Eligibility for Stroke Early Supported Discharge Services: An Implementation Workshop

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1. Introduction

National policy has recommended the implementation of Early Supported Discharge (ESD) services to provide specialist stroke rehabilitation for patients in their own homes\textsuperscript{1}. Some areas of the country have yet to achieve this and those services which have been established do not always conform to the recommended standards based on the findings from the Cochrane systematic review on ESD\textsuperscript{2}. Our work on eligibility for ESD services is part of a programmatic study within the stroke theme of the Collaboration for Leadership in Applied Health Research and Care -Nottinghamshire Derbyshire and Lincolnshire (CLAHRC-NDL). The CLAHRC model aims to close the research to practice gap by the process of knowledge mobilisation using an organisational learning approach\textsuperscript{3}. This approach helps to make a service more amenable to constructive change and, if successful, will lead to the delivery of evidence based services. In accordance with the Knowledge into Action Model\textsuperscript{4}, the implementation aspect of our study is informed by an extensive collaboration with key ESD stakeholders. The first stage was to work with the ESD Cochrane systematic review trialists to develop the ESD consensus\textsuperscript{5} which features the aspirational ESD service. This was followed by a mapping exercise\textsuperscript{6} which was based on over 60 semi structured interviews with ESD service providers, commissioners and service users across the region, focusing on the barriers and enablers to ESD implementation. Both the ESD consensus and the mapping research have identified a number of topics influencing ESD service models in practice. The first of our practical implementation activities took the form of interactive workshops that focused on the topic of eligibility of stroke patients for ESD and was carried out with the two local ESD teams.

It is our opinion and that of the ESD consensus panelists\textsuperscript{5} that the effectiveness of an ESD service relies on collaborative decision making between ESD and acute services. There is a clear need to involve hospital and ESD team staff in the identification of patients who meet the criteria for ESD. The areas covered by these criteria, distilled from the Cochrane systematic review, include medical
stability, physical mobility and rehabilitation goals and have been well established supported by the evidence-base \textsuperscript{2,5}. However, according to the findings of the consensus and the mapping, there can be varying degrees of flexibility in how the criteria are interpreted and applied. There are potential negative implications to criteria being misinterpreted or applied too loosely such as the creation of bottlenecks or blocking of the service.

2. Aims

The primary aim of our workshops was to facilitate an evidence based approach to the joint decision making involved in establishing the eligibility of stroke patients for ESD services. The eligibility criteria promoted were those established by the Cochrane trialists \textsuperscript{2} and the ESD consensus \textsuperscript{5}. The workshops aimed to provide an overview of a ‘gold standard’ ESD service; factors impacting on eligibility; research versus practice and understanding and applying criteria. Communication and collaborative working across organisational and professional boundaries were also addressed.

3. Methodology

Overview:

A structured, facilitated, multidisciplinary, interactive workshop approach was selected as our method of choice as it took advantage of natural interactions and participants were more likely to be influenced by others, giving this model face validity. The workshops provided the opportunity for direct interaction between researchers and service providers allowing for wider discussion, clarification and follow up questions.

The workshops provided an overview of the evidence and context of ESD within the stroke pathway and incorporated ‘real life’ ESD vignettes representing multiple scenarios. This helped to facilitate key discussion of important issues derived from our findings from the ESD mapping exercise previously conducted. The workshops were designed for use with joint multidisciplinary team (MDT)/ESD teams.
Content of workshop (Appendix 1):

(double click icon for PowerPoint presentation) is a group. The questions covered topics such as: which aspects of eligibility are most important; what are the advantages of specific criteria versus holistic assessment; where and how could improvements be made?

Target group: The sessions were designed to involve all of those involved in the ESD referral process. The members of both ESD teams, and the hospital based teams referring to them, were invited to participate in the workshop. The sessions were attended by both community and hospital based medical staff, occupational therapists, physiotherapists, nurses, speech and language therapists, social workers and discharge coordinators. Participants were representative of both rural and urban services. The sessions would also be relevant for all those involved in emerging ESD services.

