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Tailoring stroke best practice recommendations to the care home context: Identifying a balance between theory and real-world practice

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**Tailoring stroke best practice
recommendations to the care home
context: Identifying a balance
between theory and real-world
practice**

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Title of study

Tailoring stroke best practice recommendations in the care home context: Identifying a balance between theory and real-world practice.

Abstract

This thesis is a study designed to advance understanding of 'tailoring' within the field of implementation research. The study took place in the care home context, where tailoring was examined in action, to adapt the evidence for stroke and to tailor implementation of the adapted evidence-based stroke care guidelines within the United Kingdom care home context.

Study aim and objectives

The aims of the study were to advance implementation theory about tailoring.

A key objective was to perform an in-depth study of tailoring in action to examine the value of tailoring as part of the implementation process.

The second object was to develop a process map for tailoring to advance implementation in practice.

Methods

An interpretive, constructivist approach was employed, to examine tailoring in action, which sought to develop a theoretical map of the tailoring processes examined in action in the care home setting. The qualitative case study approach (Stake, 2006) was chosen to study the phenomena of tailoring, through which stroke best practice recommendation were adapted to and implemented in the care home context. Data were collected from care home staff during interviews (n = 48), to establish the context of existing interventions for residents with stroke living in the care home setting. Consensus workshops (n = 6) were then undertaken in participating care homes (n = 3) to tailor stroke best practice recommendations for the local context. The use of cognitive questioning during the workshops helped to identify aspects of tailoring in action to enable the construction of a process map. The use of the case study approach enabled the examination of tailoring in action to determine theoretical constructs.

Findings

Of relevance to the field of implementation research, key theoretical constructs of tailoring, were illuminated. Constructs included feasibility, which sought to create a fit to the local context. This construct was counterbalanced by maintaining the fidelity of the original evidence. The need to balance feasibility and fidelity within the process of tailoring, revealed a 'sweet spot' for successful implementation where evidence meets the real world of practice. These findings have implications for other implementation researchers who are seeking methods to facilitate research evidence in to day to day practices, and thereby reduce the evidence to practice gap. Findings also highlighted aspects of research practice and influencing factors when collaborating with care homes, such as the influence of the customer / provider model, and the constraints of meeting regulators criteria.

Recommendations

The theoretical propositions uncovered in the discovery of a 'sweet spot' for implementing evidence into practice within this study provide important new knowledge for implementation research and health care practice, in that they identified theoretical constructs which can be employed by, for example, researchers and practice development facilitators to tailor evidence and implementation strategies for any given context. Of specific interest is the identification of a tailoring map designed to balance feasibility and fidelity, and thus help to reduce the evidence to practice gap, by tailoring evidence to create a fit for the local setting whilst ensuring fidelity of the original evidence is protected.

Acknowledgements

I would like to pay tribute to and thank some very special people, without whom this thesis would not have been possible. First of all, I offer special thanks to my supervisors Professors Chris Burton and Jo Rycroft-Malone. I would also like to thank Professor Debbie Roberts and Dr. Lynne Williams for their supervision and endless support, I really appreciated it!

This study was conducted in the care home setting and I would like to thank the care homes, the managers who engaged their care homes in this study, and in particular the care home staff who gave up their time, often on their days off, to participate. Their enthusiasm to improve the residents experience was both encouraging and motivating.

I would also like to pay special thanks to the amazing students we have at Bangor University, who challenged and motivated me on a daily basis and more importantly helped me to keep a sense of reality amidst my PhD universe.

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Chapter 1

Introduction

1:1 Study synopsis

This thesis reports upon a study, which advances understanding of 'tailoring' within the field of implementation research. Tailoring is mentioned within the implementation literature, for example; Graham et al. (2006) include tailoring as part of their knowledge to action process, where tailoring is suggested to tailor both knowledge and implementation strategies. Baker et al. (2010) performed a systemic review of tailoring for the Cochrane data base; they focused upon tailoring implementation strategies to address potential barriers in order to enhance uptake of evidence-based practice. There is however, no process map or theoretical constructs for tailoring; this PhD study seeks to address this.

A National Institute for Social Care and Health Research (NISCHR), now Health and Care Research Wales, PhD scholarship was awarded, to investigate ways to implement national stroke best practice guideline recommendations into the care home context. The consequent study examined tailoring in action within the care home setting, in order to adapt existing national stroke best practice guidelines (RCP, 2012), and used tailoring to identify implementation barriers and enablers in order to create a fit within day to day routines in the care home context. Engaging care homes in this process enabled multiple case studies of tailoring in action. The resulting theory provides a clearer understanding of tailoring and offers a conceptual map for implementation researchers.

1:2 Background

I qualified as a Registered General Nurse in 1985, and as a district nurse in 1998, I moved into nurse education in 2000, becoming a Registered Nurse Tutor in 2001. Throughout my career I have always strived to implement evidence-based practice, and as a result have first-hand insight into the complexities of implementing research into practice and the complex contextual factors which influence change. During the course of my career as a district nurse in the United Kingdom (UK) I have spent many years working with care home

staff and have seen the desire to care and improve the experience of residents who are living with the effects of stroke. This care sector however, is often undervalued and underdeveloped by policy makers and researchers.

1:2:1 The care home sector – a UK context

Nursing or Residential homes, now termed 'Care Homes' (Standard 3, Care Standards Act, 2000) are institutions which provide accommodation, together with nursing and or personal care. The 1980 Supplementary Benefits (Requirements) Regulations introduced by the Thatcher government led to an exponential increase in private sector provision and the number of private residential care home places grew by 60% (Lievesley, Crosby, Bowman & Midwinter, 2011). The boom in care home provision in England and Wales, peaked at around 575,500 places in 1996 and it has been declining ever since. Around the millennium, the introduction of the National Minimum Wage and new National Minimum Standards for care homes brought about the closure of a number of, mainly smaller, homes that were too expensive to adapt. This has been part of a general trend towards larger care homes owned by corporate entities rather than by individuals or families. Care homes are getting larger on average (Lievesley et al. 2011). In 2004 the average care home in England had 23.13 places but by 2010 this had risen to 25.17 places. In total, there are an estimated 3,836 nursing homes and 10, 445 residential homes for people aged 65+ in the UK (Laing & Buisson, 2010). The residential care market is estimated to be £14 billion, of which the private (for-profit) sector is worth £9.9 billion and the value of the voluntary /not-for-profit sector is a further £1.9 billion. The public sector accounts for the remaining £2.2 billion, (Laing & Buisson, 2010).

In Wales, 1,594 adults' services with 26,191 service places were registered with Care and Social Services Wales (CSSIW) as at 31 March 2015, a decrease of 9 services and 49 places since the same quarter the previous year (CSSIW, 2015). Indicating a decline in care home capacity, and the volatile and fragile nature of the care market in Wales (Older People's Commissioner for Wales, 2014).

Wales has 1191 registered care homes with a total of 26869 places (CSSIW, 2009). Care is delivered by some 15584 staff, 44% of which are employed by the local authority, with the remaining 56% being employed by the independent sector (Care Council for Wales, [CCfW]

2010). The majority of UK care homes deliver long-term care. Most long-term care is designed to assist people with support services such as activities of daily living like dressing, bathing, and using the bathroom.

Care homes often house some of the UK's most vulnerable individuals. Many individuals entering care homes do so because of their inability to care for themselves. Some individuals may have gone through a process of rehabilitation, but are still unable to self-care and are as a result admitted into long term care in care homes (WAG, 2006). The quality of the care worker in the long-term care environment plays a significant role in the standard of care delivered (Kane, 2004). It is more likely to be the trained care attendant, or the health care support worker who would have the most interactive care contact with residents. Crotty et al. (2004) found that carers rather than Registered Nurses were responsible for most of the day to day monitoring of residents' behaviours and interventions, and that interventions which focus upon professionals such as doctors and nurses would be insufficient in the care home setting.

Historically it is difficult to recruit and retain staff in the long-term care setting (Redfern, Hannan, Norman, & Martin, 2002). Nursing staff often choose to work in care homes to fit around personal commitments rather than to further their career options (Spilsbury, Hanratty, & McCaughan, 2015). Furthermore, during a study to implement evidenced based practice in the residential care setting Crotty et al. (2004) noted a 13% attrition rate of staff during a six-month period. Suggested reasons for this are that the long-term care environment is often viewed, by Registered Nurses and care staff as less challenging and a slower pace than the acute hospital environment. Comondore et al. (2009) suggest that the economic challenge faced by long-term care facilities often affects staffing. This can lead to a transient workforce in the long-term care environment, which is often as a result of the long-term care environment not being able to compete with the hospital environment in terms of wages offered to staff. Indeed Sharkey (2008) believes that the persistent wage imbalance between the hospital, community and long-term care sectors has meant that home operators (who are generally unable to offer higher wages) have had great difficulty competing for appropriately skilled staff. In addition, the level and type of staffing in long-term care facilities varies significantly from one facility to another.

In the UK, long-term care services include a mix of non-profit and for-profit operators, the figure for the for-profit sector is higher accounting for as many as 70% of the residential care sector (O'Connor, 2011). The financial context of the care setting can have implications for staffing and the level of stroke interventions residents have access to. This is especially relevant in the UK given the recent crisis the UK has experienced with the 'Southern Cross' group which was Britain's largest care home company and responsible for the care of some 30,000 residents. Moreover, the Older People's Commissioner for Wales (2014) suggests that a lack of forward planning means that the needs of older people in care homes are not likely to be met in the future.

Lower wages offered in long-term sector had led to an influx in immigrant workers into this care sector, especially into the lower paid care worker roles. Browne and Braun (2008) suggest that developed nations increasingly turn to immigrant women to care for their ageing population. In the UK, one in five of the adult social care workforce was born outside the UK, 72% of which are from outside the European Union (Franklin, & Brancati, 2015), raising challenges with respect to communication skills and mutual cultural awareness (Burton-Jones & Mosley, 2004). The needs of the diverse workforce in the long-term care sector, and the impact this can have upon the context of care, should be carefully considered when planning any implementation strategy for stroke. Luff, Ferreira, and Meyer, (2011) suggest that staffing pressures and the unique care home environment may impact upon the process and progress of research projects.

Luff, Ferreira, and Meyer (2011) highlight that research in care homes is a complex undertaking. It is therefore essential, when planning implementation and research interventions in the care home setting the complexities discussed above should be taken into consideration. Care home staff should be encouraged to engage in the research as partners. Stakeholders and in particular end users should be considered paramount to the research design (Luff et al., 2011). A Collaborative and a reflexive approach should be built into the research process to enable all members of the research team to input and learn from events and findings.

Individuals who enter into the care home environment after having had a stroke, tend to be older and more physically and cognitively impaired than those residing elsewhere (Quilliam

& Lapane, 2001). Care planned to increase the individual's capacity to self-care can enhance the quality of life for the long-term care resident and has the potential to enhance the job satisfaction for the care providers. In order for this to happen the people caring for individuals in care homes require the knowledge and skills to deliver effective, evidence-based stroke rehabilitation for residents aimed at enhancing their levels of self-care and autonomy. Care homes therefore have a responsibility to ensure their staff have the appropriate skills and experience to meet quality standards and resident's needs (Smith, Craig, Weir & McAlpine, 2008). Help the Aged (2006) suggest that well-trained motivated staff have a positive impact upon the care home culture and upon staff and residents' well-being.

1:2:2 Stroke

The consequences of stroke can be devastating and can affect every aspect of a sufferer's life. Stroke is defined as a *brain attack* caused by a disturbance to the blood supply to the brain (DoH, 2007, p. 10). Over 100,00 people have a stroke each year in England, Wales and Northern Ireland (Royal College of Physicians [RCP], 2014). There are approximately 1 million stroke survivors living in England, Wales and Northern Ireland (RCP, 2014). There are two main types of stroke; ischemic stroke is the most common type and is caused by a clot narrowing or blocking blood vessels preventing blood reaching the brain, which leads to the death of brain cells due to lack of oxygen. The second type of stroke is haemorrhagic stroke, which is caused by a bursting of blood vessels producing bleeding into the brain causing damage (Stroke Association, 2016). Stroke remains the major cause of long-term neurological disability in adults (Wolfe 2000; Stroke Association, 2016). Stroke can affect people of any age but is predominantly a disease of older people. Almost two thirds of all strokes occur after the age of 65 years and the loss of physical functioning following a stroke can be devastating and lifestyle limiting. Stroke affects between 174 and 216 people per 100,000 population in the United Kingdom (UK) each year, and accounts for 11% of all deaths in England and Wales. The personal and family burden of stroke is considerable, and the annual economic costs of stroke to the UK are estimated to be £7 billion (National Audit Office, 2005; Department of Health, 2007). With audit results indicating that 11% of stroke survivors are discharged to a care home (RCP, 2014).

Stroke rehabilitation should be time limited, goal orientated and a multidisciplinary activity. It should be based upon an expert evaluation and delivered in a timely, patient orientated fashion (British Society of Rehabilitative Medicine [BSRM], 2008). The high prevalence of stroke with associated long-term disability in England and Wales demonstrates that it is essential to examine what works, in terms of rehabilitation interventions for stroke survivors in England and Wales, and how the existing stroke best practice guidelines can be implemented effectively into the care home setting.

1:2:3 The evidence base for Stroke care

The stroke guidelines produced by the Stroke Intercollegiate Working Party (2014 & 2016) are widely recognised as being evidence-based and having a high level of stakeholder involvement. The aim is to provide timely, quality services which meet the needs of the individual and their carers who seek interventions as a result of stroke. Furthermore, the Scottish Intercollegiate Guideline Network and the Royal College of Physicians consistently scored highest across the domains when evaluated using the AGREE instrument (Hurdowar et al., 2007), and were as a consequence recommended for use in clinical practice. These guidelines and the consequent audit and feedback gathered from assessing stroke services will form the evidence base for stroke best practice within this study.

The virtue of a stroke guideline is that it has been developed through expert consensus and have been designed to make a user-friendly synthesis of scientific research available to busy healthcare providers. Credibility and calibre of the guideline does not guarantee widespread changes in practice. Furthermore, guidelines developed by groups have been criticised for being paternalistic and being compromised by 'group think' misjudgements (Shekelle, Woolf, Grimshaw, Schunemann & Eccles, 2012). In the care home setting, contextual issues such as staffing patterns and staffing constraints often discourage the adoption of evidenced-based stroke practices (Feldman & Kane, 2003). In addition, Dizon, Machingaidza, and Grimmer, (2016) report that there is a lack of standardisation of clinical practice guideline terminology, leading to them being poorly conceptualised. This in turn often leads to contextual barriers, which can limit implementation (Dizon et al, 2016).

