Supporting Interprofessional Education Through Shared Learning Opportunities
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SECTION 1: BACKGROUND

Stroke is the fourth leading cause of death in Canada. As the population ages, the number of patients with acute stroke is expected to increase 68% within two decades. Although there have been many treatment advances, stroke remains a leading cause of adult disability. Almost 60% of stroke survivors are left with moderate to severe impairment or are so severely disabled, they require long-term care. Stroke is one of the most costly medical conditions, reflecting an annual $2.7 billion burden on the Canadian economy.

Ontario Stroke System

In 1997, the Heart and Stroke Foundation of Ontario initiated the development of a comprehensive stroke strategy, followed by a three-year demonstration project to develop and test a regionally based model of coordinated care, culminating in the Ontario Stroke Strategy, announced in June 2000. With the successful completion of the four-year implementation phase, the Strategy was officially renamed the Ontario Stroke System (OSS) and continues to be supported by $30 million received annually from the Ministry of Health and Long Term Care. The goal of the OSS is to decrease the incidence of stroke and improve patient care and outcomes for persons who experience stroke. It aims to provide a comprehensive approach to organized stroke care prevention and care that incorporates that the full continuum of care.

Systems change, professional education, and public awareness are considered the three main components of the system. The Interprofessional Learning Objectives for Stroke Care resource is an initiative of the OSS.

SECTION 2: INTRODUCTION AND PROJECT OVERVIEW

The goal of the project was to develop and pilot test an educational resource that outlines learning objectives shared by the regulated health disciplines as well as discipline-specific learning objectives, across 16 learning areas related to stroke care.

The objectives of the resource are to:

- Give healthcare professionals working with stroke survivors a framework for learning.
- Establish guidelines for knowledge and skill development related to stroke care for all eight regulated health professionals.
- Form the foundation for learning plans for ongoing individual professional development.

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2 Ministry of Health and Long-Term Care, 2000, Towards an Integrated Stroke Strategy for Ontario.
3 Lewis et al. (2006), Health Care Quarterly, Vol. 9, No. 4, www.healthcarequarterly.com
• Support self-directed learning.
• Support interprofessional education and collaborative practice through shared learning opportunities.
• Support knowledge translation and the integration of best available evidence into practice.

The development of the Interprofessional Learning Objectives for Stroke Care resource was guided by the principles of interprofessional education and collaborative practice, self-directed learning, knowledge translation, evidence-based practice, client-centered care, interdisciplinary team dynamics, and rehabilitation.

With funding provided by the Ministry of Health and Long-Term Care (Ministry), and the Heart and Stroke Foundation of Ontario (Foundation), the development and pilot testing phases of the project were completed by the Regional Stroke Program of Hamilton Health Sciences, in Hamilton, Ontario.

The development of the resource was a three-year initiative comprising three phases.

**Phase I**
Phase I focused on the development of shared learning objectives for all regulated health professionals working with stroke survivors and their caregivers. These shared or core-learning objectives identify the knowledge, skills and values that are important to all health professionals who provide care to persons recovering from stroke in various settings across the continuum of care, regardless of discipline. The eight professional groups include: nursing, physiotherapy, occupational therapy, social work, speech-language pathology, registered dietetics, registered respiratory care and pharmacy.

**Phase II**
The second phase of development focused on discipline-specific learning objectives for health professions working with stroke survivors and their caregivers. These discipline-specific learning objectives identify the knowledge, skills and values that are important for each of the eight regulated health professions working with stroke survivors across the continuum.
The shared and discipline-specific learning objectives were developed across **16 Learning Areas** related to stroke care:

1. Principles of Stroke Care
2. Anatomy and Physiology of Stroke
3. Cardiovascular and Respiratory Effects
4. Psychosocial Effects
5. Communication
6. Independence in Mobility and Prevention of Complications of Immobility
7. Routine Activities of Daily Living
8. Instrumental Activities of Daily Living
9. Cognitive, Perceptual and Behavioural Changes Following Stroke
10. Sexuality
11. Nutrition
12. Dysphagia
13. Skin Care
14. Continence Management
15. Primary and Secondary Stroke Prevention
16. Transition Management

**Phase III: Pilot Testing**

Pilot testing represents the third and final phase of development and involved multiple, diverse clinical settings. An invitation to participate went out to regional stakeholders through the Regional Stroke Education Committee. The Committee discussed ideal settings based on the regional structure at the time of piloting. Although potentially useful elsewhere, it was decided to focus on hospital-based programs as the process and resources required to extend an effective process to the 114 LTC homes and 5 CCACs in the region (at the time of this report) would not be feasible within the scope of the project.

Quantitative and qualitative, anecdotal data were collected on a wide range of implementation and utilization issues including:

- Specific strategies undertaken to incorporate the resource into structures and activities related to orientation and continuing education.
- How the resource was used to structure and encourage individual and interprofessional education activities.
- How the resource might encourage and facilitate self-directed learning activities including self-evaluation and documentation of learning goals and plans.
- The perceived value of the resource to educators, frontline clinicians, and administrators in understanding their learning needs.
- Support of practice integration through team process with organizational support.
• Recommendations for further revision and potential utilization and dissemination strategies.

The participant organizations established teams comprised of as many representatives from the eight regulated health disciplines as possible. A project lead was identified to communicate directly with the project coordinator.

**Evaluation**

Each participant, approximately 7-10 from each site, completed a pre- and post-pilot questionnaire and attended regular project meetings led by their project lead. This process collected valuable quantitative and qualitative data that described for potential users the experience and recommendations of the pilot sites. Written updates provided by the site project lead, electronic communications, and telephone interviews were other sources of information.

The project teams participated in a pre- and post-pilot project interview with the project coordinator, which was intended to capture additional information and recommendations for revisions of the document.

**SECTION 3: SUPPORTING INTERPROFESSIONAL PRACTICE THROUGH SHARED LEARNING OPPORTUNITIES**

Health Canada\(^5\) researchers Freeth, Hammick, Reeves, Koppel and Barr (2005) at the Centre for the Advancement of Interprofessional Education in the UK (CAIPE)\(^6\), and the Interprofessional Education programs at McMaster University\(^7\) and the University of Toronto\(^8\), have described Interprofessional Education as “learning together to promote collaboration” with the goal to prepare health professionals with the knowledge, skills, values, and attitudes necessary for interprofessional practice.