Evaluation: The workshops were facilitated by a member of the research team and comprehensive notes were taken during the workshops by independent observers. Participants were asked to complete an evaluation questionnaire (appendix 2) before leaving the workshop. The questionnaire incorporated both open and closed questions relating to the perceived usefulness of the workshop as well as lessons learned. Six key staff involved in the stroke pathway were followed up at least six weeks after the workshops using telephone interviews (appendix 3). The follow up was designed to gather more in depth information on what changes may have been made to practice following the workshop. A predefined set of open ended questions were asked to elicit thoughts on the value of the workshop and any changes made to current practice.
4. Commentary and Key Themes

This section of the report draws on the notes taken by the workshop observers and the facilitator. Analytical memos were made to note emerging themes. The workshops were held in two different locations of Nottinghamshire and involved staff from the local ESD teams and their referring hospitals. The feedback from both workshops has been amalgamated and is reported as one set of findings. The workshops were attended by 25 participants over the two sites. Attendees included ESD managers, physiotherapists, OTs, SaLTs, nurses, discharge coordinators and a hospital stroke consultant. The report does not contain all of the discussions and comments made during the workshops but highlights the main issues raised and establishes common themes. The ESD mapping work characterised key eligibility issues and these have been used to structure the commentary.

- **ESD as flexible/hybrid rehabilitation systems**

  The ESD consensus identified a lack of clarity on when an ESD referral should be made. The mapping went on to establish that ESD can be accessed after varying lengths of hospital inpatient stay. An anonymised case study was used in the workshop to highlight the issues around accessing ESD following a protracted length of inpatient care.

  **86 year old man who lives alone. Had stroke 28.02.11. Patient spent 18 days on the acute stroke unit before being transferred to his local hospital for further rehabilitation. His Barthel on discharge from the acute unit was 10. He was then transferred to an intermediate care facility for 6 weeks.**

  When asked whether this patient might be eligible for ESD it was generally felt amongst the urban ESD team that each case should be considered on their individual merits. It was felt that patients should be
eligible for ESD if they had stroke specific rehabilitation needs irrespective of the time post onset of stroke. There was acknowledgment that this contradicted the evidence base but it was felt that flexibility was a key part of an effective ESD service. The hospital physiotherapy staff however felt that this particular patient was too far outside the “early acute zone” and should consequently be picked up by the community stroke team (CST). Members of the urban ESD team observed that the ESD and CST “almost operate as one service” and if the ESD team were not fully employed with those fitting their criteria then they could take patients off the CST caseload in the interests of cooperation and joint working. The rural service however did not have the benefit of a CST or any other community neurological service. As a consequence the rural ESD team felt that the patient was too long post onset to be considered. In the absence of other services it was considered that this type of patient should receive stroke rehabilitation whilst in intermediate care. It was agreed that this was not normally the case and would raise obvious funding issues but it was felt that the patient should remain on the stroke pathway and ESD was not appropriate. The rural ESD team regularly take patients from longer stay rehabilitation beds but this was considered to be part of the ‘normal’ stroke pathway.

It was apparent that the possibility of the ESD team working as a flexible and hybrid service was only possible if other community stroke/neurology teams were also available. In this context ESD teams could take patients originally referred to the CST but if they consequently required more intensive input then they could be referred across teams. This results in a “two teams within one service” scenario. It was also apparent that the CST could, if required, increase the intensity of input to ESD levels if there was no capacity within the ESD caseload. The difference in the resulting stroke pathways is shown in Figures 1 and 2.
Figure 1: Reported stroke pathway for urban ESD service
Figure 2: Reported stroke pathway for rural ESD service
Referral processes