The key to a successful post stroke journey is dependent upon the effectiveness of the multidisciplinary rehabilitation and co-ordinated longer-term services, with support and

advice from a specialist stroke rehabilitation team (Welsh Assembly Government, 2006). Effective multidisciplinary rehabilitative interventions are essential to enable individuals to maximise their post stroke physical capabilities, along with addressing issues of self-worth and independence. The Royal College of Physicians (2009) however, warn that access to intensive rehabilitation in UK care homes can be limited, and patients may be denied the vital rehabilitative part of their treatment. The Department of Health (2005) report that at present only around half of individuals, who have experienced a stroke, receive the rehabilitation to meet their needs in the first six months following discharge from hospital, this falls to around a fifth after six months. As a result, the UK the intercollegiate stroke guidelines (Intercollegiate Working Party for Stroke, 2008) advise that early hospital discharge (before the end of acute rehabilitation) should only take place if there is a specialist stroke rehabilitation team in the community and if the patient is able to transfer safely from bed to chair (Intercollegiate Working Party for Stroke, 2008). In addition, they stress that early hospital discharge to generic (non-specialist) community services, such as care homes, should not be considered. Nonetheless, Sackley et al., (2015) point out that a quarter of all people admitted to hospital with a stroke are discharged to a care home, and that others are admitted directly from their own home after a stroke. Ideally, services need to develop long-term psychological and emotional support, with co-ordinated programmes starting with psychological support in hospital and longer-term support involving the voluntary sector. Services to support adjustment to long-term effects should also be provided to people with stroke who live in care homes.

1:2:4 Stroke care in care homes

The rehabilitative function of long term care facilities has for some time been a cause for concern, especially when considering residents who have been admitted following a stroke. One in twelve people with stroke in the UK have to move into a care home because of their stroke (Intercollegiate Stroke Working Party, 2016, p.32). As many as one in six nursing home residents are residents with a stroke, and have a wide range of disabilities (Cowman et al., 2010). Many of the stroke survivors admitted into care homes will require help to engage in everyday activities, such as walking, dressing, eating and attending to their toileting needs. Cowman et al., (2010) found that one in six nursing home residents are

residents with a stroke, and have a wide range of disabilities. For example, many stroke survivors also have problems with speech or thinking clearly. Cowman et al. (2010) established that there is currently little or no structured care for people following a stroke who reside in nursing homes. Nonetheless, Murray, Singer, Dawson, Thomas, and Cabul, (2003) found that newly admitted nursing home patients who receive rehabilitation services are more likely to be discharged home and to have a longer survival than those who do not receive such services. It is essential therefore that all patients discharged into care homes should continue to have access to specialist stroke care and rehabilitation after leaving hospital (Intercollegiate Working Party for Stroke, 2008).

Help the Aged (2006), a UK third sector organisation, in collaboration with the National Care Homes Research and Development Forum, examined existing evidence and the experiences of service users about what quality of life means to older people living in care homes. The resulting report, 'My Home Life', findings indicated that only a third of people who have had a stroke and who are living in care homes received treatment for secondary stroke prevention. These findings are disappointing and highlight a need for implementation interventions to improve stroke rehabilitation in care homes. Chang et al. (2011) express the need for an intervention study to develop practice guidelines to provide cost-effective rehabilitation specifically for care home residents, which is something this thesis seeks to do.

National audit results from across the UK indicated that the evidence base for stroke was not having the desired impact upon the lives of individuals residing in the care home sector (RCP, 2009, 2014). Audit reports indicate that acute Stroke care is better than ever; nonetheless, stroke care in Care Homes still lags behind (Royal College of Physicians (RCP), 2014). Suggesting that the policy intentions within the Stroke Strategy (DH, 2007) are not having the desired impact upon the lives of care home residents. As a consequence, concerns remain over the quality of stroke care and essential rehabilitative interventions, especially in the long-term care environment. Furthermore, the Chartered Society of Physiotherapy ([CSP], 2015) report that three in five care homes are not following National Institute for Health and Care Excellence ([NICE], 2013) guidelines. The Intercollegiate Stroke Working Party's (2012) stroke best practice guidelines recommend that all patients discharged from hospital into a care home with residual stroke related problems should be

assessed by specialist stroke rehabilitation services within 72 hours of admission (p:27). The Intercollegiate Stroke Working Party, 2014 guidelines however, have diluted this message and now recommend that 'people with stroke living in care homes should be offered assessment and treatment from community stroke rehabilitation services to identify activities and adaptations that might improve quality of life' (p.32). The lack of time frame with the revised recommendations could impact upon the resident's access to timely assessment and consequent rehabilitation journey. The CSP (2015) believe that without specialist assessments and interventions, the 8,000 plus people discharged from hospital into a care home after a stroke will not get access to the therapies they need.

A report from the Centre for Policy on Ageing (2012) indicates that stroke is the second most common neurological condition among care home residents, after dementia. Patrick Olszowski, Stroke Association's head of policy and campaigns said: 'Stroke survivors in care homes are frequently good candidates for rehabilitation. Yet all too often they're not getting services vital to their recovery and quality of life because they are not properly assessed' (In CSP press release, April 2015). Indeed, Noone et al. (2001) propose that stroke survivors in care homes are less likely to receive therapist input compared with similarly disabled stroke survivors in hospital-based care. Bernhardt, Dewey, Thrift and Donnan (2004) suggest that the rehabilitation experience of stroke survivors in the acute sector is similar, with patients being left alone for more than 60% of the time. Significantly Bernhardt et al., (2004) also found activity for stroke rehabilitation did not increase throughout the acute phase of their care. Moreover, the Help the Aged (2007) enquiry into interventions in care homes found that only a third of people who have had a stroke and who are living in care homes received treatment for secondary stroke prevention. The National Clinical Guidelines for stroke (RCP, 2014) however, highlight that there is evidence that, after stroke, patients show a continuing decline, which can be reversed by further rehabilitation input, and may also prevent hospital readmission. Similarly, Teasell and Kalra (2005) found that patients recovering from severe stroke can still be quite successful in terms of gain in independency of self-care and ambulation. Furthermore, a study by Murray, Singer, Dawson, Thomas and Cabul, (2003) concluded that patients who received rehabilitation therapy, made the most progress. Their results indicate that patients who are cognitively

impaired and incontinent and felt to be less able to self-care, when admitted into nursing homes and receive a program of rehabilitation can gain a level of independence.

The delivery of interventions within the care home setting is most likely to be performed by carers and not Registered Nurses. This was highlighted by the Salford care homes project (Fawcett 2010), which identified that carers, rather than Registered Nurses, were the key to enhancing the resident's stroke rehabilitation outcomes. In this project the carer, often the head carer, took on a stroke educator / co-ordinator role for their care home. In the UK pilot sites, Somerset (Andrews, 2009) and Salford (Fawcett, 2010), both sites focused upon training and education of care home carers and senior carers. Although anecdotal evidence has been positive from carers who have attended these training interventions, and from acute sector staff in relation to readmission of stroke patients (Salford), no formal evaluation of the impact upon the resident's experiences of stroke care and the quality of rehabilitation in care homes has been sought.

In the UK, the drive to enhance the quality of health care interventions for individuals and families who have experienced the effects of stroke continues. As a result, the emphasis for effectively implementing evidence-based stroke care interventions into day to day practices has increased (RCP, 2015). Crotty et al. (2004) suggest that there are few incentives for either physicians or residential care administration staff to improve clinical care. It is nonetheless, widely accepted that health care workers should have an understanding of the purpose and process of evidence-based practice (Ciliska, 2006), but how this translates into the long-term care environment remains largely unknown; further emphasising the need for additional work. A lack of empirical evidence in relation to how the evidence base for stroke care is being implemented in the care home sector has left us poorly informed about what strategies are being utilised in this particular care environment (Janes, 2010). This study took the form of an in-depth investigation to examine care home interventions to understand the context into which National Clinical Guidelines for stroke were being implemented for residents with stroke in North Wales. The aim of the study is to examine if tailoring, can add to the implementation tool kit, and can facilitate the adaption of the intercollegiate stroke recommendations for use in day to day practices by care home staff.

1:3 Evidence-based practice

Evidence-Based Practice (EBP) is defined by Ingersoll (2000) as 'the conscientious, explicit and judicious use of theory-derived, research-based information in making decisions about care delivery to individuals or groups of patients and in consideration of individual needs and preferences' (p.28). This definition suggests that EBP uses relevant evidence to meet the specific needs of an individual or group, indicating a move away from ritualistic practices to a more person-centred approach. Bucknall and Rycroft-Malone (2010), however believe that that a focus upon using best evidence to solve patient health problems over simplified the complexities of EBP, and fails to take into account contextual, cultural and organisational influences (p:2). In order to conceptualise context one has to examine the forces at work which give the physical environment (Kitson et al., 1998), such as the care home environment, a character and feel. Kitson et al. (1998) divide context into three core elements: culture; leadership and measurement. Kent & McCormack (2010) however, warn that it is almost impossible to capture all the different contextual factors. Work place culture has a major influence upon translating evidence into practice, otherwise known as knowledge translation, or implementation.

Knowledge of evidence is required before evidence-based practice can be implemented. How knowledge of evidence is translated at practice level is complex and multifaceted. Kipiriri et al. (2007) divide knowledge translation into three levels, micro, meso and macro. At the macro-level Kipiriri et al. (2007) found contextual influences relating to resource allocation decisions were politics, public pressure, and advocacy, some of which were further complicated by the impact of international priorities. At the meso-level, the influencing factors were national priorities, guidelines, and evidence. At the micro-level, however, the contextual influences were much more localised and included attitudes and feelings of worth. Factors that were considered to be at macro-level influenced, or set the context, at the lower meso and micro-levels. Context in this study referred to the care home setting where practice took place, and where the proposed stroke best practice guideline was to be implemented. An examination of the context, takes into account the interrelationship between organisational systems, structures and processes in the care home setting and workplace cultures and social relationships (Kent & McCormack, 2010).

The process of promoting the adoption of EBP can be viewed from the perspective of those who conduct research or generate knowledge (Lavis et al., 2003), those who use the evidence-based information in practice (Schultz, 2004), and those who act as facilitators to link researchers, who create knowledge with the clinical staff who use the knowledge (Bornbaum, Karnas, Peirson & Rosella, 2015). Contandriopoulos et al. (2010) consider knowledge exchange at two different levels, the individual and the collective or organisational level. The level of the individual is held in people's heads and translated (or not) into action. The collective level is socially shared and embedded in the organisation, as a result the effect upon individual behaviour and specific outcomes is more diffuse. Contandriopoulos et al. (2010) concluded that in order to implement new initiatives and to maximise knowledge use, a detailed analysis of the context is essential.

Evidence-based practice (EBP) is central to the notion of best practice (Mantzoukas, 2007). Straus, Tetroe and Graham (2009) suggest that health systems on a global level are failing to use evidence in practice, which often results in inefficiencies and reduced quantity and quality of life (p:3). Implementation of evidence-based practice has been influenced by a number of factors. Limited time and access for retrieving and interpreting research and for applying research to day to day practices with patients has been cited as a barrier by numerous authors (Kajermo et al. 1998; Retsas, 2000; Cranney et al. 2001). Many healthcare professionals for some time have argued that they lack the expertise to assess the validity of evidence or the knowledge of how to obtain relevant information (Rycroft-Malone et al. 2004; Retsas, 2000; Kajermo et al. 1998). In addition, some healthcare workers perceived conflict with patient preferences and therefore were reluctant to implement evidence into practice (Freeman & Sweeney, 2001). Bucknall and Rycroft-Malone (2010), suggest that equal investment and emphasis should be placed upon the implementation process to promote the utilisation of best evidence.

1:3:1 Implementation research

The field of implementation research is a relatively new and growing area of healthcare research. Kent and McCormack (2010) suggest that implementation of evidence into practice is a science in its own right (p.1). The purpose of implementation research is to find processes and strategies to enable current evidence to become embedded in everyday

practices. May, Mair, Finch, MacFarlane, Dowrick et al. (2009) define implementation as 'the social organization of bringing a practice or practices into action' (p.5). Implementation research therefore, describes 'the scientific study of the processes used in the implementation of initiatives as well as the contextual factors that affect these processes' (Peters, Tran, & Adam, 2013; p.27). This in turn has the potential to promote and support the successful implementation of effective interventions. Moreover, the World Health Organisation (Peters, Tran, & Adam, 2013) believe that implementation research can address any aspect of implementation, including the factors affecting implementation, the processes of implementation themselves and the outcomes, or end-products of the implementation under study (p.26). They recommend using a conceptual framework in order to understand the implementation processes, and to measure implementation outcomes (Peters, Tran, & Adam, 2013).

1:3:2 Implementation theories and frameworks.

A theoretical framework can help the researcher to identify and examine specific factors that have the potential to influence implementation success in a given context. Rycroft-Malone and Bucknall (2010) believe that theoretical frameworks can help develop our understanding of implementing evidence into practice. And perhaps more importantly to understand what happens when individuals try to use evidence in their day to day practices. Many theories have been designed and published to help promote more effective implementation accomplishment. In 2009 Damschroder, Aron, Keith, Kirsh, Alexander, et al. presented an extensive review of implementation frameworks. Damschroder et al. (2009) used a snowball sampling technique to identify relevant implementation theories. They reviewed the work of recognized researchers in this field, such as: Greenhalgh, Robert, MacFarlane, Bate, & Kyriakidou, (2004); Klein, & Sorra, (1996); Pettigrew and Whipp (1992); Kitson, Harvey, and McCormack, (1998); Graham, Logan, Davies, and Nimrod, (2004); Grol, Bosch, Hulscher, Eccles, and Wensing, (2007) and Fixsen, Naoom, Blase, Friedman, and Wallace, (2005). This extensive review enabled the identification of eight implementation constructs. These constructs occur within five major domains; *the intervention; inner and outer setting; the individuals involved and the process by which the implementation is accomplished*. They concluded their analysis of existing theories by incorporating key

implementation constructs into a Consolidated Framework for Implementation Research (CFIR), which attempts to unpack the rich and complex ways that factors within each domain influences implementation effectiveness (Damschroder et al. 2009). These sub-constructs provide a comprehensive framework for implementation researchers. An illustration of CFIR can be seen in table 1.1.

Table 1.1: Damschroder et al. (2009) Consolidated Framework for Implementation Research (CFIR)

Damschroder et al (2009) CFIR	Implementation domains	Constructs
	Intervention characteristics	Intervention source
		Evidence strength and quality
		Relative advantage
		Adaptability
		Trialability
		Complexity
		Design quality and packaging
		Cost
	Outer setting	Patient needs and resources
		Cosmopolitanism
		Peer pressure
		External policies and incentives
	Inner setting	Structural characteristics
		Networks and communications
		Culture
		Implementation climate: Tension for change Compatibility Relative priority Organizational incentives and rewards Goals and feedback Learning climate
		Readiness for implementation: Leadership engagement Available resources Access to information and knowledge
	Characteristics of	Knowledge and beliefs about the intervention
		Self-efficacy
		Individual stage of change
		Individual identification with organization
		Other personal attributes
	Process	Planning
		Engaging: Opinion leaders Formally appointed internal implementation leaders Champions External change agents
		Executing
		Reflecting and evaluating

One framework not examined by Damschroder et al. (2009) was May, Mair, Finch, MacFarlane, Dowrick, et al.'s (2009) Normalization Process Theory (NPT). May et al.'s theory built upon the Normalization Process Model (May, Finch, Mair, Ballini, Dowrick, et al. 2007), which was originally designed to promote the implementation of tele-medicine systems. NPT consists of sociological tools, which are designed to explain the social processes through which practice change occurs and evidence is implemented. NPT addresses three core problems: implementation; embedding and integration (May et al., 2009). May et al. (2009) base their framework upon the belief that; 'practices are normalized in social contexts as the result of people working individually and collectively to enact them' (P:5). Their framework consists of components, and mechanisms within each component that are felt to influence implementation; please see table 1.2 below. May et al.'s (2009) theories offer a strategy for implementation, which promotes embedding an innovation into practice, where all actors collectively invest meaning in it. May et al (2009) believe that meaning is acquired through learned shared experiences.

