n)		
	Before the session	After the session	Change in perception of learning
Level of experience with group facilitation			
Personal support workers	1.38 (8)	3.67 (6)	2.17 (6)
Others: Educator, manager, RN, RPN	2.44 (9)	3.86 (7)	1.14 (7)
All workshop participants	1.94 (17)	3.77 (13)	1.62 (13)
Understanding of the role of the facilitator			
Personal support workers	1.63 (8)	4.57 (7)	2.86 (7)
Others: Educator, manager, RN, RPN	2.11 (9)	4.14 (7)	1.86 (7)
All workshop participants	1.88 (17)	4.36 (14)	2.36 (14)
Level of confidence related to your facilitator role			
Personal support workers	1.63 (8)	4.00 (7)	2.29 (7)
Others: Educator, manager, RN, RPN	2.44 (9)	3.50 (6)	0.83 (6)
All workshop participants	2.06 (17)	3.77 (13)	1.62 (13)

The impact of the workshop on participants' assessment of experience, understanding and confidence in acting as a facilitator. Ratings are from 1 (none or minimal) to 5 (a great deal)

by Kim Young BAH, BHSc (OT), OT Reg (Ont), Linda Kelloway RN, MN, CNN(c), and Kevin Brazil PhD.

1. To provide an opportunity for participants to familiarize themselves with the five stroke best practice modules.
2. To describe the role of the facilitators as it relates to the project.
3. To provide information and development related to facilitation skills.
4. To provide an opportunity for discussion between the facilitator pairs and the external mentors.
5. To provide an opportunity for networking and building support between participants and the external mentors.

Using a five-point Likert scale with 1 representing none or minimal and 5 representing a great deal, participants were asked to assess their perceived ability as a facilitator at the beginning of the workshop and again at the end of the workshop. As illustrated in Table 1, participants' experience, understanding and confidence in acting as a facilitator improved by taking part in the workshop, with personal support workers reporting the greatest gains.

As part of this workshop, participants identified strategies they would use when they returned to their long term care homes. In a group discussion format, participants discussed both anticipated challenges and enablers in their role of facilitator in their home. The workshop closed with participants identifying next steps, including the expectation that the facilitator pair would choose a resident with stroke from their home, choose a best practice module and facilitate a case discussion with their interdisciplinary care team regarding the application of that module.

Step 6. Design, implementation and evaluation of a facilitator-pair-led case discussion

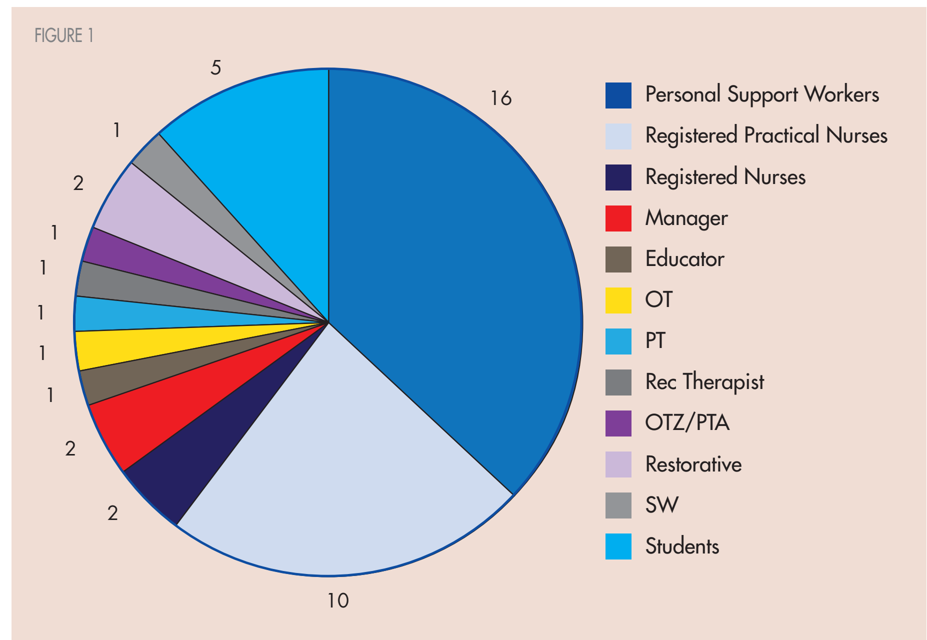
Following the facilitator workshop, the intervention shifted to the application of stroke best practice education related to resident case studies within the participating long term care homes. The facilitators were asked to choose a resident with a diagnosis of stroke from their home and select the most applicable best practice module. They were instructed to maintain the anonymity of the resident by removing any identifying information from the case study. The were further directed to use the information from the stroke best practice module and their resident case to lead a discussion with the interdisciplinary team that provides care for the resident.