The ESD consensus established that hospital and ESD staff should be involved in the identification of patients fitting the ESD eligibility criteria. The mapping research found that in reality various practices and processes exist involving varying degrees of acute and ESD communication and collaboration. There is first an initial identification of eligible patients by one of the stroke unit staff whether this is the stroke physician, nurse or member of the rehabilitation team. The process of communicating this information to the ESD team varies depending on the set up of the acute service. When there is only one stroke ward it is possible for a member of the ESD team to attend the weekly MDT meetings to take part in discussions concerning who may or may not be eligible for ESD. If patients are admitted between MDT meetings and early discharge is possible with ESD involvement, then the designated member of ward staff, usually the discharge coordinator or specialist nurse, will notify the ESD team. This might be an informal signposting phone call or a faxed referral. This boundary spanning approach can be facilitated by the stroke physician who can have a dual role in both the acute MDT and the ESD team. This occurs in both of the ESD teams included in the workshop. However the referral process is often delayed and when there is pressure on the acute beds then patients sometimes have to be transferred to rehabilitation wards/units when in reality they could have returned home with ESD support. The result of this is a more protracted inpatient stay than is necessary. Discussions at the workshop highlighted the need for a rapid decision being made by the ESD team. This urgency had not previously been apparent to the ESD managers. Some of the staff from the rural ‘feeder’ hospitals felt that they were “out on a limb” with little idea of why their referrals were not accepted as there was no feedback mechanism. In the absence of a discharge coordinator or social worker, referring staff felt that the process of referral was unclear and time consuming. There was a general feeling that more could be done to assist communication between organisations, professions and teams.
Stoke specialist knowledge

The mapping research identified the stroke physician as having a key leadership role in linking the hospital and ESD service. As a stroke specialist the physician should ensure that the medical needs of the patient have been addressed before a transfer is made to the ESD team. This role can also be supported by stroke specialist nurses who provide vital support in the decision making around medical stability. Both ESD teams reiterated that the team could only take referrals for patients with a confirmed diagnosis of stroke. Concern was raised however that this confirmation was not always forthcoming as there was sometimes disagreement amongst medical staff. The interpretation of test results was also open to individual interpretation. One of the anonymised case studies demonstrated issues around stroke diagnosis.

56 year old man who lives with his wife. Had a stroke 21.11.11. Diagnosis changed whilst on the stroke unit to TIA. Discharged 25.1.11. Barthel score on discharge of 20.

The fact that the patient had a change of diagnosis was thought not to preclude him from accessing ESD. It was felt that when there was disagreement over diagnosis the professionals should use their stroke specialist judgement to decide whether the patient should be able to access stroke services. The consensus was that they should be guided by any residual stroke symptoms and if the patient had any stroke specific rehabilitation needs. When informed that this particular patient had received ESD and still had restricted movement at a year post onset, the group felt that this supported their decision as the TIA diagnosis was obviously incorrect.
> **Criteria**

The systematic review and the consensus both highlighted the criteria which should be applied when considering eligibility for a ‘gold standard’ ESD service. These eligibility criteria include medical stability, ability to transfer with one (or independently if living alone) and the presence of stroke specific rehabilitation goals. However the mapping research found that in reality the criteria applied to make decisions about which patients access the ESD service were more numerous and complex. They included the geographical location of the patient’s home, psychological and social wellbeing, safety in the home, communication issues and the presence of risk factors. There was also great flexibility in how these were applied. On discussion, the issue of medical stability was considered to be of paramount importance. GPs were unlikely to be able to respond quickly enough to support those with residual medical problems. Non-clinical factors such as the location of the patient’s GP and service capacity were also key criteria to be considered. In reality, in the area where there were no alternative community rehabilitation services, patients would be accepted from out of the designated area if the team had the capacity to do so. However when the ESD team were working at full capacity these patients might not be accepted creating what the therapists from the outlying hospitals referred to as a “postcode lottery”. The apparent lack of consistency in how rigidly the eligibility criteria are applied was reported as creating problems for stroke unit staff. It was considered to be essential that there should be regular communication between ESD and hospital staff to communicate capacity levels. This would facilitate a greater understanding of the respective service pressures. Although therapists understood that the criteria established via the systematic review and the consensus identified those most likely to benefit from ESD, the general feeling was that in practice there should be more flexibility and professional judgment exercised.
➢ **Challenges**

- Both ESD teams involved in the workshop activities report that they operate differently in response to local challenges. This could result in the services not achieving what they were commissioned for.
- The presence of other stroke specialist community services allows for greater compliance with research based eligibility criteria. However there are no such teams in some areas.
- The referral system between the hospital and ESD team can be convoluted and fraught with misunderstanding.
- Effectiveness of ESD can be difficult to quantify due to flexibility in the way eligibility criteria are applied.
- It was felt that fewer patients would go through ESD if eligibility criteria were rigidly applied.