It is further described by Barr et al (2005)\(^9\) to involve healthcare providers learning to work together, sharing in problem solving and decision making, to the benefit of patients, guided by principles such as:

- Developing a mutual understanding of, and respect for, the contributions of various disciplines.
- Socializing healthcare providers in working together, in shared problem solving and decision making, towards enhancing the benefit for patients, and other recipients of services.
- Instilling the requisite competencies for collaborative practice that include skills and strategies related to teamwork, which include:

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\(^7\) University of Toronto, Interprofessional Education [http://ipe.utoronto.ca/tools/about.htm](http://ipe.utoronto.ca/tools/about.htm)

\(^8\) McMaster University, Interprofessional Education [http://www.fhs.mcmaster.ca/ipe/contact.htm](http://www.fhs.mcmaster.ca/ipe/contact.htm)

• Recognizing the patient/client and their support systems as central components of the team.
• Establishing a team decision-making process.
• Agreeing on shared goals, expectations and responsibility.
• Recognizing the differences and overlaps in the approach of different disciplines.
• Building consensus, being flexible and resolving conflicts.
• Developing communication skills such as attentive listening, good record keeping and a common vocabulary.
• Learning consultation, collaboration and referral skills.

The principles described above very much reflect the spirit with which the learning objectives were designed and intended for use by interprofessional teams. The shared learning objectives were intended to engage team members in identifying common learning interests and opportunities while enhancing awareness, appreciation, and respect for the role and contributions of other team members. The specific strategies for how teams may use the document were purposefully not prescribed during the pilot test; rather, the pilot teams were strongly encouraged to explore how the resource may support their particular interests as a team, and as individuals, in relation to any organizational goals. Teams reported enjoying the opportunity to identify learning priorities, learn together and from each other while considering how the new knowledge gained could be transferred to practice.

Health Canada maintains that changing the way health providers are educated is key to achieving system change and to ensuring that health providers have the necessary knowledge and training to work effectively in interprofessional teams within the evolving health care system.

SECTION 4: SUPPORTING SELF-DIRECTED LEARNING AND OPTIMIZING LEARNING OUTCOMES

Self-directed learning, as first espoused by Knowles (1975)\textsuperscript{10}, has long been identified as a modality important to optimizing learning. Knowles’ early thinking with respect to self-directed learning includes: Encouraging individuals to take initiative in identifying their learning needs and goals and relevant resources for learning, choosing and implementing learning strategies and evaluating learning outcomes. Knowles proposed that learning is more likely if individuals took initiative and responsibility for their learning. Adult learning theory reinforces the concept that adults “commit to learning when goals and objectives are considered realistic and important and perceived as being immediately useful,” and that adults want to be “involved in [the] selection of objectives, content, activities, and assessment in inservice training programs” (Brook, 1989)\textsuperscript{11}.

The *Interprofessional Learning Objectives for Stroke Care (HSFO, 2006)* resource was intended to support the principle of self-directed learning and participation by providing focus to the needs of the individual learner while still creating opportunities for interprofessional education. The Self-Evaluation Tool was provided as a tool to support individual practitioners in identifying their learning needs, choosing their learning goals and strategies for learning, evaluating their learning outcomes and documenting change in their knowledge/experience. This can be done individually or with an expert resource person or as a team. The Learning Plan is a tool to record educational strategies with respect to identified learning needs and interests. The learning plan may remain personal to the user or be used to communicate strategies for learning for management or the practitioners’ respective professional colleges where applicable.

The learning areas identified encompass many learning objectives that can be achieved through multiple strategies including comparison of the best available evidence in a content area to current practice, formal continuing education, attendance at stroke conferences, web-based CE courses, etc.

**SECTION 5: SUPPORTING EVIDENCE-BASED PRACTICE**

Earlier models of evidence-based practice (EBP) espoused by Sackett, Rosenberg, Gray, Haynes, Richardson (1996)\(^\text{12}\) emphasized the conscientious and judicious use of current best evidence with less emphasis on the patient’s values and circumstance.

Emphasis in the EBP literature is now on the integration of best research evidence with clinical expertise and patient values and actions, which include: preferences for therapy service, preferred style of learning and doing, responses to therapy, goals, wishes and interests, personal factors such as age, gender, etc. Tacit knowledge, or wisdom acquired through clinical practice is important and needs to be explicit to others, as is linking clinical judgment to the evidence base. Clinicians are encouraged to have a critical attitude towards their own practice and to the evidence. Additionally, reflective practice is viewed as an important skill of EBP.

With this consideration, individuals and teams are encouraged to identify personal and/or shared learning interests across the areas of stroke care described in the resource. The Self-Evaluation Tool is provided to support this process. By selecting a common set of learning objectives, teams can reflect on their current knowledge and practice in comparison with the best available evidence to identify potential changes in practice deemed feasible by the team and within the context of patient-centeredness. With team support and organizational support, concerted efforts to institute change in practice are more likely.

This was a positive outcome described by clinical teams who participated in piloting the resource. To support this process, a **Professional Education Reference Guide** was developed to help practitioners access recommended resources with respect to the objectives selected. The Professional Education Reference Guide is provided in the accompanying *Tips for the User Guide*.

**SECTION 6: THE INTERPROFESSIONAL LEARNING OBJECTIVES FOR STROKE CARE DEVELOPMENT PROCESS**

In November 2002, a regional work group was by the Central South Regional Stroke Program to facilitate the development of the project and supporting tools and resources (see Acknowledgements). The group included clinical practice leaders and frontline healthcare providers from nursing, physiotherapy, social work, occupational therapy, speech-language pathology and dietetics who worked in a range of practice settings across the region. This group conceptualized the project and developed the core learning objectives, tools, and accompanying resource *Tips for the User Guide*.

The Regional Stroke Education Committee, the Regional Stroke Community Partners Advisory Group, as well as other multiple stakeholders reviewed the resource. Several focus groups were held to gather direct input and feedback on both content and implementation planning from all targeted health disciplines. Recreation Therapy, although not a regulated health discipline at the time, was identified as an important team member. While feedback was received from a small number of recreation therapists, it is recognized there could be greater emphasis on this discipline within the learning objectives.

In the second phase of development the discipline-specific learning objectives were completed. The group’s membership was expanded to include representatives of respiratory therapy and pharmacy.

Phases I and II were guided by resources provided by the Heart and Stroke Foundation, including the *Best Practice Guidelines for Stroke Care, 2003*. The manual is a compendium of 19 best practice guidelines across the continuum of care and includes current evidence, proposed care maps, sample protocols, assessment and outcome measurement tools.

Formative evaluation strategies undertaken during the development phase of the project included focus groups and extensive review by regional networks, clinical teams and individuals to elicit information useful to improving the resource and its dissemination, in keeping with the project’s intended objectives. Providers across the continuum of care in Central South Ontario were given a number of opportunities to provide feedback and input to a draft version of the objectives.