Table 1.2: May et al. (2009) Normalization Process Theory (NPT)

May et al (2009) NPT	Components	Mechanisms			
		Coherence	Cognitive Participation	Collective Action	Reflexive Monitoring
	Components (1) Immediate work	Differentiation	Initiation	Interactional workability	Systematization
		Individual specification	Legitimation	Relational integration	Individual appraisal
	Components (2) Organizing work	Communal specification	Enrolment	Contextual integration	Communal appraisal
		Internalization	Activation	Skills set	Reconfiguration
				Workability	
	Investments	Meaning	Commitment	Effort	Comprehension

Implementation frameworks are designed to establish what is and was is not working or likely to work in a given context. With this in mind Damschroder et al.'s (2009) framework encourages implementation researchers to examine the outer and inner settings, which includes sub-constructs of communications, culture and the capacity to change. The key is

to examine the attributes of a given context to establish the capacity and readiness for implementation. At the same time the attributes of key players also come under scrutiny to establish individual and team commitment and skills for implementation.

In order to create a fit between the evidence and a given context Damschroder et al. (2009) suggest researchers examine the intervention characteristics and consider the 'adaptability' or the degree to which an intervention can be 'tailored' to meet local needs. Similarly, May et al. (2009) refer to 'contextual integration' where the recommendation is incorporated into a social context. May et al. (2009) found that when the recommendation adds complexity and workload, implementation outcomes are less likely to be achieved. May et al. (2009) suggest that 'reconfiguration' may offer a solution, where the recommendation is modified to the specific context. Graham et al. (2006) suggested a map for knowledge translation, which features 'tailoring' as a key construct. Tailoring can be used to adapt evidence and to customize implementation strategies depending upon local need (Graham et al. 2006). In order to tailor for a given context, Perrin et al. (2006) recommends that researchers have to negotiate between maintaining the fidelity to the evidence whilst balancing the real-world requirements of a given setting. Graham et al., (2006) use tailoring as part of their Knowledge To Action (KTA) cycle (Fig. 1.1), which they propose as a framework for implementing evidence into practice. The KTA cycle assumes a systems perspective, where on stage in the system relies upon another to move implementation forward. In order for the framework to operate effectively Graham et al., emphasise the importance of appropriate relationships between researchers and knowledge users.

The United Kingdom's National Health Services promote the use of best practice guidelines and has infrastructure incentives to deliver care using guideline recommendations. Indeed, the National Institute for Health and Care Excellence (NICE) are dedicated to synthesizing evidence and producing guidelines to promote best practice within the NHS. Despite these efforts, national audit, such as the Sentinel Stroke National Audit Programme (RCP, 2015) highlights that the uptake and adherence to guideline implementation is somewhat sporadic and even more haphazard in the care home sector (RCP, 2015). With this in mind, the notion of tailoring best practice guidelines to create a fit for the care home context would

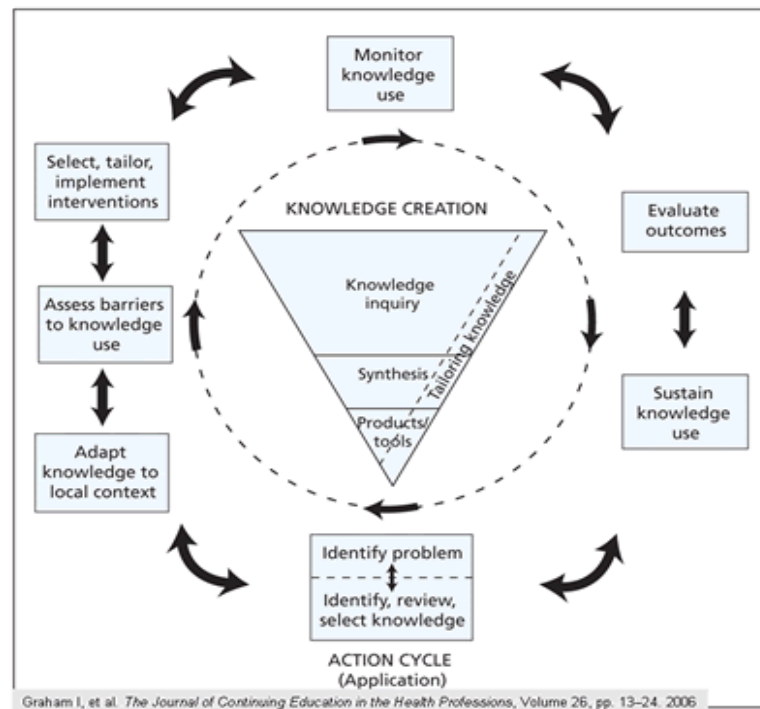


Figure 1.1: Knowledge to Action Cycle

seem a logical step to take in order to promote implementation of best practice recommendations. Furthermore, Harrison, Légaré, Graham, and Fervers (2010) believe that tailoring a clinical practice guideline to a particular context may improve acceptance and adherence. Baker et al., (2010) concluded that tailored interventions that addressed identified implementation barriers were more likely to improve professional practice. They also highlight the need for further research to determine the effectiveness of tailored interventions (Baker et al., 2010).

1:4 Study aims and objectives

This study aimed to examine tailoring in action to identify theoretical constructs of tailoring (Figure: 1.2). In the first instance the objective was to examine and understand current practice in relation to stroke care in the care home context in order to plan tailoring in action in this setting. This was achieved by interviewing care home staff about their day to day experiences of delivering care for residents with stroke.

The second objective was to use tailoring as a vehicle to adapt best practice recommendations to the care home context. By carrying out this process with care homes staff the researcher aims to use the identified tailoring paradigms to construct a map of the

tailoring in action. This resulting process will inform implementation research knowledge and be used to compliment future implementation strategies. A map of this study can be seen in figure 1.2, which provides an overview of the study and the investigative steps taken.

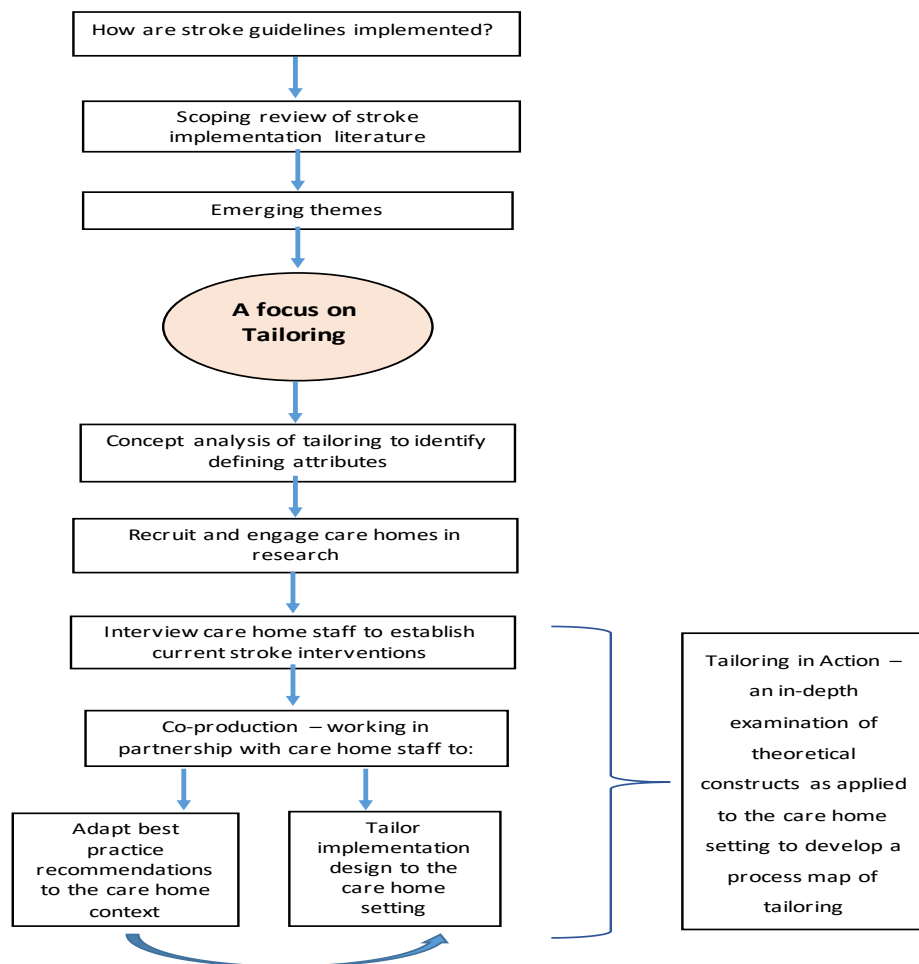


Figure 1.2: Research study map.

1:4:1 Study overview

Chapter two focuses upon the literature review. A scoping review was undertaken to examine how the evidence base for stroke was being implemented in healthcare practice. The purpose of the scoping review was to identify implementation strategies to facilitate the implementation of the evidence base for stroke in the care home context. This review

was enhanced by examining implementation research studies on the Effective Practice and Organisation of Care (EPOC) Cochrane database, which focused upon implementing the evidence base for stroke.

Analysis of reviewed studies highlighted ‘tailoring’ as a possible implementation strategy. What was often unclear was whether tailoring was a deliberate strategy or something that happened subconsciously as the study evolved. The notion of tailoring was of immediate interest, as national guidelines are rarely designed for this sector and would therefore require adapting with the intention of creating a fit for the care home context. This then posed the question of what tailoring actually meant within implementation research and what it had to offer within this process. In order to examine the attributes of tailoring as an implementation mechanism, a concept analysis was performed.

Chapter three presents a concept analysis of tailoring. Tailoring is a poorly developed concept within the discipline of implementation. A concept analysis of tailoring was designed to unpick the mechanisms used within the various tailoring processes adopted within the literature, and to extract the necessary evidence to establish a worthwhile framework for tailoring within implementation research. Subsequently, the concept analysis informed the research design, data collection and analysis.

Chapter 4 discusses the research methods used to conduct this study and explains the researcher’s real-world view. The research approach and data collection methods are also discussed in this chapter. In addition, ethical considerations and research governance issues are addressed.

Chapters 5 presents an investigation of the experiences and current practices of care home staff in relation to the sector contribution to supporting life after stroke for residents. Interview data highlighted current practice in care homes for residents with stroke, and identified key theoretical themes. This chapter moves to discuss and develop an understanding of the interview data, which was essential to plan workshop data collection in order to tailor the stroke best practice recommendations for this care context.

Chapter 6 presents findings from the workshops, which used consensus methods to tailor the stroke best practice recommendations for the care home context and examined

tailoring in action. The examination of the workshop data and consequent thematic analysis puts the spot light on tailoring in action and helps to create a visual conceptual map of tailoring constructs.

Chapter 7 discusses key themes identified within Chapter 6, which included: Leadership, Care homes as a business, Raising awareness, Stakeholders, and Balancing Fidelity. This discussion around key tailoring constructs enables a theoretical process map of tailoring to emerge. Key challenges faced when tailoring in action, such as balancing feasibility and fidelity are also explored and a 'sweet spot', which emerges when tailoring in action is identified and discussed.

Chapter 8 concludes and by proposing a theoretically constructed process map of tailoring, which is designed to tailor evidence to a given context, and to move on to adapt implementation strategies to create a fit for the local setting. Furthermore, this chapter highlights the theoretical propositions uncovered in the discovery of a 'sweet spot' for implementing evidence into practice within this study, which provides important new knowledge for implementation research and health care practice.

Chapter 2

A Scoping Review of the Stroke Implementation Literature.

A scoping review (Arksey & O'Malley, 2005) was conducted to determine the range and nature of implementation research activity in stroke, and to identify gaps in the evidence base in relation to the how best to enhance the use of evidence in practice. Choosing a methodology to examine existing literature can be a challenge and as the quantity of literature increases, it becomes even more essential to determine the most appropriate method to enable a rigorous literature survey. A scoping review is an approach which facilitates the rigorous collection, evaluation and presentation of findings in relation to a research question, such as 'how is the evidence for stroke being implemented?' Arksey and O'Malley (2005) suggest that the researcher should choose a scoping review if they want to; "summarise and disseminate research findings and identifying gaps in the existing research literature". Arksey and O'Malley (2005) offer a clearly defined, systematic approach to conducting scoping reviews. The basic framework involved in a scoping review is similar to a systematic review in that, the review question is identified, relevant studies are found and scrutinised using an inclusion, exclusion criteria. The aim of a scoping review is to identify relevant literature, rather than searching for a particular study design (Armstrong, Hall, Doyle, & Waters, 2011). As a result, a scoping review does not necessarily focus upon the quality of the included studies, the emphasis is upon structuring, mapping and organising the information within the literature, which helps the researcher examine the review question. Results from the scoping study are charted and key themes and issues are identified. These themes can help the researcher identify gaps in the existing research.

2:1 Background

Evidence within stroke can be defined as the knowledge derived from a variety of sources that has been subjected to testing and has been found to be credible (Grimmer & Loftus, 2008, P:311). The stroke intercollegiate working group (2010), working on behalf of the royal College of Physicians produce best practice guidelines for stroke to ensure that individuals following their stroke receive a comprehensive examination of stroke care, encompassing the

whole of the stroke pathway from acute care through to longer-term rehabilitation, including secondary prevention. The guidelines also inform healthcare professionals about the interventions that should be delivered to people who have had a stroke and how this should be organised. The guideline is broken down into recommendations, which are designed to offer best practice advice for healthcare practitioners working with people post-stroke. Moreover, chapter 7 provides a set of recommendations for people with stroke residing in care homes, for example recommendation 7.5.1 states that, “All people with stroke in care homes should receive assessment and treatment from stroke rehabilitation services in the same way as patients living in their own homes.” (Stroke Intercollegiate Working Group, 2010, p.128). The overall aim of these stroke best practice guidelines is to improve the quality of care for everyone who has a stroke, regardless of age, gender, type of stroke, or location (RCP, 2010 and 2015).

In order to ensure effective use of best practice guidelines, robust implementation strategies which facilitate the sustainable integration of best practice guidelines into everyday stroke care and interventions for stroke are required. Indeed, the use of evidence-based knowledge within stroke care is improving (RCP 2010), as highlighted by the Sentinel audit (RCP, 2010 and 2015). This indicates that dramatic improvements in the quality of stroke care have been made in the UK, and that the vast majority of people admitted with stroke will now have access to stroke unit beds. Furthermore, admission to a stroke unit has increased from 46% in 2004 to 88% in 2010 (RCP 2010), with the number of people dying in the first month from stroke falling from 24% in 2004 to 17% in 2010. Nonetheless, the RCP audit also points to the need to develop implementation research throughout the stroke journey as it suggests that currently ‘the chances of a patient receiving high quality care across the whole pathway is low’ (RCP, 2010, p. 20). The evidence base for stroke continues to grow, but the implementation of evidence within stroke is often slow to respond. There is a need therefore, to examine implementation within stroke in order to maximise the use of stroke research findings and to foster the utilisation of innovations in practice and policy.