➢ **Aspirations of the ESD teams**

- Creation of channels to address issues around what is referred to as ‘bad’ or inappropriate discharge.
- Communication with stroke physicians on issues and problems experienced by the ESD and hospital rehabilitation teams as a result of disparity in stroke diagnosis.
- Identification of stroke specific outcome measures.
- Improvement in the structure and content of the locally derived discharge documentation required when referring to ESD.
- Improvements in joint working and decision making between hospital and ESD teams.
5. Workshop Evaluation

Questionnaires

Questionnaires were completed by all of the course participants (n=25) prior to their departure from the workshop. The questions comprised both open and closed questions. The closed questions are displayed in pictorial form with a short summary. Topics from the open questions will be discussed and key themes extracted.

Question 1: How would you rate the workshop overall?

All of the course participants rated the workshop favourably. When asked what the most useful aspects of the workshop were, the most commonly raised issues related to communication and relationship building. This forum was the first time that all of the individuals involved in the ESD stroke pathway had met in one place. One of the participants commented that “it was refreshing to have an honest and open dialogue”. Comments were also made about the value of the workshop in raising awareness of CLAHRC stroke theme activities. The only negative aspects highlighted were the lack of clearer objectives prior to the event and restricted time for discussion.
Question 4: To what extent was the session worth your time?

<table>
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<tr>
<th>Rating</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Well worth the time</td>
<td>44%</td>
</tr>
<tr>
<td>Worth the time</td>
<td>48%</td>
</tr>
<tr>
<td>Somewhat worth the time</td>
<td>8%</td>
</tr>
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<td>Not worth the time</td>
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All participants felt that the workshop was worth the time spent.

Question 5: Please rate the workshop on the following items:

- **Facilitation of decision making**
  - Poor: 4%
  - Fair: 52%
  - Good: 44%

- **Relevance**
  - Poor: 40%
  - Fair: 60%

- **Involvement of participants**
  - Poor: 44%
  - Fair: 56%

- **Organization**
  - Poor: 4%
  - Fair: 64%
  - Good: 32%

- **Content**
  - Poor: 76%
  - Fair: 24%

The vast majority of participants found all aspects of the activity either good or very good. The only topics rated as fair by one person was the organization of the workshop and the facilitation of decision making.

The topic which was felt to be missing from the implementation activity was the inclusion of more information from ESD services in the region including feedback.
from the regional cardiovascular network ESD review (it was noted by the facilitator that this report was not yet in the public domain so could not be included in the information presented.)

When asked how the workshop might impact on the participant’s role, a number of areas were raised. The main issue appeared to be the raised awareness of the roles of other professionals on the stroke pathway and the acute service pressures that existed. The channels of communication were felt to have been enhanced and there was a general feeling of confidence when communicating with others. The information contained in the workshop was felt to build on existing knowledge of the evidence base and raise understanding of the ESD service. When asked what might be done differently as a result of the workshop, most of the proposed changes related to the referral process. Improvements in communication and more discussion between professionals were suggested as ways to speed up the referrals and consequently identify those most suitable for the service. Improvements in the acute/ESD interface were felt to be essential. Some participants thought that the eligibility criteria should be applied more flexibly rather than adhering to the recommendations from the evidence base.

**Question 8: To what extent do you think you can apply the learning of today to your work?**

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<tr>
<th>Response</th>
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<tbody>
<tr>
<td>Very significantly</td>
<td>25%</td>
</tr>
<tr>
<td>Significantly</td>
<td>46%</td>
</tr>
<tr>
<td>Slightly</td>
<td>29%</td>
</tr>
<tr>
<td>Not at all</td>
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Over 70% of attendees felt that the workshop had contributed to their knowledge which could then be applied to their role. The remainder felt that the workshop had made a slight contribution.

Question 10: To what extent do you think the workshop addressed the aims?

<table>
<thead>
<tr>
<th>Aim</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
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<tr>
<td>Encouraged joint decision making</td>
<td>50%</td>
<td>50%</td>
<td></td>
<td></td>
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<tr>
<td>Facilitated communication and collaborative working across teams/organizations</td>
<td>29%</td>
<td>71%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased knowledge of the evidence base</td>
<td>63%</td>
<td>25%</td>
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<tr>
<td>Provided an evidence based approach to establishing eligibility for ESD services</td>
<td>54%</td>
<td>38%</td>
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The workshop was considered to have achieved it aims of encouraging joint decision making and facilitating communication across teams. The sessions also increased knowledge of the evidence base and an evidence based approach to establishing eligibility.