In June 2003, a regional focus group of 72 regulated health professionals working with stroke patients across the continuum was convened to gather feedback on the content of the shared learning objectives and a dissemination strategy. Participants were asked to complete a two-page evaluation form in advance of the meeting and worked with evaluation tools in small groups.
throughout the day. With four to five clinicians from each discipline in attendance, key information was captured to guide the revision of the content and the implementation phase of the project. With agreement on the shared learning objectives, Phase II development of the discipline-specific learning objectives could proceed.

Extensive feedback from all sources was incorporated into subsequent drafts of the resource. The final draft of the shared objectives and the discipline-specific objectives was disseminated to the Ontario Regional Education Group of the Ontario Stroke System for provincial review. The project was presented provincially at the 2004 HSFO Stroke Collaborative and a regional stroke conference in Northwestern Ontario in 2005. Feedback was incorporated into the final document.

SECTION 7: REGIONAL PILOT TESTING
The Regional Pilot Project was the logical next step towards readying the resource for dissemination and integration into organizational structures and processes related to professional education. Early in the development process, pilot testing was deemed an effective approach for developing implementation strategies, identifying clinical settings that could benefit from the resource, and determining the value of the resource to individual practitioners, educators, and managers.

Feedback from focus groups conducted during Phases I and II suggested that participant organizations in the pilot project should be located across the region and represent a variety of clinical settings and organizational structures. Recommended pilot sites included:

Acute Care
- Community-based hospital with clustered stroke patients on stroke or medical unit.
- Small community-based hospital with non-clustered stroke patients.
- Tertiary level stroke unit, multi-site regional stroke centre.

Rehabilitation
- Inpatient rehabilitation.
- Outpatient rehabilitation.

Relevance of the resource to community-based and long term care providers was considered in light of their different organizational structures. Representatives from the Continuing Gerontological Education Cooperative (CGEC) and CCAC were consulted about the value of the resource to this sector. According to the CGEC, health professionals, including a significant staffing complement of allied health practitioners, would benefit significantly from stroke-related education, assuming a large percentage of their clients may experience the effects of stroke.
It is recommended that this resource be considered for its ability to guide stroke-related education for the community and long term care sectors. High priority areas targeted for education in these sectors by the Regional Stroke Education Committee at the time of the development of this resource included: dysphagia, mobility and positioning, and aphasia.

**Process**

The pilot process was not intended to be prescriptive, rather, it was viewed as important to allow for a ‘natural’ process so each organization could truly customize their approach to their unique setting; more accurately identifying barriers and enablers to their project objectives. It was the intention that each pilot site, with its unique staffing model, corporate structure, and educational practices and resources, determine how the resource can best be used to support staff education and training and the provision of best practice stroke care.

Through the establishment of a project team, comprised of at least one representative from the eight regulated health professionals, an educator, and clinical manager, each organization explored how the resource could support their team in providing best practice stroke care and how it contributes to and melds with current individual and organizational practices with respect to staff education and training.

To familiarize the project team and team lead with the resource and to generate some thinking with the team about how to structure the project, a focus group was conducted to complete a SWOT analysis. This promoted discussion of the Strengths (current situations likely to lead to the achievement of the project goals) the Weaknesses (factors that potentially compromise the achievement of the project goals), the Opportunities (practical openings likely to result in positive change), and the Threats (potential challenges that must be overcome if opportunities are to be realized), that shaped the process undertaken at each of the pilot sites. A follow up meeting was arranged if required.

**The Pilot Site Experience**

The pilot testing of the resource was designed to discover how each pilot site approached the utilization of the resource, specifically:

- Use of the resource to support professional development of regulated health professionals who provide care to stroke patients.
- Specific strategies to incorporate the resource into organizational structures and activities relating to staff education and training.
- Use of resource to support self-directed learning approaches at the level of the individual practitioner.
- Value of the resource to educators, frontline staff and administrators at each pilot site.
- Changes in practice related to the nature and provision of care.
The experiences of each pilot site, described below, are intended to provide future users of the resource with examples of different applications of the resource and strategies to overcome common barriers to implementation.

**Norfolk General Hospital**
Small Community Hospital: Acute Stroke Care & Outpatient Rehabilitation

**Site Description**
Norfolk General Hospital, a small community-based hospital in Simcoe, Ontario, provides acute stroke care and outpatient rehabilitation care, including occupational therapy and speech-language pathology.

Four to six stroke patients receive care in the hospital at any one time. Patients are not clustered on a dedicated stroke unit at this time. Service is provided to approximately 60 stroke patients annually. Although there is no identified stroke team; movement is afoot to establish a team within the hospital. The hospital provides an additional 35-40 CCC beds.

Some stroke patients are admitted directly from the emergency department, and emergency physicians initiate an established clinical pathway before sending patients to the ward. Other patients identified as suitable candidates for thrombolytic therapy are sent to Brantford General, and then repatriated to Norfolk General Hospital when stabilized.

Common discharge destinations include Brantford General rehabilitation program, CCC services, outpatient services and LTC homes. Other community resources include a secondary stroke prevention clinic (located at Norfolk General Hospital), a Stroke Recovery Network (support group), the Norfolk Aphasia Program, and Senior Support Services (e.g., transportation, respite care).

**Professional Education and Training**
Typically, Norfolk General Hospital uses the expertise of its interdisciplinary team to facilitate stroke care learning such as positioning, feeding and swallowing, and nutrition. These efforts were described as disjointed, offered on an "as needed" basis for specific patients.

Education needs are identified informally through staff/manager requests or in reaction to problematic situations. Unfortunately, limited educational resources (particularly human resources) are ongoing challenges to timely, proactive, comprehensive training programs related to stroke care. Staff members have been encouraged to attend Ontario Stroke System workshops and many have participated in these opportunities. Because stroke patients are cared for throughout all units, a continuing challenge is to increase the knowledge base of the nursing staff that cares for a broad range of patients and illnesses.

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Linda Vancso, Education Director
Rhona Vandekerckhove, Respiratory Therapist
Christine VanWalleghem, Physiotherapist
Margaret Saporsantos, Registered Dietitian

Team Process
The Working Group established for this pilot project met regularly to identify and support the staff’s educational needs, facilitating the provision of stroke care based on current evidence-based best practice guidelines.

The Working Group met seven times during the course of the project, almost always over lunch. Meetings took place in hospital, usually in the conference room, and typically were two hours in length. Meeting over lunch proved to be less disruptive to the participants’ schedules. Providing lunch may have helped with attendance, which was greater than 80% for all meetings.