Each facility already had processes in place for teams to meet to discuss resident care, including in-service schedules and resident case-review sessions. These established processes could be used as the 'teachable moment'[5] in which the health care team could be educated as to stroke best practice in an interdisciplinary forum. It was hoped that this teachable moment could be paired with reflective practice. Therefore, the underlying purpose of the facilitator-pair-led case discussion was to use the teachable moment of bringing providers together to reflect on their experiences with the resident in order to address stroke-related issues and identify opportunities for implementing best practice to improve care.

Facilitator pairs selected the stroke best practice module most salient to the resident's care and then planned an interdisciplinary staff gathering. The facilitator pairs were encouraged to identify a familiar team communication format and a familiar team meeting space to facilitate the discussion. All teams chose to lead their resident case discussion on the care area of the resident.

The facilitator pairs demonstrated the ability to choose and prepare a relevant resident case study, select an applicable stroke best practice module and facilitate a discussion with their interdisciplinary team regarding the application of the module. They also demonstrated the ability to lead an active discussion that resulted in recommendations related to the resident's care plan.

Participants in the facilitator-pair-led resident case discussions included 44 long term care home staff (Figure 1).



Staff participants by position/discipline.

The external mentors observed the interdisciplinary teams applying the stroke best practice information to the resident case and observed the teams' ability to make recommendations for the resident's care plan. The external mentors also noted that the case discussion reinforced learnings from the facilitator workshop.

Evaluation of the facilitator-pair-led case discussion included self-perceived learning related to best practice, the application of best practice information to care planning and the effectiveness of the discussion. Staff who participated in the sessions reported satisfaction with their ability to apply the stroke best practice information to residents' care. Table 2 demonstrates the degree to which the interdisciplinary team participants were satisfied with the case discussions.

Participants demonstrated the ability to apply stroke best practice strategies to their resident care plan through a case discussion led by peer facilitators. The inter-

TABLE 2

Question	Mean rating (n)
How would you rate:	
Being able to discuss this resident's case with your team members?	4.63 (40)
The information provided in the pain, continence and acute stroke module presentation related to this resident?	4.59 (39)
The helpfulness of the information in the pain, continence and acute stroke module to use with this resident's care planning?	4.49 (39)
Having two of your peers lead the discussion of the resident case?	4.59 (39)

Assessment of the facilitator-pair-led case discussions. Ratings are on a scale of 1 (none or minimal) to 5 (extensive).

disciplinary team discussion led to proposed changes to the resident care plan related to stroke best practice. The findings of this project have important implications that facilitate building capacity and sustainability to support the implementation of best practices within long term care homes.

Step 7. Design, implementation and evaluation of a follow-up debriefing session

A debriefing workshop was designed to allow the facilitator pairs to network, share stories regarding their experiences, provide feedback and collect the anonymous resident case studies. It also allowed the facilitators to share the ways in which they assimilated the stroke best practice information into their case discussions and resident care planning.

Enabling factors[6] were considered when designing the facilitator workshop and debriefing session. In this case, staff were paid an hourly wage for the time they spent at both sessions.

Main messages and lessons learned

The following main messages and lessons learned have been derived from the evaluation of this project.

Main messages

1. Engagement of executive leadership support is key to the successful implementation of stroke best practices in long term care environments.
2. Internal mentors without formal training currently exist in health care settings.
3. Internal mentors can be recruited as facilitator pairs to support the implementation of best practice.
4. Formulating partnerships between regulated and unregulated health care professionals can result in increased team participation, collaboration and understanding of team members' contributions in care delivery.
5. Incorporation of leadership and facilitation skills training should be included to support the implementation of best practices.
6. External partnerships for mentoring should be identified to support initiatives.
7. Internal facilitator pairs help to cultivate a sense of pride and confidence that brings a willingness to apply these experiences to other case discussions.

Lessons learned

1. Educational initiatives need to be flexible and easily accessible to health care providers to support the use of teachable moments.
2. Creating opportunities for staff learning through established processes such as in-service events, resident case review, facilitated reflective practice and the identification of teachable moments related to stroke best practices is of critical importance.
3. The engagement of administration support is essential for planning, coordination of time, understanding of the role of the facilitator pair and support of facilitator pair.
4. Communication and development of the relationship of the facilitator pair is most effective if the pair work in the same care area.
5. Educational initiatives should be adaptable to variations in health care environments and the needs of individual teams.
6. The peer-to-peer support approach is important in encouraging openness, respect and listening among staff and as a forum for broadening awareness.
7. A desire and ability to repeat/duplicate the case discussion format with other residents, including those with diagnoses other than stroke, is a natural outcome of the workshop experience.
8. Partnering regulated and unregulated staff (e.g., personal support workers with registered nurses and registered practical nurses) fosters a relationship of interdisciplinary collaboration and communication.
9. Enabling factors, such as remuneration for staff, should be incorporated to support their involvement in best practice initiatives.