When asked if the workshop would be of value to others in a similar field, participants felt that they provided a useful knowledge sharing opportunity as well as providing assistance with decision making. It was also thought that the sessions would be of great value to emerging ESD teams. The majority of respondents reported that the most valuable aspect of the workshop was the opportunity to improve working relationships and increase awareness and understanding of the service pressures experienced by others.
Question 12: Overall, what sort of learning experience was this workshop?

The majority of respondents found the workshop to be a positive learning experience. Those rating it as fair were those who have a peripheral role in establishing eligibility for ESD.

Most of those attending would have liked more time for open discussion. More pre workshop information and handouts were also requested.

Participants were very positive about the opportunity to have an honest and open discussion. The interactive format was appreciated. It was felt that the workshop highlighted that the strict application of eligibility criteria was not always possible in practice due to service pressures.
Post workshop interviews

Six workshop participants who play key roles in the stroke ESD pathway were followed up at a minimum of six weeks post event with a telephone call. They were asked five open ended questions to establish what changes might have been made to practice as a result of the workshop (Appendix 3).

The agreement amongst the staff interviewed was that the workshop provided one of the only opportunities for all of those involved with the ESD service to meet and discuss common issues. It was felt that discussions were frank and open with almost all participants involved. An ESD manager stated that she “valued the opportunity to speak to clinicians on operational issues”. The link with the research team was also seen as positive with one clinician reporting that “it was useful to get some preliminary feedback from the research team – we were aware that the research was happening but it’s nice to know that something is being done with it”.

When asked what changes have been made as a result of the workshops most of the feedback centered on the process of ESD referral. One of the rehabilitation team from a rural ‘feeder’ hospital noted that they “had a patient who didn’t meet the criteria but when they did it was too late as the team was at full capacity”. Because of the information sharing at the workshop around cut off times, referrals are now made much earlier rather than waiting until the patient fulfills all of the eligibility criteria. Earlier referral was a common theme amongst interviewees. Discussions around the need for a speedy decision on referrals to prevent transfer to rehabilitation beds had prompted one of the ESD managers to initiate a brain-storming session. The session looked at how the referral process might be made more efficient particularly as it was apparent from workshop discussions that the decision sometimes needs to be made within 2 hours. The idea of having an ESD team member on-call at all times is being considered and further meetings are planned with the stroke unit rehabilitation team to progress this idea.
There was an agreement amongst the staff interviewed that the workshop had facilitated communication and collaborative working. It was reported that since the workshop, one of the rural ‘feeder’ hospitals that had been represented at the workshop, had been in touch with the ESD team. The links that had been forged at the workshop resulted in an increase in referrals from this area. ESD staff are now attending more meetings with patients and their families at the rehabilitation unit in order to identify eligible patients more quickly. Data is being collected to establish whether this has been successful. Meetings have also taken place in some areas to identify an ESD link person to oversee referrals. This is now in place and it is hoped that it will result in a build up of rapport and understanding.

Issues raised at the workshop which are being taken further are the possibility of an on-call member of ESD staff to consider urgent referrals; regular MDT/ESD meetings to discuss any ‘bad referrals’ and to update on any service/capacity issues; possible ‘Time Out’ days for ESD/MDT staff and the reconsideration of the SNAP document which is required for ESD referral. A meeting has been arranged to further proposed alterations to the SNAP which is thought to be too time consuming and may contribute to delays in ESD referral.

The general feeling amongst those interviewed was that the workshop had improved working relationships and communication. The discussion of shared challenges and possible solutions was considered to be one of the main benefits of the session. It was felt that some of the forums operating presently involving community and hospital staff “are not practical for improving things on the ground with little opportunity to raise issues. I thought the workshop provided this forum”. It was also commented that “it was a very useful meeting and an opportunity for everyone involved to get together and talk about issues in a frank and honest way”.
6. Conclusions and recommendations

Core messages

The primary aim of the workshop was to increase knowledge of the evidence base relating to ESD. In turn it was hoped that this would facilitate an evidence based approach to establishing eligibility of stroke survivors for ESD services. The workshop evaluation and follow up interviews suggest that this was achieved. However, it was apparent that those involved in delivering the ESD service considered it essential that the application of ESD eligibility criteria should be flexible if required. Stroke specialist opinion was also felt to play a vital role in identifying those who would most benefit from ESD input. The flexibility being operated by ESD teams had consequently led to diverse and convoluted stroke pathways. The existence of other stroke specialist community teams in the area appeared to support the possibility of increased compliance with evidence based practice. Where no such teams exist, the ESD team is the only community based option and consequently has to be more flexible in the patients accepted by the service.