At the first meeting, the participants were provided with the self-evaluation templates and directions for completion. These templates were completed independently and submitted to the team lead prior to the second meeting. The team lead compiled and analyzed the data from the templates to establish any trends in strengths and weaknesses. Based on the response patterns of the participants, learning objectives within the following areas were identified (areas in which the knowledge base was agreed to be weakest):

- Principles of Stroke Care
- Anatomy and Physiology of Stroke
- Sexuality
- Continence management

Through discussion, however, the group expressed a preference to tackle a topic that was not only particularly relevant to the facility, but that could be addressed within the scope of the pilot project. This discussion eventually led the group to abandon the above topics and focus on Depression Management in stroke patients.

The group established objectives as a team and did not set out individual objectives for each of the participants. Those with greater expertise in particular areas (e.g., pharmacist’s knowledge of medications for depression) presented the evidence on that aspect of care to the group.
Perceived Value of the Resource

Overall, pilot participants at Norfolk General Hospital found their experience with the resource a highly positive one. “I enjoyed it immensely,” reported one practitioner.

Learning was identified as a key benefit of the resource, as it not only enhanced interest in self-directed learning, but also promoted reflection on current knowledge/learning needs and development of a learning plan to guide educational goals.

To some extent, interdisciplinary teamwork was already occurring at Norfolk General Hospital. However, the resource fostered a collaborative approach with colleagues to learning about stroke care. According to a practitioner, this project “facilitated discussion with team members about better stroke care across disciplines and areas of potential change.”

The resource was deemed helpful in accessing current information, resources and research on stroke, particularly the Internet resources provided in the Inventory of Resources. This resource was described as an “easy-to-use, concise reference manual for resource links and information summary.”

The resource enabled practitioners to identify opportunities for practice change and to make these changes in practice. It encouraged collaboration between team members by presenting a “group opportunity to share information and feedback around acute inpatient issues.”

Through “increased exposure to practices of other disciplines,” the resource provided “a varied perspective on stroke care,” and an improved understanding of the overlapping scopes of practice around patient needs and goals.

Practitioners unanimously reported that they would encourage other colleagues to use the Interprofessional Learning Objectives for Stroke Care resource.

Barriers to Implementation

The lack of a dedicated stroke team and non-clustering of stroke patients hampered the ability of practitioners to realize all intended learning and practice changes. “I am not specialized to stroke, so I’m not sure, realistically, that I can spend enough time to have an educational learning plan [exclusive to stroke],” reported one practitioner. Other sites, described below, specifically recommended that objectives serve the learning plan that they are required to submit to their respective colleges. This appeared most relevant to physiotherapy.

Time constraints were cited as a common barrier, with practitioners “frustrated” that “there was not enough time during working hours to devote to the pilot team’s objectives with the project.” Furthermore, due to organizational constraints, group meetings around the pilot project were less frequent than preferred, although valuable. While participants were unable to complete the
group’s learning objectives within the timeframe of the pilot, this was not a requirement. Rather, the pilot focused on identifying how the resource could support and guide the team/organization’s efforts with stroke education. It is recognized the learning with respect to stroke care is vast, perhaps limitless, and an ongoing process.

Of note is the process undertaken in a small, community hospital to form a dedicated team committed to enhancing learning and delivery of stroke care, and how they used the resource to structure an approach that identified and prioritized their learning interests.

**Initiatives Prompted by the Pilot Project**

On an informal basis, the Working Group will be approaching the committees of stroke-related disciplines to encourage incorporation of the resource into the orientation of new staff and utilization by existing staff. As well, the resource will be used to provide structure and organization to individual learning plans.

Finally, the Working Group has submitted a proposal for a depression management project, intended to build on the progress made during the trial implementation. The project will identify current issues and educational needs relating to stroke at Norfolk General Hospital, and will establish a plan to implement best practice, such as procedures, documentation and staff training.

**Guelph General Hospital**

**Mid-Size Community Hospital: Acute Stroke Care & Inpatient Rehabilitation**

**Site Description**

Guelph General Hospital provides acute care and inpatient rehabilitation services to approximately 134 stroke patients annually. There are no designated beds for stroke patients.

Stroke patients are not clustered on a dedicated unit and there is no identified stroke team, although a nurse, speech-language pathologist, occupational therapist, physiotherapist, dietitian, pharmacist and social worker provide “team services.”

Patient are generally assessed, diagnosed and then admitted by the Emergency Department to an appropriate bed (usually medicine). At the end of the acute-care stage, patients may be discharged back to the community or may meet the criteria for short- or long-term rehabilitation. Common discharge destinations include:

- CCAC at home.
- Short-term rehabilitation services (<14 days).
- Long-term rehabilitation services (>14 days): Freeport, Kitchener, St. Joseph’s health Centre, Guelph.
- Outpatient rehabilitation services: St. Joseph’s Health Centre, Guelph.
Established partnerships include:

- Wellington County Hospital Network (Rehabilitation Steering Committee).
- Central South Regional Stroke Steering Committee.
- Central South Regional Stroke Education Committee.
- Central South Rehabilitation Stroke Pilot Project.
- Waterloo Wellington District Stroke Committee.

In 2006 Guelph General Hospital completed the integration of short-term and long-term rehabilitation services into one site at St. Joseph’s Health Centre in Guelph, Ontario. This integration will enable the community to develop a centre of excellence in rehabilitation services.

**Professional Education and Training**

Although Guelph General Hospital does not have a formal mentorship program, it does offer preceptorship during orientation of new staff. “Buddy” time can be extended to meet individual needs of new employees.

Educational needs are identified in a variety of ways, including needs assessments, staff meetings, one-on-one feedback and best practice identification. Several educational formats are employed, from one-on-one training to formal education (on- and off-site), lunch & learns and information packages. Education is supported through Organizational Development and individual units. Budget dollars support registration fees but not time spent.

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Madlin Hopiavuori, Registered Dietitian  
Andrea Martin, Pharmacist  
Lindsay Page, Physiotherapist  
Wendy Thrasher, Occupational Therapist  
Linda Tyschenko, Physiotherapist

**Team Process**

The pilot project group held two initial meetings, each meeting was two hours in duration. Commitment from team members was critical to the successful planning and implementation of the pilot project.

The selection of priority learning objectives was made through group discussion regarding current gaps in stroke care at Guelph General Hospital, team members’ perspective on their specific learning priorities, and identification of reasonable goals that were achievable within the pilot project timeframe.
Perceived Value of the Resource
The pilot project team at Guelph General Hospital found the resource useful on a practical level. “It was valuable to meet regularly and to establish concrete goals. We learned a great deal through this process,” observed a practitioner.