Implementation research seeks to enhance research utilisation by addressing knowledge delivery issues, and by exploring the challenges of generalising research findings in the real world and contextualising for specific settings (WHO, 2012). Effective implementation

strategies have the potential to use the products of stroke research to improve the lives of individuals with stroke and to help reduce stroke risk. Implementation therefore is synonymous with coordinated change at system, organisation, program and practice levels (Fixsen et al., 2005). The context in which change takes place has a huge influence upon the successful implementation of the evidence for stroke into practice (Rycroft-Malone et al., 2004). In addition, the positive and negative role that individuals and teams can play in affecting change and implementing evidence into practice has to be acknowledged when designing implementation strategies (Rycroft-Malone et al., 2004).

The flexibility offered by the scoping review to map the existing stroke implementation literature and to look for recurring themes within the literature made it the most relevant approach to inform this research study. As with any extensive review of the literature the starting point is to identify the research question, which in this case was: *Which implementation theories and strategies have been applied to the evidence base for stroke.*

2:2 Methods

A methodical structured search was performed (Arksey & O'Malley, 2005) using Proquest, which included the following databases: Applied Social Sciences Index and Abstracts (ASSIA); MEDLINE®; PILOTS; PsycINFO; Social Services Abstracts; Sociological Abstracts. In addition, a wide breadth of evidence, which included existing networks, a Google search, relevant organisations and conferences, such as the UK stroke forum was reviewed.

The primary search terms were:

(exp Practice Guidelines or exp AUDIOVISUAL AIDS/ or exp PAMPHLETS or exp MANUALS or exp CLINICAL PROTOCOLS or exp Inservice Training or seminar or workshop. or clinical education or staff instructor* or exp Consultants/ or chang* near/2 agent* or facilitator* near/2 chang* or coordinator* near/2 chang* or champion* near/2 chang* or journal club or exp Quality Assurance, Health Care/ or exp REMINDER SYSTEMS/ or exp "Innovation"/ or exp Evidence-based Medicine/ or utilizat* or utilisat* or implement* or disseminat* or translate*) and MESH.EXACT.EXPLODE("Stroke")

The search was based on research published during the years 2000-2011. This search revealed potential pool of 3305 papers. These 3305 papers which were narrowed down to 262 based, where possible, on title and abstract information using the following inclusion and exclusion criteria:

Exclusion criteria: Drug and or treatment trials (without explanation of or related to implementation); non-stroke related; concentrates upon cardiovascular system only; dealt with practice housekeeping issues, such as cost comparisons; articles about carers emotions; quality of life after stroke; bio-medical interventions or a lack of clarity with regards to implementation strategies or implementation intervention methods.

Inclusion criteria: Papers written in English; peer-reviewed studies that address: implementation strategies or interventions for stroke; organisational interventions to improve stroke care; literature reviews of strategies to improve stroke care; enhancing knowledge in stroke practices; educational interventions for stroke.

Where it was not possible to exclude articles based on title and abstract, full text versions were obtained and their eligibility was assessed. Duplicates were then removed and the remaining 262 results were put into an excel table and further reviewed to exclude; results that were not written in English, were not peer reviewed, were not research; systematic reviews of relevant literature were however included. The goal was to ensure the capture of the most relevant articles (Arksey & O'Malley, 2005). Papers related to stroke implementation were screened independently by two reviewers, and those studies that did not meet the inclusion criteria were excluded. The main reason for excluding studies was the lack of clarity with regards to implementation strategies or implementation intervention. As the focus of this review was to identify implementation strategies and their use within practice, studies that did not identify the implementation strategies used or how they were used offered little insight into the actual implementation process. These were studies that focused upon what was to be implemented and the consequent results, without explaining the implementation process used. Such studies added little value, as it was impossible to identify and pick out the necessary implementation information required to inform this review. Other studies described setting up of services for stroke or the need for stroke services in line with National

recommendations but did not explore implementation interventions or strategies involved or required.

Studies included used implementation interventions and or discussed views of stakeholders in relation to implementing the evidence within stroke. On completion of the review 113 studies were identified for in depth analysis. Some papers were a compilation of reviewed evidence directed at providing the reader with advice and recommendations for performing interventions within stroke care (Veazie, Galloway, Matson-Koffman, LaBarthe, Brownstein, et al., 2005; Schwamm, Holloway, Amarenco, Audebert, Bakas et al., 2009; Provinciali, 2006; Quaglini, tefanelli, Cavallini, Micieli, Fassino, et al., 2000; Légaré, Ratté, Gravel, & Graham, 2008; Furie, Kasner, Adams, Albers, Bush, et al., 2011; Doggett, Tappe, Mitchell, Chapell, Coates, et al., 2001). Whilst these papers provide a valuable resource they do not examine how the evidence base is implemented within stroke, and therefore offered little practical value to this review.

The next stage of work involved systematically and comprehensively extracting data from all relevant studies, this enabling identification and organisation of key themes (Arksey & O'Malley, 2005). A more in-depth synthesis and interpretation of key issues and themes emerged to unpick implementation research in relation to the evidence within stroke. Information was recorded as follows:

Author(s), year of publication; Implementation strategies/interventions; Research methods; Research design; Theoretical perspective; Setting; Target group; Identified barriers; Identified enablers; Process evaluation or outcome evaluation (or both); Sustainability; Study quality.

These criteria were applied to all the 113 studies included in the review. This involved the examination of each paper to identify and chart implementation qualities consistent with the agreed criteria. It was impossible to extract all the criteria information required as not all research reports included relevant material, making uniformity problematic.

The included studies offered a wide breadth of information in relation to implementation interventions for stroke, which ranged from conference discussion abstracts to well-designed RCT's. Some studies, although not examining implementation interventions, highlighted practice intervention needs or where stroke best practice implementation was required.

These quality of life studies provide a valuable insight and drive within current stroke practice to engage with the evidence base to improve the experience of the individual diagnosed with stroke. Of the 113 studies analysed 77 papers focused upon implementing evidence within stroke (Please see Appendix 2.1).

2:3 Analysing the data

The Effective Practice and Organisation of Care (EPOC) taxonomy of implementation interventions is widely used in the research impact field, it was developed by the EPOC review group within the Cochrane Collaboration. The EPOC taxonomy was used to categorise papers in order to identify and describe the interventions used to facilitate a summary of interventions for each study reviewed. The focus of EPOC is on reviews of interventions designed to improve professional practice and the delivery of effective health services. to undertake systematic reviews of educational, behavioural, financial, regulatory and organisational interventions designed to improve health professional practice and the organisation of health care services. The EPOC taxonomy categories include professional interventions, financial interventions, organisational interventions and regulatory interventions. The use of the EPOC taxonomy enabled categorisation of the interventions used to implement the evidence base within stroke. A table illustrating the EPOC categories used in stroke implementation can be viewed in Figure 2.1 below.

The EPOC categories can be further broken down into more specific interventions. In this scoping review, the most widely utilised category was professional interventions. Within the 55 professional intervention studies, 5 studies used educational meetings, 2 local consensus process, 4 educational outreach visits, 18 used marketing to survey a targeted provider to ascertain possible barriers to implementing stroke best practice initiatives, 6 used local opinion leaders, 3 distribution of educational materials and 1 used mass media campaigns to reach a target population, by far the most utilised intervention within this category was audit and feedback, which was used in 29 studies. Some studies used more than one of these interventions.

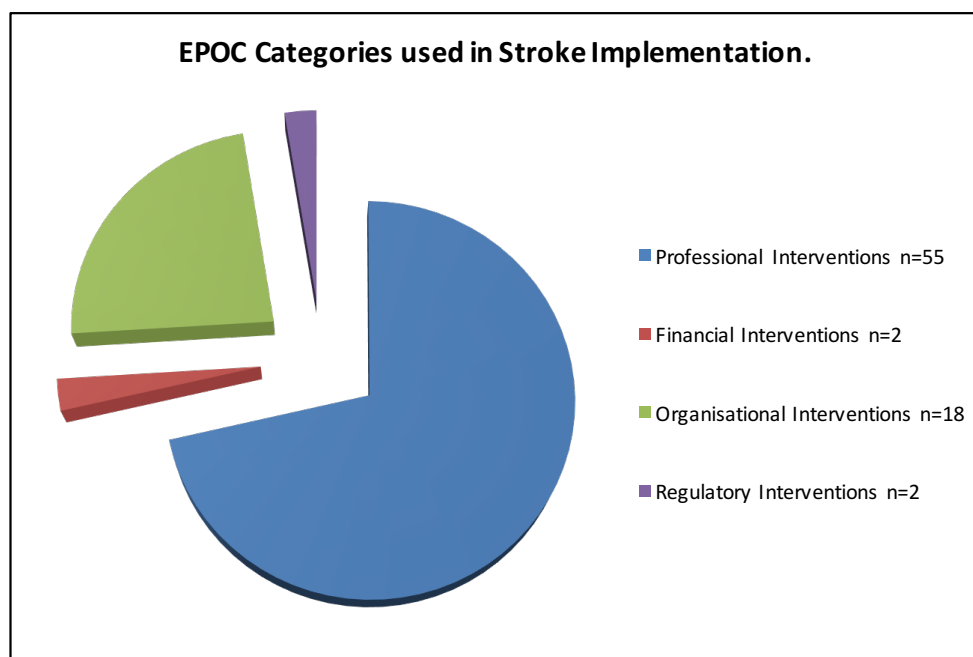


Figure 2.1: EPOC categories

The financial intervention category was only used in two studies (Cadilhac, Carter, Thrift, & Dewey, 2007; Chappel, Bailey, Sracy, Thomson, & Rodger, 2001), both used provider incentives, with Cadilhac et al. (2007) also using provider salaried service when implementing the evidence base for stroke. Eighteen studies were in the organisational interventions category, of these two used the communication and case discussion to implement the evidence base for stroke. Four used the clinical multidisciplinary team intervention. One study by Donnelly, Power, Russell, and Fullerton (2004) used the skill mix change intervention. Four studies opted for the continuity of care intervention, three of these examined arrangements for follow-up and one (Woo, Chan, Sum, Wong, & Chui, 2008) looked at case management. Two studies used the formal integration of services intervention. Only one study, Newell, Lyons, Martin-Misener, and Shearer, (2009) used the presence and functioning of adequate mechanisms for dealing with patient suggestions as an intervention when they collected and published local narratives in order to raise stroke awareness. Four studies used changes in scope and nature of benefits and services. Four studies opted for presence and organisation

of quality monitoring mechanisms to implement the evidence base for stroke. The regulatory interventions category was used by only two studies (Acker, Pancioli, Crocco, Eckstein, Jauch, et al., 2007; Schwamm, Holloway, Amarenco, Audebert, Bakas, et al., 2009), both papers used the peer review intervention to make recommendations for implementing evidence within stroke. Both papers were policy statements from the American Heart Association.

In order to unpick the interplay of the complexities of clinical practice and the effects upon implementation of evidence it is essential to recognise the barriers and enablers that exist within the context under study (Rycroft-Malone, 2008). Barriers and enablers revealed within the studies were therefore examined and inserted into a table (Please see appendix 2.1), to provide a map of interventions along with the barriers and enablers which influenced the success or otherwise of the implementation of evidence within stroke.

The EPOC taxonomy focus upon interventions offers little insight into the implementation methods adopted when using identified interventions. Furthermore, there is no indication of the success or otherwise of particular implementation interventions, other than in outcome measurement. As a result, the reader has information about what the intervention was and often whether or not it worked but not the mechanisms used to transfer the evidence into practice. It is useful therefore, to develop a data extraction framework based on elements included in a model or theory that reflects the steps of the implementation processes used when attempting to implement the evidence within stroke services. Graham and Tetroe (2010) recommend a Knowledge to Action (KTA) framework to help implementers make sense of implementation research by integrating concepts of knowledge creation and action.

The KTA framework is based on the theory of planned action and is designed to make sense of the “black box” of knowledge translation or implementation research (Graham and Tetroe, 2010, p.207). The KTA process begins with tailoring research evidence, taking local context and culture into account. The KTA framework assumes a systems perspective and falls within the social constructivist paradigm. KTA involves active collaboration between researchers and end users throughout the research and application process. Graham, Brick, Tetroe, Straus, and Harrison (2010) also believe that barriers and enablers to implementing evidence should be investigated prior to implementation in order to identify strategies which can help to overcome identified barriers.

Gathering information about the informal exchange of knowledge and the interpersonal relationships and power struggles which influence implementation, is hard to come by (Pawson, 2006). In order to further investigate the implementation interventions employed within this review, studies were examined and mapped to the KTA constructs in order to interpret and unpack the intervention characteristics as they apply to implementation research, a table of these characteristics can be seen in appendix 2:2. Interpreting implementation traits highlighted by the Knowledge to Action framework sought to provide a critical synthesis of the implementation approaches adopted and as a consequence to inform implementation research. Studies were scrutinised to establish ways in which the literature had constructed the implementation of the evidence base for stroke, the nature of the assumptions about the evidence, and what had influenced choice of proposed implementation solutions. This enabled an insight into how studies went about implementing the evidence in stroke and the complexities that emerged for the researchers.

A critical interpretive synthesis of studies enabled a creative map of key constructs as illustrated in figure 2.2. From which the following higher-level themes were identified:

- The nature of the evidence
- Creating a fit to the local context
- Facilitating implementation
- Challenges for the researcher

The following text presents excerpts from relevant studies within the scoping review to unpick and explore identified themes.

2:3:1 The nature of the evidence

The nature of the evidence was influenced by; existing best practice guidelines and pathways, the local context and the desire for change.

