STROKE & APHASIA BEST PRACTICE

A Canadian KTE Collaboration

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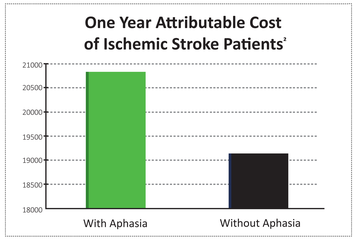
BACKGROUND

One in three patients with stroke have aphasia[1] [2]. Stroke is the single greatest cause of disability in most Western nations and presents a significant global health care burden[3]. Stroke patients with aphasia have longer lengths of stay, higher costs of care, lower rates of returning home and less favourable outcomes overall[1] [2]. Aphasia is included in the ten top stroke research priorities[4] and a large Canadian study identified aphasia as the primary factor that negatively impacts quality of life for stroke patients[5]. In contrast to recommendations for most physical interventions, stroke guidelines around the world, including Canada, have had relatively few references to aphasia management. Out goal was to address this issue.



A decision was therefore made to develop comprehensive best practice recommendations (BPR's) for stroke and aphasia in Canada and to influence actual practice in stroke care. A team of stroke and aphasia thought leaders secured a *Canadian Institutes of Health Research* (CIHR) *Knowledge Transfer and Exchange* (KTE) *Planning Grant* (#12197) to lay the groundwork to move this agenda forward.

APHASIA INSTITUTE

CIHR IRSC Canadian Institutes of Health Research / Instituts de recherche en santé du Canada

PLANNING GRANT ACCOMPLISHMENTS

1 EVALUATE RESEARCH EVIDENCE

A national group of aphasia researchers, stroke thought leaders, and practitioners reviewed existing research inventories and BPRs from around the world. The group examined evidence sources and levels of evidence to identify gaps in research and priorities for knowledge translation.

2 ENGAGE KNOWLEDGE USERS >>> Compare current research evidence and BPRs with:

What consumers want

Via focus groups with people with aphasia (PWA) and family caregivers

Key Findings:

The need for all team members to adjust their interventions in a manner that emphasizes communication, patient involvement, and participation in rehabilitation.

> *"You should take the whole staff in the acute care hospital and make them learn about aphasia."* -PWA

There is a lack of emphasis paid by the Canadian health care system to support communication focused services for the stroke population with aphasia.

> *"My husband is allowed $500 a year in speech therapy so that is 4 private speech lessons... It isn't enough."* -Family Member

Existing evidence synthesis not clearly integrating family interventions into aphasia rehabilitation

> *"I wasn't allowed to attend (SLP sessions), I had to stand outside the door."* -Family Member

The system was difficult to navigate, and services related to communication, education, and support were not received throughout the care continuum.

> *"No one told us about aphasia until we got here (Aphasia Institute)."* -Family Member

What SLPs do

Via a survey of Canadian speech-language pathologists (SLPs) about their management of PWA

Key Findings:

54% of SLPs agreed that they use BPRs to inform practice

42% indicated that they typically begin communication therapy for stroke patients 1-3 days after admission or referral

59% indicated that they typically assess stroke patients for communication/speech 24–48 hours after admission or referral

Priority items that would enable the consistent use of evidence-based practices

- Time (read and implement BPR)
- Training and education
- Interdisciplinary approach
- Resources (space, SLPs, community programs and do-able BPR)
- Support from management, physicians, team and family
- Technology (learning and therapy)
- Funding for SLP resources
- Services and system

3 EVALUATE EXISTING EVIDENCE & GAPS >>> In relation to BPRs

Key Findings

Based on stakeholder data, along with a discussion of the gaps and misalignments between existing BPRs, current research, patient/client values, and expert opinion[6], the team made a major contribution to the development of a set of nine new best practice recommendations for stroke and aphasia. These were subsequently incorporated into the *Canadian Stroke Best Practice Recommendations* (Spring 2013)[7].

The *Canadian Stroke and Aphasia Team*, along with invited knowledge users from across Canada (including PWA, researchers, educators, health care providers, and policy makers) met prior to the 2013 *Canadian Stroke Congress* to answer the question:

Which stroke and aphasia best practices are ready to mobilize from research and recommendations to practice?

CANADIAN STROKE BEST PRACTICE RECOMMENDATIONS FOR STROKE CARE – REHABILITATION TO IMPROVE COMMUNICATION

(4th Edition, July 10, 2013)

1. **All health care providers working with persons with stroke across the continuum of care should be trained about aphasia, including the recognition of the impact of aphasia and methods to support communication.**
2. All Stroke patients should be screened for communication deficits using a simple, reliable, validated tool.
3. Patients with suspected communication deficits should be referred to a Speech-Language Pathologist (SLP) for assessment of communication ability in the following areas: listening, speaking, reading, writing, gesturing, use of technology, pragmatics (e.g. social cues, turn-taking, body language, etc.),
4. Persons with aphasia should have access to a combination of intensive language therapy and communication therapy according to their needs, goals and impairment severity.
5. Treatment to improve functional communication can include language therapy focusing on production and/or comprehension of words, sentences and discourse (including reading and writing); conversational treatment, and constraint-induced language therapy; use of non-verbal strategies, assistive devices and technology (e.g., I-Pads, Tablets, other computer-guided therapies) can be incorporated to improve communication. Therapy benefits can be enhanced with computerized language therapy.
6. Treatment for aphasia should include group therapy and conversation groups. Groups can be guided by trained volunteers and caregivers overseen by an SLP to supplement the intensity of therapy during hospitalization and/or as continuing therapy following discharge.
7. **Treatment to improve functional communication should include Supported Conversation techniques for potential communication partners of the person with aphasia.**
8. All information intended for patient use should be available in aphasia-friendly formats (e.g., patient education material should be available in audio/visual format). This includes materials such as educational information, consent forms and information regarding participation in stroke rehabilitation research, and assessment tools.
9. **Families of persons with aphasia should be engaged in the entire process from screening through intervention, including family education and training in supported communication.**

LEGEND:

Team decision regarding priorities for mobilization based on readiness, evidence, and impact

NEXT STEPS

Using stakeholder input regarding readiness, ease and impact on the health system, as well as those directly affected by aphasia, our team made a decision to mobilize three of the nine BPRs. The guideline that combined desired features of high level of evidence, readiness, and impact was BPR #7, related to 'Supported Conversation for Adults with Aphasia' (SCA™). Two additional guidelines were included because of the logical relationship to BPR #7: first, BPR #1 (training for stroke care providers about aphasia); and second, BPR #9 (training and support for families).

The team aims to adapt SCA™ for the early acute care hospital setting. The goal is to enable the 'critical conversations' essential to quality of care and key family relationships. Objectives may include:

1) To adapt and evaluate an intervention relevant to acute care that improves the ability of stroke care providers to communicate successfully with their patients with aphasia, and,

2) To adapt and evaluate an intervention that improves the ability of a stroke team to support and teach families of patients with aphasia in the acute care setting to communicate successfully.

The team anticipates that a project of this nature will provide valuable insights into how the implementation of the BPRs can be effectively customized to acute care settings. The over arching goal is to develop a practical and relevant intervention program for stroke teams which will also result in more positive experiences reported by family members. Findings will ultimately guide the translation of BPRs to front line practice in other interprofessional settings, as well as other professions interested in implementing best practices.

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