The evaluation process, undertaken as a team, was identified as the resource’s key benefit, as it helped to identify gaps in stroke care—timely recognition of depression, communication issues related to aphasia and facilitation of transition management. Furthermore, the resource promoted the development of practice tools to meet these gaps (see “Initiatives Prompted by the Pilot Project” below).

The practitioners found the resource helpful in accessing current information and research in stroke. They reported that teamwork across the disciplines was enhanced throughout the trial implementation, with regular lunch & learn sessions working particularly well. The group expressed interest in regrouping to further advance stroke care at the hospital and thought this would happen best around particular priorities of interest.

Barriers to Implementation
Staff time and availability to meet were identified as significant challenges during the pilot testing. The group identified support from management, engaging the larger team, and having an identified ‘team leader’ as very important to the team’s endeavors with instituting change in practice. Nursing as a discipline found it most challenging to attend the team meetings and as a result some areas of the resource “were not touched upon or delved into as deeply” within the timeframe of the pilot. The manager supported the resource as useful and valuable to the team, but reinforced the team’s challenge of meeting frequently during the time of the pilot to accomplish targeted goals. As a result, efforts to institute practice changes will continue beyond the scope of the pilot testing—a positive outcome.

Initiatives Prompted by the Pilot Project
As a result of the Pilot Project, Guelph General Hospital has endeavored to implement several practice tools to improve stroke care including a:

- Depression Screening Tool: “Depression interferes with engagement in treatment, particularly rehabilitation, so it was critical that we learn how to intervene and support the patient. If depression isn’t on the treatment plan or not identified at discharge, it is easily missed,” explained a practitioner.
- Aphasia Tool Kit to help frontline staff better communicate with stroke survivors with aphasia.
- Transition Management Tool to facilitate transfer of stroke patients to other organizations, or to home or rehabilitation services (both short- and long-term).
Hotel Dieu Shaver Health and Rehabilitation Centre
Inpatient/Outpatient Rehabilitation Unit

Site Description
Hotel Dieu Shaver Health and Rehabilitation Centre provides inpatient and outpatient rehabilitation services in the Niagara Region. Some 22 beds are allocated to stroke patients who are clustered on one unit. An identified stroke-team is comprised of a nurse, speech-language pathologist, physiotherapist, dietitian, pharmacist, social worker/case manager, occupational therapist and physiatrist.

Inpatients are referred from acute hospitals in the Niagara Region. Patients are admitted if they are residents of Niagara Region and meet the criteria for an active rehabilitation unit. When patients are discharged, the stroke team coordinates ongoing care or therapy needs via referral to appropriate agencies (e.g., CCAC, outpatient Neuro program. Discharge destinations include:

- Home (with services): 40%
- Home (no services): 40%
- Long-term care facility: 15%

Professional Education and Training
This site employs various approaches to promote professional education and training:

- New employees/new graduates are matched with a mentor for clinical and non-clinical coaching.
- Teams are able to identify learning needs for upcoming budgets. Clinicians are also encouraged to develop personal learning objectives that are considered when budget requests are made.
- Staff are able to request time and funds for continuing education courses. Typically, each clinician attends one course per year.
- In-services are arranged monthly to cover topics of interest to the program, or to review courses attended by colleagues.

Pilot Project Team
Project Lead: Jeane Davis, Senior Therapist 1st Floor Rehab, Occupational Therapist
Team Members:
John Attard, Speech-Language Pathologist
Jeanne Boc, Physiotherapist
Susan Guertin, Charge Nurse
Chris Pollard, Manager
Dan Tisi, Registered Dietitian
Andrea Wist, Pharmacist
Ad hoc: Dr. Richard McMillan, physiatrist
Team Process
The pilot project team met on a bi-weekly basis for one hour in a conference room at the site. The frequency of these meetings was maintained throughout the pilot phase and, in fact, the pilot project team continues to meet as an executive committee dedicated to promoting stroke education and best practice (see “Initiatives Prompted by the Pilot Project”). Importantly, support from management with regards to scheduling and time allotment has enabled this team to meet its commitments during the pilot phase and on an ongoing basis.

The pilot project team selected learning objectives according to a rating system devised at the first meeting. All disciplines rated the 16 learning objectives in terms of importance to their scope of practice. The project leader then collated this information and identified the top three learning objectives to be addressed first by the group. During this process, individual team members often explored and presented to the group a component of the learning objectives specific to their discipline.

Perceived Value of the Resource
Overall, utilization of the resource at Hotel Dieu Shaver was described as “a great and valuable experience. It provided us with an opportunity to meet as a team to discuss our learning needs and learning styles, and grow as a knowledgeable team.”

Most practitioners found the resource to be quite helpful in supporting and stimulating self-directed learning, particularly in assisting with the development of a learning plan.

The resource was helpful to accessing current information about stroke. One practitioner noted that the Inventory of Resources was one of the most useful parts of the pilot project.

The trial implementation helped several practitioners to not only identify opportunities for practice change, but also to implement change. The recreation therapist, for example, has already been in contact with administrators/managers and other recreational therapies to effect practice change as a result of her experience with the resource.

Interdisciplinary learning and teamwork was deemed a key benefit of the resource—the “mini-presentations from other disciplines” and a “better understanding of other team members’ roles” were highly valued.

Barriers to Implementation
The main barrier to implementation was scheduling and staff shortages, which limited greater participation from all disciplines involved in stroke care. Other barriers were not noted.
Initiatives Prompted by the Pilot Project

The trial implementation of the resource highlighted staff support for creating a forum for ongoing interprofessional education related to stroke care and best practice. This support, in turn, has stimulated the creation of two key initiatives:

- **IE Best Practice Stroke Group:** This group, hailing from the 1E rehab ward at Hotel Dieu Shaver, is currently assessing the use of a modified Goal Attainment Scale tool as a client-centred tool, and creating goals/objectives, soon to be reviewed by the entire rehab team at Hotel Dieu Shaver.
- **Stroke Interest Group** is comprised of members of the Pilot Project Working Team and has organized lunch and learn sessions. At the inaugural session (attended by over 50 people), a pharmacist addressed the use of stroke and antihypertensive medications. A second event will feature a young stroke survivor reflecting on her experiences. An extensive topic list has been compiled for the future and there are plans to hold sessions on a bi-monthly basis.

Hamilton Health Sciences (HHS)
Integrated Stroke Unit, Regional Stroke Center, Hamilton General Hospital

Site Description
The Integrated Stoke Unit (ISU) provides acute stroke care, inpatient rehabilitation and 3-month follow-up for stroke patients. It provides 16 acute and 16 rehabilitation beds to stroke patients on the ISU. On an annual basis, the regional stroke centre provides services to 450 acute stroke patients and 250 rehab patients. Approximately 44% of patients are referred to rehabilitation services. The dedicated ISU stroke team is comprised of a physician, nurses, speech-language pathologists, occupational therapists, physiotherapists, registered dietitian, registered dietetic assistant, pharmacist, social workers, registered practical nurses, neuropsychologist, and an acute care nurse practitioner.