Relevant and reliable evidence was the key to evidence utilisation, with all studies reviewed identifying the need to implement existing evidence within stroke into practice in order to

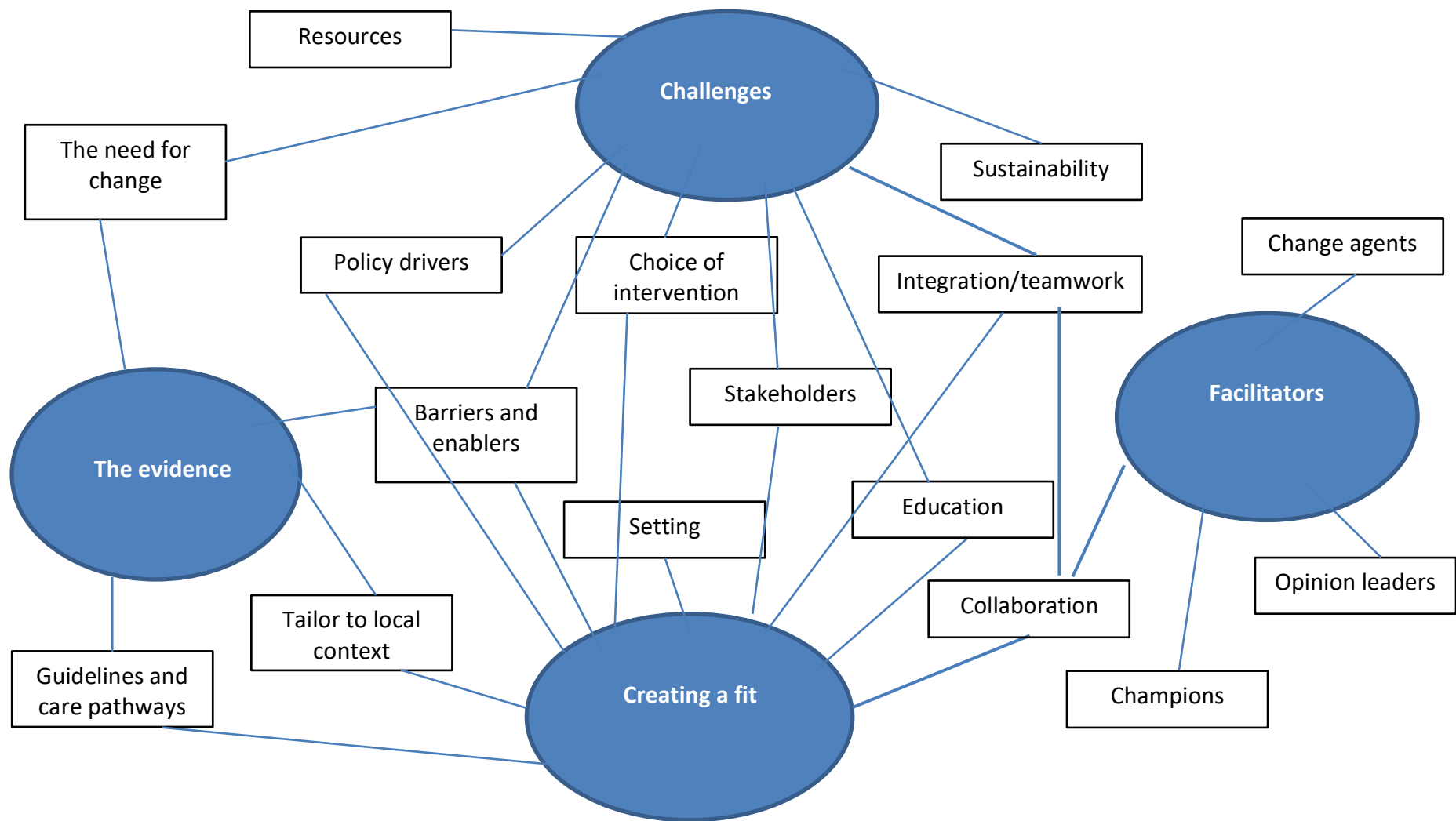


Figure 2.2: Critical interpretive synthesis of EPOC literature using KTA constructs – developing theoretical constructs.

The following text presents excerpts from relevant studies within the scoping review to unpick and explore identified themes.

2:3:1 The nature of the evidence

The nature of the evidence was influenced by; existing best practice guidelines and pathways, the local context and the desire for change.

Relevant and reliable evidence was the key to evidence utilisation, with all studies reviewed identifying the need to implement existing evidence within stroke into practice in order to improve the quality of stroke services and the lives of people living with the effects of a stroke and their families and or carers. Many researchers appeared to expect practices to embrace change and result in altered outcomes throughout the stroke spectrum with the uptake of all aspects of the implemented guideline or evidence (Perry and McLaren, 2003; Albakri et al., 2003). In reality this rarely happened; for example Van Peppen et al. (2008) measured compliance through self-report, of use of a stroke clinical practice guideline, they found that although there was a positive attitude towards guideline use, compliance rates were poor. Compliance varied between 49% to as low as 2% for some recommendations (Van Peppen et al., 2008).

Bedregal and Ferlie (2001) surveyed healthcare providers to find their views around implementing evidence. They found that stakeholders often considered government proposed interventions as not being evidence-based, and this led to implementation difficulties. Chappel et al., (2001) sought consensus about the evidence base for stroke when implementing and evaluating a local-level health improvement programme for stroke. Their study highlighted that some clinical staff felt that evidence-based systems were often out of date and that practice had to be more responsive. Stakeholders' perceptions of the quality and validity of evidence will influence implementation outcomes (Damschroder et al., 2009). It is vital that all available sources of evidence are used, such as: research studies, clinical experience, and patient experience (Rycroft-Malone et al., 2002). The individuals involved in implementing interventions can hold different perceptions around what works and what does not work in their particular environment, these variations in practices were highlighted by the use of foam mouth swabs in Brady et al.'s (2011) study, where one group relied upon their

experiences, whilst the other group used evidence-based interventions. Furthermore, Luker and Grimmer-Somers (2008) suggest that in their study staff perceptions and beliefs influenced prioritisation of guideline implementation, as they identified older age as a barrier to patients receiving optimal care.

Most studies appeared to increase awareness around stroke by discussing the evidence and explaining rationales for the particular stroke interventions being implemented, the profile of stroke is therefore heightened. Van Peppen et al. (2008) found enthusiasm and awareness of the Dutch clinical practice guideline for stroke, but only half of the professionals studied actually implemented elements of the guideline into their practice. This indicates that increasing awareness does not necessarily lead to improved outcomes, but does have the potential to underpin implementation interventions.

Knowledge is used in different ways by different stakeholders. End users of an intervention seem to be influenced by a mixture of knowledge about stroke and personal or team beliefs. Whilst little is reported about the influence of outcomes upon professional reasoning, rituals and beliefs seem to influence knowledge uptake and use. For example, Brady et al.'s (2011) study identified differing beliefs and consequent practices between staff. Identification of this potential barrier to implementation enabled them to use this knowledge to plan a Randomised Controlled Trial (RCT) which would put mechanisms in place to overcome identified barriers.

Nineteen of the reviewed papers tailored or adapted existing evidence for stroke to the local context. More specifically several studies adapted national or global guidelines to the local context (Gage et al. 2001; Ferry et al. 2004; De Koning et al. 2005; Heuschmann et al. 2006; Micieli & Cavallini, 2006; Bo et al. 2007; Wright et al. 2007; Middleton et al. 2009). Following an audit to examine compliance with recommended antithrombotic therapy, Bo et al. (2007) adapted a guideline for the prevention of cardio-embolic events to better suit the local context. They found that this led to better guideline compliance and as a consequence, better patient outcomes.

Panella et al., (2003) used a before and after study to measure performance following implementation of a clinical pathway. They found that doctors sometimes refused to change their routines even when they had been proved to be ineffective. They did nonetheless observe that the main determinant to successful implementation related to the level of involvement of healthcare providers in the development of the pathways. Organisational culture is believed to be amongst the most critical barrier to overcome when implementing evidence, and the organisational assumptions, thinking and or culture are often the reasons why implementation initiatives fail (Damschroder et al., 2009). Damschroder et al., (2009) suggest that information should be sought from individuals and then consolidated by the research team to highlight organisational culture.

Studies overcame implementation barriers in several ways: resource implications were overcome in one study by using nursing students to increase and sustain interventions (Stoeckle-Roberts et al., 2006). Whereas, Wright et al. (2007) promoted their implementation strategies, designed to implement the evidence within stroke in primary care, as affordable. They concluded that their implementation research intervention was affordable, feasible and effective in a variety of contexts spanning a health district.

Other studies suggested that local governance systems can help to promote implementation interventions and eliminate financial barriers. Stuart et al., (2009) suggest that comprehensive administrative data to monitor process and outcomes for chronic stroke has the potential to save money and improve outcomes. De Koning et al. (2005) believe that the level of integrated organisation structures for stroke prevention in general practice is linked to suboptimal care. Engagement with local governance systems: is essential to enable measurement of existing care quality and the impact of consequent interventions (Wright et al., 2007).

One study (Brady et al. 2001) used a pilot design to identify barriers and enablers, and to highlight possible implementation interventions. Brady et al.'s (2011) study on dental care following stroke, identifies potential barriers which enabled them to use this knowledge to plan a Randomised Control Trial (RCT) which would put implementation mechanisms in place to overcome identified barriers. This demonstrates that the ability to reflect and evaluate findings can help to plan and realise implementation potentials.

The desire for change was influenced by many factors but a key barrier found was the fear of doing harm (Bo et al., 2007; Wright et al., 2007). Bo et al., (2007) used marketing as an intervention in order to survey a targeted provider to ascertain possible barriers to implementing hospital guidelines designed to improve warfarin use in non-valvular atrial fibrillation. This enabled them to identify potential barriers to guideline adoption, such as, the fear of bleeding caused by oral anticoagulant therapy. They overcame this barrier by providing physicians with clear recommendations that clearly weighed up the risks. They found that tailored guideline implementation substantially improved the use of oral anticoagulant therapy. This study highlights the possible gains of engaging with end users to identify potential barriers and facilitators for change when designing implementation initiatives for practice.

2:3:2 Creating a fit to the local context

Creating a fit to the local context was influenced by; the nature of context, the choice of intervention, collaboration and stakeholders.

This scoping review highlights that the work place culture often influenced how information was received and had the potential to create barriers to implementation. The impact of rituals and beliefs as highlighted in Brady et al.'s (2011) study, led to conflicting practices when performing mouth care for patients following a stroke. Mechanisms to overcome these barriers can seem to be straight forward, but in reality, are often complex. Despite providing information about their interventions, Panella et al. (2003) experienced active resistance to their implementation interventions; this may have been due to a lack of engagement with end users, or the team culture within the implementation setting. It is reasonable to conclude that although information is vital, it seems that without engagement and involvement of key stakeholders, it has little influence upon actual implementation outcomes. This led Van Peppen et al. (2008) to conclude that there was a need for a setting-specific tailored implementation strategy.

The evidence implemented in many studies is national evidence and the relationship to the local context is not always made clear. Some authors seem to expect clinicians to implement

national guidelines without local mapping of some form (Hart & Morris, 2008). Where studies attempt to tailor national evidence to the local context there seems to be a greater motivation for change (Middleton et al. 2011; Perry & McLaren, 2003; Wright et al. 2007). Although it is unclear if this is due to practitioners being more aware of the evidence or the fact that they can tailor the evidence to their local context. Crotty et al., (2004) found that during their outreach intervention to implement evidence-based practice in residential care using a randomised control trial, heightened awareness, but rates of compliance with recommendations were not improved. Bendz (2003) highlighted the differences between patient perceptions about rehabilitation and those of the health care professionals, thus raising awareness of the need for health professionals to consider the impact of stroke and the life limiting implications for the stroke survivor. Bendz's (2003) study also raises awareness of the need to ensure stroke services are patient centred and not just focusing upon what clinicians think individuals need. Implementation strategies therefore, should encompass the patient's perspective where possible.

Collaboration with key stakeholders is seen as good practice when implementing evidence into practice (Estabrooks et al. 2008). Several studies claim to have engaged with relevant stakeholders, but authors do not always make it clear if the stakeholder group included end users. Some 28 studies used links to appropriate individuals or groups who had a vested interest in the project. Engagement with stakeholders varied from recommendations for stakeholder engagement (Ford-Lattimore et al. 2008; La Bresh 2006; Schwamm et al. 2006; Schwamm et al. 2009; Veazie et al. 2005), to analysis of stakeholder views (Bedregal & Ferlie 2001), to engaging with stakeholders to adapt and develop interventions for the local context (Allen et al. 2003; Bo et al., 2007; Chappel et al., 2001; Hurdowar et al. 2006; Brown et al. 2007; Gropen et al. 2009; Heuschmann et al. 2006; Middleton et al. 2009; Perry & McLaren 2003; Power et al. 2005; Rudd et al. 2001; Sandercock et al. 2002; Sullivan et al. 2008; Taylor et al. 2006; Wright et al. 2007). Wright et al., (2007) sought local ownership of clinical guidelines by involving relevant stakeholders to adapt and implement national guidelines for stroke. Other studies involved multidisciplinary team members in implementation of interventions, using opinion leaders, champions and key individuals and or provided information for key individuals and stakeholders (Amato et al. 2006; Bisailon et al. 2004; Ferry

et al. 2004; Joubert et al. 2008; Luker & Grimmer-Somers 2009; Panella et al. 2003; Stoeckle-Roberts et al. 2006).

Twenty-six studies within this review sought links with appropriate individuals and groups who had a vested interest in the project in order to engage stakeholders and minimise implementation barriers. Graham and Tetroe (2010) propose that involvement of end users is vital to the success and sustainability of implementation interventions. Teamwork is regarded as the cornerstone of effective post-stroke care. Some interventions within this review therefore, were aimed at targeting staff groups and enhancing teamwork to produce enhanced stroke outcomes for patients (Bisaillon et al. 2004; Gibbon et al. 2002; Mayo et al. 2008; Middleton et al. 2011; Penella et al. 2003). Bisaillon et al. (2004) and Middleton et al. (2011) reported enhanced outcomes following implementation of multidisciplinary evidence-based interventions to enhance teamwork. Efforts to promote better teamwork were often overshadowed by a perceived lack of support by management or uncertainty about their intentions (Gibbon et al. 2002). Other studies found resistance from some team members, in Panella et al.'s (2003) study doctors refused to adopt a clinical pathway because they considered the process to be like a 'cookbook'. Sackett et al. (1996) believe that evidence-based medicine is not 'cookbook' medicine. They suggest that external clinical evidence can inform but never replace individual clinical expertise. External clinical guidelines must therefore be tailored for use in the local context.

York (2003) developed a community based screening and educational programme in an attempt to improve time delays for individuals with stroke seeking medical interventions. The research measures outcome with no evidence of process evaluation or sustainability. Nonetheless York does allude to the success of this intervention being a result of the interdisciplinary approach that was adopted.

Other studies reviewed reported a lack of collaboration or agreement between professionals, or lack of confidence in other professionals. Tan et al., (2007) implemented stroke guidelines, without consensus with local stakeholders and end users, the guideline was not widely adopted and as a result had little impact upon the quality of acute stroke interventions. Taylor et al., (2006) implemented a stroke pathway in the emergency department and medical unit. The pathway was developed by a stroke pathway team, the relevance of team members to

the practice setting is not made clear, nor whether relevant stakeholders and guideline end users were involved. A retrospective audit indicated that the pathway appeared to have no benefit for the outcome or processes of care and may even have been associated with worse outcomes.

Brady et al., (2011) found that differing practices and a lack of role clarity, along with conflicting beliefs between clinical staff created barriers to change. Practice guidelines involving more complex interventions, which involve interdisciplinary collaboration and communication can lead to a reduction in uptake (Luker & Grimmer-Somers, 2008). Kwan and Sandercock (2004) however found it was the integrated approach to the development of an integrated care pathway which influenced teamwork and consequent outcomes and not the integrated care pathway itself. This suggests that it is engagement and ownership that motivates clinicians to use evidence in their practice. Power et al. (2006) claim that modernising service delivery by changing traditional roles can expedite aspirin delivery for acute stroke patients, and influence service provision to improve patient care.

Higgs and Jones (2000) point out that implementing evidence in practice requires more than access to new knowledge, it requires skills in reasoning to integrate that knowledge into existing knowledge frameworks (P. 313). This requires an awareness of the context into which the evidence is being implemented. Middleton et al. (2011) and Wright et al. (2007) concluded that engaging with the end users of the new knowledge enabled them to tailor (encompass the evidence within existing practice knowledge frameworks) the knowledge for the local context. This in turn led to a more successful implementation of the evidence.

Hart and Morris, (2008) believe that the theory of planned behaviour provides a framework for understanding end user intentions with regards to preparing to implement the evidence within stroke care. Although their study using a questionnaire had a low response rate of 21%, and it is reasonable to assume that respondents were the individuals who were motivated to change. They did not explore the local contextual influences that influence evidence-based practices. Nevertheless, Brady et al. (2001) suggest that complex interventions can be captured and described in order to inform more in-depth implementation and consequent translation of evidence into clinical practice.