The aim of the workshop was also to facilitate closer communication and collaborative working between the acute and ESD services. This was perhaps the most successful outcome of the sessions. All participants reported improved communication and cross boundary working. This has resulted in earlier, more appropriate referrals. Relationships forged at the workshop are supporting more effective inter agency working and it was reported that there was generally a greater understanding of the working practices of others within the stroke service.
Recommendations

The recommendations derived from the workshop are those suggested by the participants, some of which have already been implemented:

- The development of key worker roles to facilitate the referral process and act as boundary spanners
- Joint Stroke Unit MDT/ESD meetings to make decisions on eligibility for ESD services
- Possible introduction of joint acute/ESD posts or staff rotation to increase knowledge of the stroke pathway
- Time Out days involving both Stroke Unit and ESD staff
- Review of the referral process including the assessments used i.e. SNAP (discharge document)
- Meetings to review and discuss ‘bad’/inappropriate discharges
7. References


8. Appendices

Appendix 1: Content of PowerPoint Slides

Slide 1
Eligibility for ESD:
An Implementation Workshop

Slide 2
The Successful Implementation of Early Supported Discharge Services

Slide 3
1. ESD consensus: core components of evidence based ESD services
2. Mapping ESD services: qualitative investigation of context
3. Implementation activities: addressing barriers
4. Evaluation of ESD services operating in practice

Slide 4
Why are we running the workshops?

- Promoting evidence based practice
- Implementation phase – addressing challenges raised in stakeholder interviews
- Collaborative partnership with East Midlands Cardiovascular Network
- ESD service specification informed by ESD consensus

Slide 5
• ESD service reviews 2012 – highlighting common issues across the East Midlands

• Eligibility and decision making – which patients should benefit from ESD and why?

• Data handling – what outcomes to collect and why; measuring effectiveness

• Outcome: piloted workshop and educational materials – potential use across the East Midlands in collaboration with NHS Stroke Improvement

Aims of our implementation

• To facilitate communication and collaborative working across teams and organisations

• To encourage joint decision making
References

- Langhorne P for the ESD trialists. Services for reducing duration of hospital care for acute patients (review). Cochrane database of systematic reviews 2005, issue 2

Eligibility: Criteria

- Confirmed diagnosis of stroke
- Medically stable
- Able to transfer independently/assistance of one
- Identified rehabilitation goals
- Over 18 years of age
- Able to provide informed consent
- 14 days or less post onset of stroke
Eligibility: Timing

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<tr>
<td>Snowall et al (2010)</td>
<td>Home care vs conventional care</td>
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Eligibility: Decision making

- Decisions about the suitability of ESD for patients rely on effective communication and collaboration processes between hospital ward staff, the ESD team and the patient

Consensus


- Core elements of an ESD service: list of statements
• ESD consensus identified core elements of an evidence based ESD service based on findings from clinical trials and recommended optimal methods for measuring success. The findings of the consensus have informed the East Midlands stroke service specification.

Mapping

• The ESD consensus and qualitative mapping research carried out in Nottinghamshire have identified a number of topics influencing ESD service models in practice.

CONSENSUS v MAPPING

• Hospital staff and ESD team staff should identify patients for ESD

• Various and variable acute to ESD communication and collaborative practices
• ESD is beneficial for mild to moderate stroke severity

• Decision making involves using stroke specialist knowledge and MDT working

• Specific ESD eligibility criteria are required

• More numerous and complex criteria used, plus flexibility in how they are applied

• Barthel score of 10-17/20

• Barthel scores are used but high scores do not exclude patients

• Lack of clarity of when most optimal to make decision around ESD referral

• ESD can be accessed after varying lengths of acute rehab inpatient stay
ESD Case Studies

Who should receive ESD according to your understanding of ESD eligibility criteria?