Acute inpatient admissions come from the Regional Stroke Centre Emergency Department, other HHS emergency departments, as well as other HHS inpatient units. Rehabilitation inpatient admissions come from the acute ISU service and from other HHS acute inpatient units.

Acute inpatient discharge destinations include:
- Long-term care home
- Home (with or without services)
- Palliative care
- Home hospital (acute)
- Rehabilitation
- Convalescent care
- Complex continuing care

Rehabilitation inpatient discharge destinations include:
- Long-term care home
• Convalescent care
• Home (with or without services)
• Other rehabilitation facilities
• Supportive housing
• Outpatient rehabilitation services

With regards to discharge, approximately:
• 40% are transitioned to home
• 17% are transitioned to long-term care
• At least 25% are transitioned to CCAC
• 15% are repatriated to the home acute hospital

Local partners include EMS, long-term care, CCAC, surrounding community and district hospitals, local respite and hospice services, and the Acquired Brain Injury Program of HHS.

Professional Education and Training
Preceptor and mentorship models are utilized on the ISU for all disciplines. Annual learning plans are developed by all staff and submitted to the Clinical Educator for review and support.

The Clinical Manager and Clinical Educator support professional education and training needs with an allocated budget. HHS also supports professional development by funding resources and providing training workshops. However, funding is limited—the Clinical Educator and Clinical Manager prioritize needs, resources and opportunities for free educational opportunities.

The use of learning objectives often helps to inform the development of a learning plan for ISU staff, which helps the Clinical Manager to identify and support their interests and needs. This process is done in conjunction with the corporate bi-annual core competency performance development system that is conducted with all ISU staff.

Pilot Project Team
Project Lead: Jana Lee Breton, Clinical Educator
Team Members:
Leigh Barr, Speech-Language Pathologist
Michelle Bryant, Pharmacist
Krista Greenwood, Occupational Therapist
Ellen Gregg, Registered Dietitian
Alicija Koper, Registered Nurse
Kathryn LeBlanc, Clinical Manager
Stef Pagliuso, Physiotherapist
Cynthia Rinella, Social Worker

Team Process
The ISU pilot project team met initially as a group for an hour (over lunch) in the unit conference room; then individually during the work day for approximately 30
minutes in the Clinical Educator’s office. Before ending all meetings, subsequent meetings were booked to ensure continued progress on the pilot project. Support from the Clinical Manager and written resources distributed to pilot participants were vital to the successful implementation of this project on the ISU.

To decide which learning objectives would be tackled first, the Clinical Educator asked staff to indicate their learning needs. When the data were collected, learning needs were grouped according to the 16 learning areas in the ILO Resource. The data were weighted by the number of responses in each section, identifying the top three learning priorities overall.

Group members explored all learning objectives before choosing their top three priorities. Their choices were based on the needs of the unit in general, and the needs of the team to improve their functioning as a whole across all professions.

**Perceived Value of the Resource**

Pilot participants described their experience as beneficial. “The broad spectrum of stroke issues and deficits was highlighted for me,” said one practitioner. It is “a timely and useful” resource.

The resource stimulated interest in self-directed learning and encouraged practitioners to reflect on current knowledge and learning needs. The resource helped to “narrow in on specific areas for further learning,” explained another practitioner, particularly in areas that were less specific to her discipline.

The resource increased awareness of and attendance at regional stroke education workshops and projects, and encouraged and supported formal training at external agencies (e.g., Aphasia Institute).

Many appreciated the self-directed nature of the resource, where individuals could proceed at their own pace and create a personalized learning plan. As well, the resource assisted ISU practitioners with short- and long-term goal setting.

Practitioners found the *Inventory of Resources* valuable, although time to review and access resources was challenging. Interest was expressed in reviewing resources more thoroughly and the value in knowing where to look for recommended sources was helpful.

All practitioners reported that they would encourage other colleagues to use the ILO resource and tools.

**Barriers to Implementation**

Corporate objectives at ISU made it difficult for participants to dedicate sufficient time to achieve intended learning objectives within the timeframe of the pilot, “although, if there was no project timeline, we would have been able to move through the project at our own pace more easily,” explained the Clinical Manager. This is in fact an intended outcome of the project, that the resource
would be viewed as valuable and incorporated into organizational structures related to staff education activities and that it continued to be used beyond the parameters of the pilot testing.

**Initiatives Prompted by the Pilot Project**

From the Clinical Educator’s standpoint, the benefits of the resource have continued beyond the scope of the pilot project. The resource is now being used in several innovative ways (outlined below).

**New Staff Orientation**

All new staff members are given the complete package of learning objectives for review. The Clinical Educator reviews the package with them to identify initial learning priorities that, in turn, inform development of a learning plan. While some new staff are overwhelmed by the number of learning objectives presented, reassurance is provided to support an ongoing learning plan and learning environment.

**Core Competencies for ISU**

The Clinical Educator has incorporated the learning objectives into the core competences specifically related to the ISU, an initiative that includes skills and general systems theory of assessment. Particular emphasis is given to the level of neurological assessment as related to specific stroke etiology and the use of specialized assessment tools.

**Identification of Priority Learning Needs**

The learning objectives have been used to identify priority learning needs in the unit. By gathering and grouping data according to one of the 16 learning areas, the Clinical Educator was able to identify the top three sections that would serve as a focal point for education. This was communicated to staff to prepare them for upcoming educational initiatives.

**Learning Plans to Support Competent Practice**

On a few occasions, the learning objectives have been used to support competent practice. Competency issues have been related to foundation gaps in basic professional practice.

**Stroke Clinical Reference Binder**

**Project Team**

**Project Lead:** Rhonda McNicoll Whiteman, HHS Stroke Best Practice Coordinator

**Team Members:**

Jana Lee Breton, Clinical Educator, ISU  
Trish Haycock, Project Consultant, RN  
Pat Hoover Physiotherapist, Specialized Outpatient Rehabilitation Services

When the McMaster and Henderson sites were invited to participate in the pilot project, their managers and educators felt they could not participate as true pilot
sites. However, they envisaged the pilot project as a unique opportunity to develop a clinical resource binder—a resource based on the 16 learning areas identified to support the enhancement of stroke best practice across HHS.