Some authors (Sullivan et al. 2008; Van Peppen et al. 2008) who found low compliance with evidence-based recommendations, recommend the use of tailoring interventions when discussing their results and implementation compliance. Other studies (Ferry et al. 2004; La Bresh 2006; Wright et al. 2007; Ford-Lattimore et al. 2008; Kormer-Bitenskey et al. 2008; Luker and Grimmer-Somers 2009; Hoe Heo et al. 2010; Brady et al. 2011) tailored implementation interventions to the local context. Indeed, Wright et al. (2007) concluded that healthcare professionals are significantly more likely to comply with clinical guidelines following a tailored and multifaceted intervention. Luker and Grimmer-Somers (2009) suggest that implementation strategies must be tailored to the local setting and the traits of the staff involved. Beliefs and priorities of the staff involved in the translation of evidence into practice should be explored before implementation strategies can be tailored.

2:3:3 Facilitating implementation

The studies reviewed highlighted facilitation to implement evidence in terms of; champions, opinion leaders and change agents.

The presence of change agents or opinion leaders seems to influence implementation and could therefore be an effective mechanism (Cadilhac et al. 2008; Ferry et al. 2004; Joubert et al. 2005; Middleton et al. 2009; Perry et al. 2003; Stevens et al. 2007; Stoeckle-Roberts et al. 2006; York, 2003). Local opinion leaders are individuals who are viewed by their colleagues as 'influential' (either positively or negatively) in relation to the proposed intervention and who are able to exert influence on their colleagues to change by setting an example, providing education and creating new norms (Locock et al. 2001). Flodgren et al. (2011) performed a systematic review of opinion leaders as an intervention, and concluded that opinion leader interventions appeared to improve performance. How these individuals influence uptake of interventions is not always clear. In addition, Perry and McLaren, (2003) indicate that time is required for acceptance of new roles in order for change to occur. Stoeckle-Roberts et al., (2006) used opinion leaders, to overcome local opposition to change. Locock, Dopson, Chambers and Gabbay (2001) suggest that both expert and peers have particularly important and distinct roles to play, and that opinion leaders who emerge informally during the change process at the peer level are seen as especially persuasive by colleagues. Flodgren

et al. (2011) called for researchers using opinion leaders to ensure they collect detailed descriptions of the intervention provided. To ascertain what opinion leaders do, how they do it and how frequently, in order to unpick the actual activity carried out by opinion leaders. Albakri et al., (2003) performed a retrospective audit of compliance with national guidelines. They used their audit data to feedback findings in order to encourage hospitals in Florida to enhance stroke guideline adherence. Many hospitals implemented interventions to improve guideline adherence. Whilst there is no indication as to how these interventions were implemented, Albarkri et al., (2003) found significant improvement in guideline compliance after six months. This may indicate the influence or incentive of market forces and competitive pressures upon implementation and change in practice. Damschroder et al., (2009) believe that peer pressure and competitive pressure to implement an intervention can produce positive outcomes. They also suggest that external policies and incentives such as: pay for performance, public benchmark reporting, government regulations and guidelines can have an influence upon implementation. Murray et al (2003) found that financial policies can impact upon stroke rehabilitation practices and consequently upon implementation of best practice.

2:3:4 Challenges for the researcher

Challenges identified were; sustaining the intervention, resources and the influence of policy drivers.

A couple of papers within this review present policy directions aimed at disseminating the evidence for stroke to a wider audience and to promote better use of resources (Acker et al. 2007; Schwamm et al. 2009). Several studies performed education sessions, launched pathways at conferences or local events and gave out information about the evidence being implemented, but this level of involvement did not always produce compliance with recommendations. Tan et al. (2007) performed a pre- and post-audit review to assess the impact of implementing a stroke care pathway in an acute teaching hospital. Following a launch of their recommendations at a local conference, Tan et al. (2007) found that care deficits persisted and compliance with the stroke care pathway was poor. The authors provided little information as to their implementation strategy and there is no indication that end users of the pathway were involved in the design or choice of implementation strategy.

Indeed, there appeared to be no consideration given to the context in which the care pathway was being implemented. In contrast, Wright et al. (2007) believe that they achieved an enhanced rate of compliance when they implemented a stroke prevention guideline, as a result of engaging with end users, gaining consensus around the guideline and its suitability for the context into which it was implemented.

Perry and McLaren, (2003) achieved compliance, in relation to implementing evidence-based guidelines for specified patient outcomes, with more than half of the total number of guideline recommendations for nutritional support in acute stroke. The reasons behind this were not explored, for example why do staff only implement certain elements of a guideline? What influences what they adopt and what they do not? Luker and Grimmer-Somers performed retrospective patient record audits and interviewed patients at six months post-stroke. They found that compliance with guideline recommendations was variable, and was particularly low, 40%, for patients discharged back into the community; with better care compliance found for younger patients. These studies highlight challenges for implementation researchers.

Locock et al. (2001) however, warn that whilst the enthusiasts in favour of a change are an obvious manifestation of opinion leadership, the impact of hostile opinion leaders is a crucial but neglected factor. Furthermore, organisational activities have the potential to reduce motivation to engage in implementation. Perry and McLaren, (2003) propose that severe staff shortages and winter beds crises impacted upon implementation of a nutritional guideline in acute stroke. Moreover, they suggest that a lack of specific equipment to meet certain aspects of their guideline intervention influenced uptake in relation to this aspect. Stoeckle-Roberts et al., (2006) implemented a National Institute of Health Stroke Scale (NIHSS) to screen patients on admission, end users reported that the use of the NIHSS tool required much more human resources and was difficult to initiate in multiple venues within the hospital. They did nonetheless find performance improvement using this tool, but the need for additional resources may not fit with the organisations service plan and may mean that sustainability would be a challenge. Indeed, issues such as lack of equipment to weigh clients (Perry and McLaren, 2003) were identified as reasons why compliance with guideline recommendations was poor. Indicating that researchers should be aware of the resource implications of implementing evidence-based recommendations.

Another characteristic which influenced the expected outcomes to implementing evidence within stroke was a fear of doing harm, Wright et al (2007) and Bo et al (2007) found that prescribing rates for compliance with recommendations for warfarin use were linked to the perceived risk of causing bleeding. Bedgregal and Ferlie (2001) claim that end users often lacked confidence with the quality of the evidence-based information provided by policy makers. This resulted in differing expectations between policy makers and end user clinicians, which have the potential to create barriers to implementation. In addition, unwanted outcomes can create barriers to evidence implementation; for example, Bo et al., (2007), reported that guideline adherence related to an increase in inappropriate procedure use as well as a rise in appropriate procedure use. This led them to suggest that more efficient ways to implement knowledge into clinical practice were needed.

An emphasis on local engagement and involvement in order to implement stroke best practices into the local context was perceived as essential by many researchers (Middleton et al., 2009; 2011; Wright et al., 2007; Perry & McLaren, 2003; Chappel et al., 2001; Bo et al., 2007). Motivation and positive attitudes do not necessarily influence the use of evidence in practice (Van Peppen et al., 2008). Whereas, Perry and McLaren, (2003) believed the use of education, opinion leadership, consensus guidelines linked to audit and feedback was associated with significant improvements in guideline compliance. Conversely, Crotty et al., (2004) adopted a multifaceted intervention approach, which included outreach visits, education, change management sessions, and local link nurses. Despite these measures Crotty et al., found no change in physician prescribing patterns in relation to stroke risk reduction practices.

Wright et al., (2007) found their tailored intervention was successful in improving atrial fibrillation case-findings and diagnosis, but the effects upon guideline compliance were less clear. Tailoring planned implementation interventions within the stroke care environment is worthy of further investigation. The question therefore is, 'can tailoring be used to adapt national stroke recommendations for implementation in the care home setting?'

Findings from this review indicate that successful implementation relies upon credible evidence being accepted and implemented by practitioners who have collaborated to design a fit to the local context. The complexities of this will be explored further in the discussion.

2:4 Discussion

The identified themes highlight some interesting concepts about implementing evidence within stroke. The key to the success of many interventions seemed to lie in the amount and type of preparation that took place prior to implementation. Wright et al.'s (2007) study is an example of how engaging with key stakeholders to collaborate in tailoring national guidelines to the local context, along with examining potential barriers and enablers to implementation and agreeing appropriate implementation strategies with end users, can enhance compliance with stroke guidelines. This study highlighted that introducing end users to the evidence and enabling them to adapt the evidence for implementation into their practice setting, not only helped with acceptance of the evidence itself, but can create a team focus upon implementation.

The role of barriers and enablers in implementation research is well documented (Beune et al. 2011; French et al. 2012; Jones et al. 2007), but findings highlighted other implementation influences which emerged from the findings, as illustrated in figure 2.3. These theoretical constructs included, *increasing awareness and how knowledge is used*, the role of *local governance systems*, and *tailoring interventions*, as compelling factors worthy of further investigation and analysis. This is something which this thesis seeks to address.

2:4:1 Increasing awareness

Awareness is defined as a 'knowledge or understanding of a subject, issue or situation' (MacMillan 2012). Awareness is essential in order for people to react to new information, but awareness can also be problematic, as if individuals feel they do not have sufficient knowledge and skills they may resist the proposed changes. Alternatively, individuals may seek out new knowledge and skills as a result of their enhanced awareness. Within the scoping review of the stroke implementation literature, the need for further developing knowledge and skills following awareness interventions was most frequently highlighted by the researchers and not the clinicians. Linking awareness with further learning would seem a good idea, but how this information could be captured is challenging. These concepts could

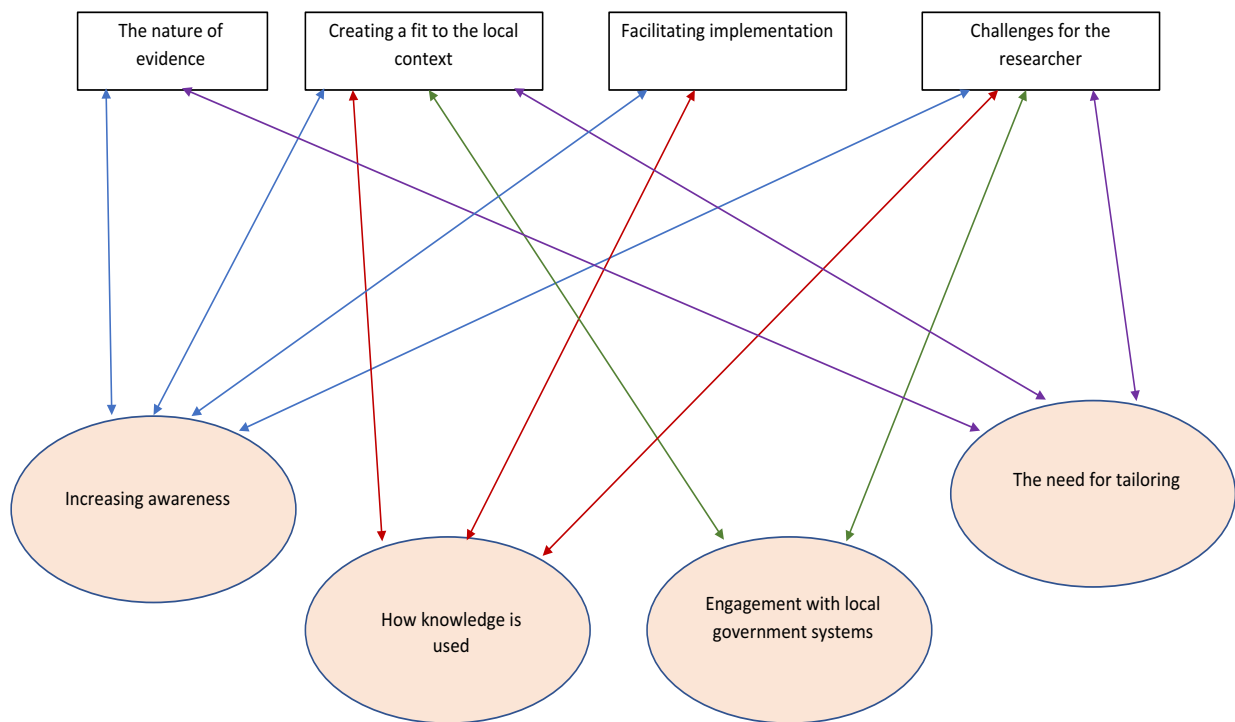


Figure 2.3: Implementation theoretical construct

possibly link to a behavioural change model, such as Procheska et al.'s (1992) Stages of Change model, which suggest that individuals modify their behaviour by moving through a series of stages from precontemplation to maintenance. Awareness of evidence can create a stage of contemplating change and preparing for change and, where clinicians will make preparations to implement the new knowledge. Conversely, they may choose to revert to a pre-contemplation stage where they are aware of the new knowledge but have no aspiration, support or skills to transfer this knowledge into their practice. Capturing the reasons why clinicians are not prepared to change will help researchers design more innovative and inclusive implementation strategies.

Literature examined within this scoping review also highlights that raising awareness within the process of implementation interventions, can help the researcher become more aware of factors which influence implementation such as a lack of equipment to weigh clients (Perry & McLaren, 2003), or a fear of doing harm, as Wright et al., (2007) found when GP's reported a fear of causing bleeding as a reason for not prescribing warfarin when implementing stroke

prevention guidelines. Mechanisms to overcome these barriers can be straight forward, but in reality, are often complex.

Raising awareness can have an adverse impact upon collected data, for example Crotty et al.'s (2004) study to reduce falls and enhance stroke prevention in the residential care setting found that due to the trial sites being more falls aware, reporting of falls increased, and as a result reduced the likelihood of effect within their trial results.

When the aim is to raise awareness, it is essential that the target audience trust the source of the information. In other words, when planning implementation initiatives, the researcher has to consider the intervention characteristics (Damschroder et al., 2009). Papers within this scoping review found that trust was a key factor when engaging stakeholders, Bedregal and Ferlie (2001) surveyed healthcare providers to find their views around evidence. They found that stakeholders often considered government proposed interventions as not being evidence-based, and this led to implementation difficulties. Chappel et al., (2001) sought consensus about the evidence base for stroke when implementing and evaluating a local-level health improvement programme for stroke. Their study highlighted that some clinical staff felt that evidence-based systems were often out of date and that practice had to be more responsive. Stakeholder perceptions of the quality and validity of evidence will influence implementation outcomes (Damschroder et al., 2009). It is vital that the knowledge to be implemented is credible and generated using a compilation of all available sources of evidence, such as: research studies, clinical experience, and patient experience (Rycroft-Malone et al., 2002).

2:4:2 How is knowledge used

Whether practitioners distinguish between explicit and tacit knowledge is unlikely, they are more likely to base their decisions on 'what they know', which at any given time will be a compilation of both explicit knowledge, that is knowledge that is gained from national and local guidelines and policies, and tacit knowledge, which has been built up over a period of time and relates to experiences and role models.

Sandars and Heller (2006) suggest that tacit knowledge is distributed within teams via the transfer of experiences via mentoring, meetings and general day to day team work.

Knowledge used by the individual becomes part of the collective knowledge. This collective knowledge is usually more resistant to change than the individual knowledge. Nutley et al. (2003) add that tacit knowledge is inherent in being a professional, but can be built around custom and practices that are ineffective and as a result can create a barrier to implementing evidence in stroke care. Damschroder et al., (2009) suggest that subjective opinions obtained from peers, based on personal experiences can create a negative source of active or passive resistance. This collective knowledge therefore, is usually more resistant to change than the individual knowledge.