PATIENT A

- 90 year old man who lives with wife who is registered blind. Had stroke 1.11.10. Spent 4 days on acute ward then transferred to rehab ward for 14 days. Discharged 18.1.11. Barthel on discharge of 20. Patient also has terminal cancer

PATIENT B

- 86 year old man who lives alone. Had stroke 28.2.11. Patient spent 18 days on stroke unit then transferred to local hospital for further rehab. Barthel on discharge from acute ward of 10. Patient then transferred to Intermediate Care facility for 6 weeks.

PATIENT C

PATIENT D


PATIENT E

- 51 year old man who lives with his wife. Had stroke 16.3.11 admitted to acute stroke ward. Discharged home 23.3.11. Received outpatient physiotherapy. Barthel on discharge of 15.

Eligibility discussion

Key questions around aspects of ESD eligibility criteria derived from the ESD mapping
What are the key features of eligibility for ESD? ESD research versus ESD service

• How do ESD research team members define and characterise ESD eligibility?

• How do ward staff and ESD teams define and characterise ESD eligibility?

• How does eligibility for ESD compare to eligibility for other services?

• When and how are decisions made about eligibility? By whom? How has the process changed over time?

• How is eligibility assessed, measured and evaluated?
• Which aspects of eligibility are most important?

• What are the advantages of specific criteria versus holistic assessment?

• Can criteria be categorized into: factual vs quantitative vs qualitative?

• Can criteria be weighed?

• What has been the impact/influence on ward/ESD team practices?

• Where and how could improvements be made?

• What can we use and apply for future implementation activities?
Appendix 2

ESD Eligibility Workshop Questionnaire

We would be grateful if you could complete this questionnaire to give us feedback on our implementation activity. You may keep your responses anonymous if you so choose.

1. How would you rate the workshop overall?
   - Poor □
   - Fair □
   - Good □
   - Very good □

2. What was the most useful thing about the workshop?

   __________________________________________
   __________________________________________

3. What was the least useful thing about the workshop?

   __________________________________________
   __________________________________________

4. To what extent was the session worth your time?
   - Not worth the time □
   - Somewhat worth the time □
   - Worth the time □
   - Well worth the time □
5. Please rate the workshop on the following items:

<table>
<thead>
<tr>
<th>Item</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very good</th>
</tr>
</thead>
<tbody>
<tr>
<td>Content</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Organisation</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Involvement of participants</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Relevance</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Facilitation of decision making</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

6. What did you expect to get from the workshop but did not?

______________________________________________________________

______________________________________________________________

7. How do you think the workshop will assist with your role?

______________________________________________________________

______________________________________________________________

8. To what extent do you think you can apply the learning of today to your work?

Not at all ☐   Slightly ☐   Significantly ☐   Very significantly ☐
9. Do you intend to do anything differently as a result of this workshop? If so, what?


10. To what extent do you think the workshop addressed its 4 aims?

- Provided an evidence based approach to establishing eligibility for ESD services.
  Poor □  Fair □  Good □  Very good □

- Increased knowledge of the evidence base.
  Poor □  Fair □  Good □  Very good □

- Facilitated communication and collaborative working across teams/organisations.
  Poor □  Fair □  Good □  Very good □

- Encouraged joint decision-making.
  Poor □  Fair □  Good □  Very good □

11. Do you think this workshop would be of value to others in a similar field to your own? If so, how?


12. Overall, what sort of learning experience was this workshop?

Poor □  Fair □  Good □  Very good □
13. Do you have any suggestions as to how this session might have been improved?

___________________________________________________________________
___________________________________________________________________
___________________________________________________________________

Do you have any further comments? _____________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________

Thank you for your assistance.

Optional:
Name: ______________________________

Position: ___________________________
Appendix 3

Post-workshop interview questions

a) In hindsight do you feel that the eligibility workshop was of value?

b) Has it changed anything that you do?
   If so, how?

c) Has the workshop assisted with communication and collaborative working?
   If so, how?

d) Were there any areas raised at the workshop which you think should be taken further?
   If so, are these things that could be facilitated by the research team and how?

e) Are there any other comments or observations you would like to make regarding this implementation workshop?