The project’s goal is to develop a stroke clinical resource binder that will guide frontline clinical staff in providing evidence-based stroke care. It will meet this goal through the provision of comprehensive information on stroke care across the continuum, and the identification of tools and resources that currently support stroke best practice within HHS and the community.

At the outset, a project nurse was designated as project leader to:

- Complete a needs assessment using the 16 learning areas to identify key priority areas for inclusion in the binder.
- Develop the binder’s content by organizing the learning areas to reflect the continuum identified in the Heart and Stroke Foundation of Ontario’s *Best Practices Guideline for Stroke Care* and the learning areas from the ILO resource.
- Devise an implementation and evaluation plan for the project (see below).

**SECTION 8: EVALUATION**

Each participant, approximately 7-10 from each site, completed a pre- and post-pilot questionnaire. This process served the collection of valuable quantitative and qualitative data that would describe for potential users the experience and recommendations of the pilot sites. Written updates provided by the site team lead were other sources of information.

The pilot sites participated in a pre- and post-pilot project interview with the project coordinator, which was intended to capture additional information and recommendations for revision of the document.

**Summative Evaluation**

Formal data collection occurred during the pre- and post-pilot phases using detailed questionnaires, meetings, electronic communication and telephone interviews. Anecdotal information was collected through regular updates and interviews conducted throughout the pilot phase and following its completion.

Pre-and post-pilot questionnaires were developed for the practitioner group, educator group, and manager group. They were designed to elicit information such as:

- Descriptive data about clinical setting (clustered/non-clustered), stroke volumes, resources, and staff structure to provide a general description of the pilot settings so similarly structured providers can identify with the pilot site experience.
- Familiarity with each of the 16 Learning Areas related to stroke care.
- Access to resources/evidenced based practice.
- Professional development and corporate practice.
• Interdisciplinary team functioning gathered before and after pilot testing, communication, collaboration.

Findings
Familiarity with each of the 16 Learning Areas showed a positive increase; although not all statistically significant. If the design had been more controlled and the surveys matched from pre to post on the basis of respondent, then a lot of these increases may have proved to be statistically significant. It was preferred, however, in the interest of maintaining anonymity, to group respondents into 3 groups: 1) Practitioner, 2) Educator and 3) Manager. No significant difference between pilot locations was found on their familiarity with each learning area pre-pilot.

When comparing pre and post questionnaires, 6 statistically significant measures were of interest.

1. Significantly more participants used the *Best Practice Guidelines for Stroke Care* (*M* = .88) post-pilot compared to prior (*M* = .47), *t*(32) = -2.67, *p*<.05.
2. Participants were significantly more familiar with their learning needs post pilot (*M* = 4.00) compared to prior (*M* = 3.21), *t*(32) = -2.39, *p*<.05.
3. Participants were significantly more familiar with the principles of stroke care (*M* = 7.46) compared to before (*M* = 6.00), *t*(24) = -2.31, *p*<.05.
4. Participants were more familiar with primary and secondary stroke prevention (*M* = 7.62) compared with before (*M* = 6.33), *t*(25) = -2.12, *p*<.05.
5. Participants were significantly more familiar with the role of skin care (*M* = 6.62) than before (*M* = 4.47), *t*(25) = -2.49, *p*<.05.
6. Participants were more familiar with the role of continence in stroke care (*M* = 5.85) compared to before (*M* = 4.00), *t*(25) = -2.35, *p*<.05.

Table 1 shows descriptive statistics for the variables of interest as measured using the questionnaires. All questions, with the exception of that related to team members mentoring each other, have means above 3, the middle, neutral option. Therefore, on average, respondents selected a response of ‘4’ or a ‘5’ (5 most positive) from the scale of options.
### Table 1

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhanced interest in self-directed learning/stroke</td>
<td>3.4167</td>
<td>1.24011</td>
<td>.35799</td>
</tr>
<tr>
<td>Interest in reflecting on learning needs related to stroke</td>
<td>3.9333</td>
<td>.88372</td>
<td>.22817</td>
</tr>
<tr>
<td>Interest in using Learning Plan</td>
<td>3.6667</td>
<td>.89974</td>
<td>.23231</td>
</tr>
<tr>
<td>Team Participation in Learning about Stroke</td>
<td>3.9333</td>
<td>.88372</td>
<td>.22817</td>
</tr>
<tr>
<td>Helpful to Accessing Current Info on Stroke</td>
<td>3.9333</td>
<td>.70373</td>
<td>.18170</td>
</tr>
<tr>
<td>Value of Prof. Ed. Reference Manual to access information</td>
<td>4.0000</td>
<td>.63246</td>
<td>.19069</td>
</tr>
<tr>
<td>Helped identify opportunities for practice change</td>
<td>3.8333</td>
<td>1.02986</td>
<td>.29729</td>
</tr>
<tr>
<td>Supported actual change in practice</td>
<td>3.5000</td>
<td>.67420</td>
<td>.19462</td>
</tr>
<tr>
<td>Enhanced evidence-based practice</td>
<td>3.5833</td>
<td>.79296</td>
<td>.22891</td>
</tr>
<tr>
<td>Team Collaboration/greater understanding of other roles</td>
<td>3.6000</td>
<td>.91026</td>
<td>.23503</td>
</tr>
<tr>
<td>Prompted team members to be mentors for my learning</td>
<td>2.8182</td>
<td>1.16775</td>
<td>.35209</td>
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</tbody>
</table>

The middle option on the scale was considered the neutral option and then further tested to see if people responded significantly higher than neutral. A series of one-sample t-tests was conducted and the outcome of those tests can be seen in Table 2. This was to determine if respondents weighted each measure consistently positive. The column of most interest is the **Sig.(2-tailed)** column. If this value is below .05 (i.e., .001, .023, .000) then the question was scored, on average, significantly higher than neutral, or stated another way, significantly positive. Only 2 of the analyses were not below .05; therefore, all questions with the exception of 2 questions, one related to increases in interest in self-directed learning and the other related to team members mentoring each other, scored significantly positively. This indicates the resource was very well received and has had an overall statistically significant, positive, impact.
### Table 2

<table>
<thead>
<tr>
<th></th>
<th>Test Value = 3</th>
<th>Sig. (2-tailed)</th>
<th>Mean Difference</th>
<th>95% Confidence Interval of the Difference</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>T</td>
<td>df</td>
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<tr>
<td>Enhanced interest in self-directed learning/ stroke</td>
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<tr>
<td>Interest in reflecting on learning needs related to stroke</td>
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<td>14</td>
<td>.001</td>
<td>.93333</td>
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<tr>
<td>Interest in using Learning Plan</td>
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<td>.66667</td>
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<tr>
<td>Team Participation in Learning about Stroke</td>
<td>4.090</td>
<td>14</td>
<td>.001</td>
<td>.93333</td>
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<tr>
<td>Helpful to Accessing Current Info on Stroke</td>
<td>5.137</td>
<td>14</td>
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<td>Supported actual change in practice</td>
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<td>Prompted team members to be mentors for my learning</td>
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<td>.617</td>
<td>-.18182</td>
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</tbody>
</table>