This scoping review highlights the barriers which tacit knowledge can create in practice; this was evident in Brady et al.'s (2011) study where rituals and beliefs created barriers to implementing evidence-based mouth care. In addition, the Wright et al., (2007) paper discusses the GP's need to do no harm and as a consequence choosing not to follow warfarin prescribing recommendations. It is reasonable therefore to suggest that when planning to implement explicit knowledge (evidence) within stroke, such as national guidelines the researcher would be well advised to investigate how tacit knowledge is used within the local context. Data collection should focus upon the identification of knowledge cultures within the implementation setting in order to determine how implementation strategies can be tailored to fit within the care home context. Initial data collection should focus upon the identification of knowledge cultures within the implementation setting in order to determine how implementation strategies can be tailored to fit the local context.

Individuals and groups can refuse to accept explicit knowledge and create a culture of resistance to change. Within the 'Inner setting' of a particular research setting the organisational culture is believed to be amongst the most critical barrier to overcome when implementing new knowledge and the organisational assumptions, thinking and or culture are often the reasons why implementation initiatives fail (Damschroder et al., 2009). Panella et al., (2003) used a before and after study to measure performance following implementation of a clinical pathway. They found that doctors sometimes refused to change their routines even when they had been proved to be ineffective. They did nonetheless observe that the main determinant to successful implementation related to the level of involvement of healthcare providers in the development of the pathways. Damschroder et al., (2009) suggest that information should be sought from individuals and then consolidated by the research

team to highlight organisational culture. Grol (1997) suggests that the key is making the evidence fit with the actual problems and experiences of health care clinicians.

How knowledge is used and what influences knowledge implementation may be linked to local opinion leaders. Stoeckle-Roberts et al., (2006) used opinion leaders, to overcome local opposition to change when implementing a tailored stroke practice guideline. The presence of change agents or opinion leaders (Perry & McLaren, 2003) seems to influence implementation and could therefore be an effective mechanism, how these individuals influence uptake of interventions is not clear. Perry and McLaren, (2003) indicate that time is required for acceptance of new roles in order for change to occur. The 'effort' required to implement evidence seems to be an issue for clinicians, as Joubert et al. (2006) found that point-of-care reminders and support and reminders via telephone contact with local experts/opinion leaders enhanced physician guideline use. This raises interesting questions around the 'effort' required in order for clinicians/health care workers to change their practices towards the implementation of new knowledge.

The organisational and political desire to enhance quality outcomes suggests that there is a need to create a culture where new knowledge is tailored and utilised in everyday practices by healthcare professionals skilled in implementation research. If change in clinical practice is continuous and clinicians are constantly updating their practices, the notion of sustainability is interesting. Should sustainability be a short-term goal in order to embed one initiative before moving onto the next? This would seem to be a very linear inflexible approach to practice development. Are we therefore striving for adaptability expertise, where the practitioners in a given context have the skills and abilities to tailor and use evidence into their practices with minimal disruption. An examination of how this process may or may not work in practice is required. This thesis examines tailoring in action.

Researchers develop new insights into what works and what does not when attempting to implement evidence. These insights or new knowledge can help the original researchers and other researchers, to adapt methodologies to create a better fit between the implementation strategy and the context. Perry and McLaren (2003) present an example of this when they found that their research design, used to evaluate change, used too short a time frame and imposed rigid boundaries, and as a result limited the data they collected. These findings

highlight the significance of analysing the work of other researchers prior to commencing an implementation design.

2:4:3 Engagement with local governance systems

Local governance systems offer clinicians the opportunity to identify levels of guideline compliance or non-compliance. Eleven studies within this review used retrospective audit to examine the impact of, or lack of, implementation of evidence within stroke (Cadilhac et al. 2008; Duffy et al. 2003; Gommans et al. 2005; Kucukyazici et al. 2009; Luker & Grommer-Somers 2008; Murray et al. 2003; Power et al. 2006; Read & Levy 2006; Tan et al. 2007; Taylor et al. 2006; Woo et al. 2008; York 2003). Suboptimum care outcomes identified through local governance systems, such as audit can be a very persuasive argument for the development of stroke specific services, such as designated stroke units. This was evident within this scoping review where studies used governance systems to highlight the need for designated stroke services such as stroke units, or specialist stroke role development (Cadilhac et al. 2008; Duffy et al. 2003; Power et al. 2006; Woo et al. 2008). Conversely, Crotty et al. (2004) who examined implementation of evidence to reduce falls and enhance stroke prevention in residential care, found that local governance systems were not in place. As a consequence, a lack of audit data within general practice and care homes weakened the case for more interventions as no measures were available. This review indicates that local data collection systems have the potential to support the case for change and the consequent measurement of change interventions.

Efficient local governance systems can be linked to the quality of care. De Koning et al. (2005) investigated the prevalence of suboptimal preventative care preceding the occurrence of stroke, by examining the relationship between practice organisation and stroke prevention in general practice. They found that general practitioners with a higher level of integrated organisational structures for stroke prevention, such as robust record keeping systems, were less likely to deliver suboptimal care. Ivers et al. (2012) systematically reviewed the effect of audit and feedback on professional practice, they concluded that audit and feedback can be a useful intervention to improve health professionals' compliance with desired practice.

Although local governance systems can highlight best practice compliance rates, they do not explain why evidence is, or is not, implemented into practice. Tan et al. (2007) and Taylor et

al. (2006) found poor implementation of a care pathway for stroke, but the factors which influenced pathway use in practice were not highlighted within their retrospective audit of care outcomes. Hart and Morris (2008) used questionnaires and semi-structured interviews to measure staff compliance with an implemented guideline in stroke units. They found that although staff had positive attitudes towards the guideline, compliance rates were poor. These studies highlight the complexities of implementing guidelines into everyday practices. They also indicate that further research is required to investigate what influences guideline use in day to day practices, along with the local contextual effects upon guideline adoption.

Local governance systems such as audit and feedback have the potential to highlight the need for change, but do not necessarily have the capacity to identify knowledge deficits, or the contextual influences upon implementation. As a result, they can only form one aspect of the implementation process and will not in isolation influence the implementation of the evidence within stroke without being supplemented by more comprehensive implementation process designs.

Nonetheless, Albakri et al., (2003) performed a retrospective audit of compliance with national guidelines. They used their audit data to feedback findings in order to encourage hospitals in Florida to enhance stroke guideline adherence. Many hospitals implemented interventions to improve guideline adherence. Whilst there is no indication as to how these interventions were implemented, Albarkri et al., (2003) found significant improvement in guideline compliance after six months. This may indicate the influence of market forces and competitive pressures upon implementation and change in practice. Damschroder et al., believe that peer pressure and competitive pressure to implement an intervention can produce positive outcomes. They also suggest that external policies and incentives such as: pay for performance, public benchmark reporting, government regulations and guidelines can have an influence upon implementation. Governance systems which support and evaluate implementation interventions are essential to measure intervention adherence and enable implementation sites to disseminate findings for award purposes or otherwise.

2:4:4 The need for tailoring

Tailored implementation strategies can be defined as 'strategies to improve professional practice that are planned taking account of prospectively identified barriers to change' (Baker

et al., 2010, p. 5). The possible gains of engaging with end users to identify potential barriers and facilitators for change when tailoring implementation initiatives for a specific context are highlighted in Bo et al.'s (2007) study where they used a marketing intervention approach in order to survey clinicians to ascertain possible barriers to implementing hospital guidelines designed to improve warfarin use in non-valvular atrial fibrillation. This enabled them to identify potential barriers to guideline adoption, such as, the fear of bleeding caused by oral anticoagulant therapy. They overcame this barrier by providing physicians with clear recommendations that clearly weighed up the risks. They found that tailored guideline implementation substantially improved the use of oral anticoagulant therapy.

Another example of tailoring implementation to the target group is provided by Wright et al.'s, (2007) study, which evaluated the clinical and cost effectiveness of implementing stroke prevention guidelines in primary care. They performed a cluster-randomised evaluation of three primary care trusts in the North of England. They identified service gaps, educational needs and barriers to good practice, in order to tailor the intervention to the local context. They reviewed the clinical evidence and held meetings with relevant stakeholders to: obtain ownership and commitment to improving quality of care using guidelines; adapt nationally recommended evidence-based guidelines into local summary guidelines; identify barriers to and incentives for changing practice; and agree appropriate implementation strategies. Wright et al.'s, (2007) results demonstrated an improvement in the treatment of atrial fibrillation diagnosis, leading Wright et al. (2007) to conclude that healthcare professionals are significantly more likely to comply with clinical guidelines following a tailored and multifaceted intervention. Whilst this study, like the vast majority of studies in this review, highlighted interventions used and measured the consequent outcomes achieved, there is little explanation of how the mechanisms used to implement the evidence were determined or perceived. The methods used to examine the fit between the evidence, the environment and end users to achieve the recorded outcomes are therefore unclear.

Graham, Brick, Tetroe, Straus, and Harrison (2010) provide a Knowledge to Action (KTA) framework to help implementation research make sense of how evidence is translated into practice by integrating concepts of knowledge creation and action, such as warfarin use in non-valvular atrial fibrillation. Graham et al. (2010) also believe that barriers and enablers to implementing evidence should be investigated prior to implementation in order to identify

strategies which can help to overcome identified barriers. The focus is upon tailoring research evidence, taking local context and culture into account, resulting in acknowledgement of local barriers, such as the fear of bleeding caused by oral anticoagulant therapy. The KTA approach involves active collaboration between researchers and end users throughout the research and application process. Effective tailoring can help the researcher and the professionals involved in service delivery to select the most appropriate strategies to implement best practice and the most relevant theories to guide the implementation in practice (Ducharme, 2010). The Tailoring of evidence and implementation research interventions seems to be a significant factor in implementation design. The concept of tailoring requires clarification and the process of tailoring is worthy of further investigation as a tool for implementing evidence-based practice.

2:5 Overview

The majority of the studies within this review measured adherence with implementation outcomes in stroke care. Whilst this is of value to measure improvement and compliance it does not tell the whole story. Such studies do not enable the researcher to explore the end user perspectives of the knowledge being implemented and its perceived relevance to their practices. Many papers highlight that end users may adapt or use elements of the knowledge, but what is not clear is what influences these decisions. A more process orientated approach to implementation and evaluation is required in order to explore what influences how knowledge is used. Graham et al. (2010) advocate a reflexive collaborative approach when engaging with knowledge users in order to encourage a depth of enquiry, which can help the researcher to establish which interventions enable implementation of the evidence for stroke and in what context.

How the studies examined for this review consider (or not) the need to sustain evidence use is unclear. A point for consideration is whether it is sustainability we are looking to achieve or a culture of continued development, where practice evolves in order to incorporate emerging evidence. Furthermore, this raises the notion that focusing upon one element of knowledge for implementation will hinder other implementation initiatives and new ways of thinking, which in turn has the potential to stifle practice development. The impact of tailoring upon these factors is worthy of further investigation.

Graham et al. (2010) argue that the researcher and policy makers should make the knowledge fit for a given context to enable end users to adapt it into their practices. The individual clinician, the team and the organisation will also have influence upon successful implementation of the evidence within stroke services (Bucknall and Rycroft-Malone, 2010). Furthermore, Gibbon et al. (2002) found that involvement of different professionals in stroke care did not necessarily guarantee coordinated teamwork. The need to engage with key stakeholders to gain consensus with regards to the evidence to be implemented, and to appraise and identify the barriers and enablers, and the most suitable interventions, prior to implementation within a given context would seem to offer the most robust strategy for implementing the evidence with stroke. Research designed to test this theory and to unpick the success or otherwise of specific implementation interventions designed to achieve this is required.

Randomised Controlled Trials are often viewed as the gold standard for scientific measurement, however this scoping review highlights that whilst RCT's can offer valid scientific insights into implementing the evidence base in stroke, they often fall short of examining what works for whom and in what context. This can lead to assumptions that stroke innovations such as clinical pathways are ineffective in enhancing the quality of stroke care. As this scoping review reveals, often it is not the particular stroke intervention that is the issue, but the complex nature of the context into which the evidence is being implemented (Crotty et al., 2004; Van Peppen, 2008). The adoption of implementation research in stroke is essential to ensure more effective use of resources and to enhance the quality of interventions and services that stroke survivors receive. A good example of this is the Wright et al. (2007) study that used implementation research techniques in order to plan interventions prior to implementing a cluster-randomised trial to improve the quality of atrial fibrillation and TIA in primary care.

Opportunities and threats to implementing change in the care home setting can be further examined and categorised into the implementation domains recommended by Damschroder et al. (2009). This information can be discussed with care home staff and a more robust analysis of forces for change can be identified. A clear range of implementation strategies and processes to implement stroke best practices is required. This can only happen if current implementation strategies and models are examined and tested within the stroke care arena.

Analysis of studies within this scoping review identified possible forces for change in the care home sector, which may impact upon implementing the evidence base for stroke. Factors such as: the credibility and relevance of the evidence, the examination of the context into which the evidence is to be implemented, the identification of enablers and barriers to evidence implementation, the influence of policy drivers, and the need to collaborate with end users of the evidence. Indeed, a number of forces operate within the care home sector and care home environment, if these potential forces for, and forces against, change can be identified strategies to overcome or remove the barriers to change can be implemented. Forces operating in the care home environment when tailoring and implementing a stroke best practice guideline may not be subject to precise measurement, but the identification of the salient forces in operation should enable management and researchers to better assess the probable direction the care team are moving in when implementing this innovation. Whilst researchers can introduce the tools required for measuring opportunities and threats to change it is essential that each care home makes their own assessment of the relevant forces at play in implementing a stroke best practice guideline. Adapting stroke best practice guidelines using the process of tailoring would seem to be an ideal way to engage care home staff in co-production to identify barriers and enablers to guideline implementation; whilst creating a fit with the day to day practices in this particular context.

Tailoring as an implementation strategy is appealing, in terms of implementing stroke best practice recommendations in the care home setting. In order to answer the question, 'can tailoring be used to adapt national stroke recommendations for implementation in the care home setting?', a review to highlight what tailoring is and what it offers in terms of implementing the evidence base for stroke is required. An inquiry into the theoretical constructs of tailoring in order to create a practical application model was necessary.

Chapter 3

A concept analysis of Tailoring

3:1 Introduction to the Concept

The key to effective health care delivery is seen as basing practice on good, reliable evidence (Barker, 2010). The purpose of evidence-based practice is to ensure healthcare is backed by firmly grounded research evidence that includes the needs and preferences of individual service users (Carrier, Gourevitch, & Shah, 2009). Sackett (1996) suggests that evidence-based practice is the conscientious, explicit and judicious use of theory-derived, research-based information to make decisions about care delivery, taking into consideration individual needs and preferences. Implementation of evidence is a science in its own right. Implementation research seeks to understand the what, why and how evidence is used in “real world” settings and to test approaches to improve the implementation of evidence-based practices (Peters , Tran, & Adam, 2013). The implementation of evidence into practice should take into account: clinical expertise, patient preferences and values, integrated with the best available external clinical evidence from systematic research. Implementation success is often influenced by contextual factors and should therefore take into account workplace and organisational cultures and day to day custom and practice (Rycroft-Malone et al. 2004). The use of evidence in practice is therefore synonymous with change (Rycroft-Malone et al. 2004), necessitating coordinated change at system, organisation, program and practice levels (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). Unpicking the contextual influences upon evidence use in practice can further our understanding of the mechanisms used within practice which influence change and facilitate implementation strategy design. Another way of putting this is the need to examine how individuals and organisations attend to and experience context when they are embarking on an improvement intervention (Bate, Robert, Fulop, Øvretveit, & Dixon-Woods, 2014). The culture created within a care context can also impact upon evidence use in practice (Kent and McCormack, 2010). Consequently, knowledge use within every day practices is not solely about getting specific research into practice, it is about creating a culture within service contexts where practitioners automatically think about seeking evidence and translating it into practice (Dopson and Fitzgerald 2005).