Sustainability

Facilitator pairs and interdisciplinary team participants reported their intention to continue the process of facilitated case discussions and resident care planning, while incorporating stroke best practice module material. Facilitator pairs identified the use of a centralized website to house resources as a means to support this process. The five stroke best practice modules are now available on websites of the Registered Nurses' Association of Ontario (RNAO) and the Regional Geriatric Program (RGP).

Future research

Further research is required regarding the implementation of stroke best practices in long term care homes to determine their impact on resident outcomes such as stroke recurrence and the management of the sequelae of stroke (e.g., incontinence, falls, pain and dementia). Further research is needed to identify additional strategies that support sustainable knowledge translation in the long term care setting with emphasis on the health care provider.

Step 8. Development of a dissemination plan

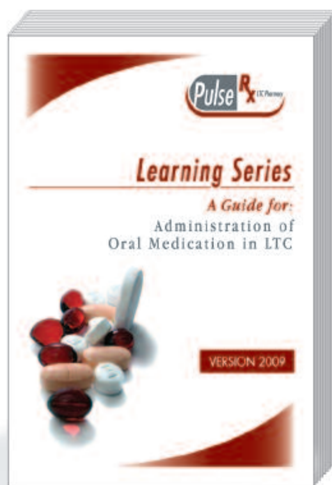
The following dissemination plan has been developed to share the results of this research project:

1. Partnership with the RNAO to post the stroke modules on the RNAO tool kit website.
2. Partnership with the Regional Geriatric Program to post the stroke best practice modules on its website.
3. Poster presentation at InterUrban Stroke Conference in London, Ontario (April 24, 2009).
4. Presentation to the provincial meeting of the Regional Stroke Community and Long Term Care Coordinators.
5. Presentation to the provincial meeting of Regional Stroke Rehabilitation Coordinators.
6. Presentation to the Ontario Regional Educators Group.
7. Presentation to the Provincial Rehab and Community Re-engagement Subcommittee.
8. Presentation at the Stroke Collaborative in Toronto (fall, 2009).
9. Presentation to the Stroke Evaluation and Advisory Committee.
10. Presentation to the Regional Rehabilitation Network.
11. Presentation to allied health groups at McMaster University.
12. Presentation to the HNHB joint CCAC/LTC groups.
13. Presentation to community networks.
14. Presentation to the Regional Stroke Community Partners Advisory Committee.
15. Presentation to the Regional Stroke Prevention Committee.
16. Presentation to the Regional Stroke Education Committee.
17. Update to the Regional Stroke Steering Committee.
18. Presentation to the OLTCA.
19. Application for publication related to journal article submissions. LTC

References

1. Saposnik G, Cote R, Phillips S, et al. Stroke outcome in those over 80: A multicenter cohort study across Canada. *Stroke* 2008;39:2310–7.
2. Goldstein LB, Adams R, Alberts MJ, et al. Primary prevention of ischemic stroke: A guideline from the American Heart Association/American Stroke Association Stroke Council. *Stroke* 2006;37:1583–633.
3. Rothwell PM, Coull AJ, Silver LE, et al. Population-based study of event-rate, incidence, case fatality and morality for all acute vascular events in all arterial territories (Oxford Vascular Study). *Lancet* 2005;366:1773–83.
4. Stroke Evaluation Advisory Committee. *Integrated Stroke Care in Ontario: Stroke Evaluation Report 2006*. Ontario Stroke Evaluation Office, 2007.
5. Rycroft-Malone J. The PARIHS framework—a framework for guiding the implementation of evidence-based practice. *J Nurs Care Qual* 2004;19:297–304.
6. Stolee P, Esbaugh J, Aylward S, et al. Factors Associated with the effectiveness of continuing education in long term care. *Gerontologist* 2005;45:399–409.

Education, Clinical Services & Technology



Toronto • Ottawa • London

111 Zenway Blvd., Suite #3, Woodbridge, ON L4H 3H9

Phone 905 856 1250 **Fax** 905 856 2316

Toll Free 877 785 8511 • www.pulserx.ca