**General Findings (from post-pilot questionnaires, interviews)**

- Overall the resource was well received, utilized effectively, and perceived as valuable to practitioners, educators and managers in different clinical settings/organizations.
- Teams continued to meet as stroke interest groups post-pilot at most sites and sought organizational support to do so.
Resource viewed as valuable to support a team learning process that helped members to understand the roles of other team members in relation to their own and to the patients’ goals.
Enhanced interest in personal learning needs, use of a learning plan, self-directed learning, learning as a team.
The value of the resource to orientation of new staff was emphasized, although seasoned practitioners identified with areas for learning they didn’t expect.
Team members could be good mentors for individual learning in particular areas.
All stated they would encourage others to utilize the resource.
The resource was helpful to accessing current information.

Least Helpful
Difficult to go through all areas and learning objectives, could go on forever.
Need to simply self-evaluation process.
Little emphasis on Recreation Therapy but adaptable.
Time away from clinical, organizational support key, and educational modules would be great.
Too many learning objectives to review (within timeframe of project).

Most Helpful
The mini presentations from other team members.
Fostered mentorship amongst team members.
Encouraged evidence-based practice.
Becoming a stronger a team and knowing what other team members do.

Application
Although the focus of the project was to develop learning objectives for the eight regulated health professionals and test their usefulness in different clinical settings, the scope of the project precluded testing outside of the hospital-based system. Feedback during the development of the resource and implementation planning implied the learning objectives are potentially useful to health professionals working with stroke survivors across the full continuum of care. Their applicability in community-based programs, adult day services, and long term care homes is of interest.

The breadth and depth of education related to the objectives will vary depending on the roles and responsibilities of each respective health professional and the resources available to them. Non-regulated health professionals must always consider their roles, responsibilities and scope of practice when reviewing the specific learning objectives.
Flexibility is key when utilizing the learning objectives due to the variable availability of education resources and organizational priorities with respect to staff education. The type of program where stroke survivors receive care and the percentage of stroke survivors on the caseload may also affect the degree to which education relevant to any of the learning objectives is supported. Organizational support is critical and recommended.

SECTION 9: INTERPROFESSIONAL LEARNING OBJECTIVES TOOLS

To assist users to review and apply the learning objectives to their practice, a number of tools have been developed. The tools include:

- Shared Learning Objectives
- Discipline-Specific Learning Objectives
- Self-Evaluation Tool: an assessment tool to help users gauge their progress in each learning area.
- Learning Plan Template: a tool for tracking/monitoring CE activities and informing managers of educational goals.
- PowerPoint Presentation: provides an overview of the project and the Learning Objectives, and recommendations for use based on the pilot experience. Intended to assist educators or identified facilitators with introducing the resource to clinical teams and key stakeholders.

All of these tools are available at [www.heartandstroke.ca/profed](http://www.heartandstroke.ca/profed).

SECTION 10: RECOMMENDATIONS FOR FUTURE USERS

A Team Approach: Supporting Interprofessional Education Opportunities

Although educators, preceptors, and mentors may find the resource helpful to identifying what learning objectives would be relevant to particular staff they work with; an interdisciplinary team may choose to meet and address a small number of learning objectives that are relevant to the focus of their work. The learning objectives selected may be those listed for one of the 16 Learning Areas laid out in the resource, or they may cross learning areas according to the team's preference. There is no prescribed process, the team needs to consider what is of greatest interest at the time, the support they have and what is manageable for the team. After reviewing the learning objectives and selecting areas of greatest interest, the team may select a small number of learning objectives to form the basis of their team learning activity. The Inventory of Resources can help them to locate relevant information for review and discussion. By reflecting on current practice and best practice, the teams may determine strategies for change in practice that are a priority and achievable.

The Shared Learning Objectives were found to be helpful to this process and encouraged an understanding of the contribution of other team members’ to the care plan of the stroke survivor. Using case studies was identified as helpful to the process and with identifying potential changes in practice. The process can
be repeated with another selection of learning objectives identified by the group as important. This was the experience of those pilot sites that used the learning objectives as a foundation for their team learning and described it as a worthwhile process.

**An Individual Approach: Supporting the Development of a Learning Plan**

Individual practitioners may wish to review the Discipline Specific Learning Objectives to identify areas of interest and be self-directed in their approach. They may opt to use the Self-Evaluation Tool for their respective discipline to do so more systematically. The rating scale is provided to assist with reflecting on current level of knowledge and change as a result of the learning process. It is not intended to be a performance evaluation tool. The Learning Plan template may be helpful to those who currently do not use a learning plan and wish to document their selected learning objectives and educational activities. Practitioners may prefer to use the learning plan from their respective College. This may also be done in collaboration with an educator or mentor.

Managers may find this helpful to understanding the support needs of their staff and with decision-making regarding the distribution of limited educational resources.

Learning objectives deemed important to orientation of new staff may be identified as priority and incorporated in any orientation activities.
Helpful Tips from the Pilot Experience

1) Choose a specific project lead or team facilitator who can dedicate their time to introduce the resource to the team and establish an interdisciplinary learning group. The project lead helps the team to identify learning objectives of priority and to establish a plan with the team and manager. Identify a timeframe to keep the process moving.

2) The facilitator should define the teams’ expectations; times to meet and needed supports to help maintain momentum. Use e-mail to communicate about meetings and ‘next steps’ and document discussions.

3) Invite key stakeholders to meetings and keep them informed of the team’s progress.

4) Use the resource to orient and establish learning plans for new hires and, plan educational activities. Request an unrestricted educational grant from industry to help support regular meetings or supplement available resources. Attend regional stroke education events that are available at no cost. Encourage team members to share what they learned with the group.

5) Use the learning objectives to develop personal learning plans for any staff working with stroke survivors.

6) Identify three major learning needs at any one time — focusing can help to identify and ensure achievement of learning priorities and the implementation of a strategy to enhance care to the stroke survivor.

7) Use available librarians and students to access the evidence.

8) Approach a team learning activity in a way that makes sense for the team, at the time, with what resources are available. Communicate the suggested changes in practice to the rest of the team who have not participated.

9) Enjoy the experience by keeping it manageable, be open to the opinions of others, focus on the goals of patient care that are relevant to all disciplines, and celebrate your successes, small or large.