Implementing evidence using best practice guidelines is thought to lead to improvements in care (Grimshaw, et al., 2006). Furthermore, the National Institute for Health and Care Excellence (NICE, 2017) suggest that implementing best practice guidelines can ensure consistency and quality of care interventions, effectively target resources, be cost efficient, and build patient confidence. Straus, Tetroe, and Graham (2011) however, believe that the key to improving the uptake of evidence-based care interventions is to move beyond simple dissemination of knowledge to use of knowledge, thus closing the gap between evidence and care delivery. For example, national guidelines set out the evidence for healthcare interventions; whilst this evidence base continues to grow the implementation within practice is often slow to respond. There is therefore, a gap between the creation of evidence for best practice and the use of evidence within day to day practices. Harrison and Graham (2012) offer a possible solution; they propose that health care based on best available evidence occurs with the tailoring and implementation of practice guidelines. Implementation research seeks to identify mechanisms, such as tailoring which have the potential to advance implementation approaches to enable the evidence to be put into operation in day to day practice.

Examination of the processes which influence implementation in practice are often difficult to identify as frequently researchers do not clearly identify how the evidence base for care is being implemented; resulting in a dearth of information around which strategies offer the key to putting evidence into operation. Implementation research is expanding and several frameworks designed to guide the implementation of evidence are now available (Rycroft-Malone and Bucknall, 2010). Examples of such frameworks include: 'The Ottawa Model of Research Use, (Logan, Harrison, Graham, Dunn, & Bissonnette, 1999); the Promoting Action on Research Implementation in Health Services (PARIHS) (Kitson, Harvey, & McCormack, 1998); and the Knowledge To Action framework (KTA) (Graham et al. 2006).

The scoping review in Chapter 2 highlighted tailoring as a way of increasing evidence use in practice through adapting evidence to create a fit with context (Harrison & Graham, 2012; Wright et al., 2007). The KTA framework (Graham et al., 2006) incorporates tailoring as an integral part of the knowledge creation and implementation processes. Graham et al. (2006) propose that knowledge or evidence can be tailored to the needs of potential users, and that evidence-based messages or recommendations can be tailored for a specific audience.

Furthermore, tailoring can be used to customize the method of implementation to better reach the intended users (Graham et al., 2006). Graham et al (2006) believe that the process of tailoring offers a good opportunity to develop mutual understandings between researchers and knowledge users in order to shape interventions for implementation. Further support for the role of tailoring in implementation was provided by Baker et al. (2010) who performed a review of Tailoring for the Cochrane Collaboration; their findings indicated that tailored interventions have the potential to change professional practice.

The notion of tailoring is intuitively appealing for researchers and service providers when considering implementing evidence-based practice but is a poorly developed concept within the discipline of implementation. A concept analysis of tailoring is required to unpick the mechanisms used within the various tailoring processes adopted within the literature, and to extract the necessary evidence to establish a worthwhile framework for tailoring within implementation research. This concept analysis seeks to contribute to scientific knowledge by offering clarity and understanding around the role of tailoring in implementation.

3:2 Methods

A concept analysis was undertaken to examine the attributes, characteristics and uses of the concept of tailoring. The procedures employed in this analysis use the methods proposed by Walker and Avant (2005), which is a process of examining the core elements of the concept by following the steps illustrated in fig:3.1. This method of concept analysis was chosen as it offers an interpretative approach to ascertain the defining attributes of the concept of tailoring within an implementation context, rather than seeking to identify the maturity of the concept as offered in other models (Morse, 1995). Nonetheless, once key constructs were identified and a more inductive approach as highlighted by Morse (1995) was adopted to unpack the empirical referents to develop a theoretical map of tailoring. Concept analysis is infrequently used in implementation research. The Walker and Avant model has however, been used within the implementation research literature by Khoddam, Rafee, and Parvizy, (2010) who performed a concept analysis of 'knowledge translation'. The walker and Avant framework has been frequently employed within the nursing literature for example; to define concepts such as: 'Compassion' (Schantz, 2007); 'Overcoming' (Brush et al.,2011) and 'Person-centred care' (Morgan & Yoder, 2012).

Procedures for concept analysis, taken from Walker and Avant (2005; p. 65)

- 1 Select a concept
- 2 Determine the aims or purpose of analysis
- 3 Identify all uses of the concept
- 4 Determine the defining attributes
- 5 Identify a model case
- 6 Identify borderline, related and contrary cases
- 7 Antecedents and Consequences
- 8 Define empirical referents

Figure 3.1: Concept analysis procedures

3:3 Uses of the concept

An examination of the uses of the term tailoring can establish current practices in relation to tailoring, along with informing a key word literature search strategy. A review of dictionaries, thesauruses and available literature highlighted uses of the concept (Walker & Avant, 2005). Definitions included: making and adapting for a particular purpose or person' (The Concise Oxford Dictionary, 1999, p. 1459); to make (a garment), especially to specific requirements or measurements; to make, alter, or adapt for a particular end or purpose (The Free Dictionary, 2012). Thesaurus verb matches for tailoring included: adapting; modifying; fitting; altering; cutting; moulding; styling; shaping; converting; customising; making; fashioning; custom-building; personalising; designing. These definitions indicate that tailoring has two main connotations: one is the trade or vocational skill of tailoring cloth for paying clients, the other relates to tailoring messages and interventions for specific users. Both connotations indicate a process of adapting something for a particular requirement.

Tailoring is a concept that is designed to create a fit between the intervention and the context into which the intervention is being implemented. Tailoring within implementation therefore has two aspects. The first is about identifying the **evidence**, and or evidence-based guidelines and adapting it for local use (Harrison et al., 2005; Lobach, 1995; Poulsen et al., 2010). The

second aspect involves identification of the barriers and facilitators which will influence guideline adoption into a specific **context** (Gallagher-Thompson et al., 2003; Poulsen et al., 2010; Wright et al., 2007). But often the definition and mechanisms involved in tailoring are unclear. Determining the defining attributes is the key to concept analysis, with the aim being to show the attributes that are most frequently associated with the concept of tailoring (Walker & Avant, 2005).

Definitions and contextual elements around tailoring were used to inform the inclusion and exclusion criteria for this review, along with facilitating identification of the following key word search terms: Adapting, tailoring, particularisation, customisation, particularization, customization and guidelines, implementation, and practice, clinical.

3:4 Identifying key literature

In order to identify relevant literature the following search engines were used, a Proquest database search incorporating MEDLINE®, Applied Social Sciences Index and Abstracts ASSIA, PsycINFO, Social Services Abstracts and Sociological Abstract, and an EBSCO data base search including CINAHL were performed. The key word search terms used were: Adapting, tailoring, particularisation, customisation, particularization, customization and guidelines, implementation, and practice, clinical.

A 'Google Scholar' search was also performed using the search term: knowledge transfer and tailoring to capture implementation literature which did not emerge from initial search. Many duplicates were produced, but nonetheless contributed to a comprehensive search of tailoring.

The search was restricted between the years 1992-2012 in order to capture the most current literature. The initial Proquest search identified 1349 results, with the initial EBSCO search producing 142 results. Both searches were analysed using the following inclusion and exclusion criteria:

Inclusion criteria: Papers written in English, as funding not available for translation; peer-reviewed studies that address: tailoring or any form of adapting evidence and or guidelines prior to or during implementation; implementation reviews which include tailoring or

adapting; organisational or policy developments which include tailoring or adapting evidence for implementation; papers which tailor or adapt information for a local context; tailoring or adapting implementation interventions for the local context.

Exclusion criteria: Papers not written in English; non-peer reviewed studies; papers which discuss implementation, but do not use tailoring or adapting of the evidence or discuss the strategies used to implement evidence into practice; papers which use tailoring in a context other than adapting evidence and or guidelines for implementation.

3:5 Literature analysis and synthesis

Where it was not possible to exclude articles based on title and abstract, full text versions were obtained and their eligibility was assessed. The first stage reduced 1349 Proquest papers to 98 and the 142 EBSCO papers to 96. Duplicates were removed, and the remaining 194 results were put into an excel table and further reviewed using the inclusion, exclusion criteria. The goal was to ensure the capture of the most relevant articles through consensus screening. A flow chart of this process can be viewed below in figure 3:2 below. A combined database total of 109 papers were identified for in depth analysis to establish themes in order to identify and define the key attributes of tailoring.

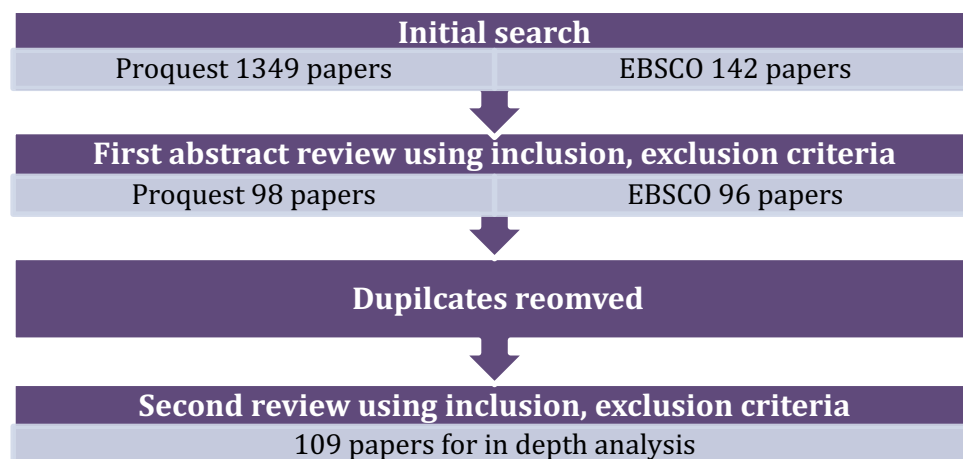


Figure 3.2: Review process

The Walker and Avant (2005) process of analysis asks the reviewer to identify the differing cases of tailoring used. From a *model case* that uses the concept and demonstrates the

defining attributes of the concept, to additional cases, which tease out attributes that closely represent the concept of tailoring. Additional cases maybe *borderline*, that is cases that contain many of the defining attributes of tailoring but not all of them. Or *related* cases that have elements that relate to aspects of tailoring. Finally, Walker and Avant (2005) identify *contrary* cases, which are examples of tailoring, but the defining attributes are contrary to the developing concept analysis of tailoring. They are therefore, not a good example of tailoring in the context of implementation. The number of studies identified into categories from the literature reviewed can be seen below in table 3.1 below.

Table 3.1: Categories of tailoring within the studies reviewed

Category	Number of studies
Model cases	2 studies
Borderline cases	17 studies
Related cases	15 studies
Contrary cases	2 studies

3:6 Defining attributes

Tailoring and adapting are terms which are often used synonymously within the implementation literature. For example, Flottorp and Oxman (2003) use ‘tailoring’ of the evidence base to improve the management of urinary tract infections; whilst Harrison et al., (2005) explain how ‘adaption’ of evidence-based guidelines was used to improve leg ulcer care in the community. Both studies transform existing evidence through a process of ‘tailoring’ or ‘adaption’ to a particular practice setting to enhance implementation outcomes.

Some studies examined for this concept analysis sought to review the implementation literature to establish frameworks for tailoring existing best practice and national guidelines to a particular setting, whilst maintaining fidelity (Fervers et al., 2006; Halder, Tiro, Glassman, Rakowski, Fernandez, et al., 2008; Harrison et al., 2010). Other studies examined did not participate in the tailoring process, but used some of the tailoring principles to establish whether or not tailoring implementation strategies was a worthwhile exercise (Baskerville, Liddy, & Hogg, 2012; Cahill & Hayland, 2010). These studies concluded that tailoring implementation interventions to the local context could have a positive impact upon improving evidence-based performance.

In order focus this concept analysis of tailoring there is a need to clarify the emerging defining attributes.

The defining attributes of tailoring can therefore be summarised as:

- A process to adapt existing evidence to a particular practice setting
- The process of tailoring will require an understanding of current practices
- Tailoring aims to create a fit between the organisational context and implementation outcomes
- Tailoring offers opportunity to engage with practitioners in a process designed to create a better fit between the evidence base and a specific care setting
- Tailoring can have two targets: The evidence, for example best practice guidelines. And context, which includes organisational resources, structures, routines, culture as well as personnel

Table 3.2, displays the reviewed tailoring literature that falls into the model case category. Model cases are studies that identify the evidence and the context of its implementation, use a transformative process that adapts existing evidence to a particular practice setting, and creates an opportunity to engage with practitioners in a process designed to create a better fit between the evidence base and a specific care setting. The table uses Walker and Avant's (2005) model case category to highlight how these studies used these stages of tailoring in order to implement best practice.

3:6:1 Model cases

Examples of comprehensive tailoring are provided by Gallagher-Thompson et al. (2003) and Wright et al.'s (2007) studies, which incorporated both evidence and context tailoring. Gallagher-Thompson et al. (2003) used stakeholder workshops where professionals, carers and families were invited to adapt guidelines to the local context; they also performed home visits to observe social interactions in order to further tailor guidelines to local culture. Gallagher-Thompson et al. (2003) and Wright et al. (2007) used oral written and visual communication to engage with stakeholders and to promote their tailored intervention.

Involvement and collaboration with key stakeholders was also highlighted in Wright et al.'s (2007) study; they engaged with patients and professionals in Primary Care Trusts to gather information in order to tailor guidelines for the local context. Information was gathered

Table 3.2: Model cases

Model cases				
Author and date	Study focus	Tailoring existing evidence/guidelines (<i>Evidence tailoring</i>)	Tailoring implementation strategies to the local context (<i>Context tailoring</i>)	Outcome
Gallagher-Thompson et al. 2003	Tailoring interventions to the special needs of racially and ethnically diverse families	Yes Stakeholder workshops. Concentrating upon the cultural values, such as the importance of family and designing interventions to embrace and augment family systems.	Yes Focus groups with families to establish contextual barriers and enablers, which led to: Home visits to observe social interactions and provide training around intervention use. Assertiveness training to enable carers to question authority Oral, written, visual and interactive presentations in simple, commonly used language blended with colloquial expressions.	Tailored interventions that are sensitive to cultural issues. Individuals implementing the guideline have training and feel confident to use recommendations in this context
Wright et al. (2007)	Multifaceted implementation of stroke prevention guidelines in primary care: cluster-randomised evaluation of clinical and cost effectiveness	Yes Guideline adaption: Engagement with local stakeholders Consensus group methods Identified gaps in service	Yes Identification of barriers to good practice Establish educational needs, such as underdevelopment of training and difficulties in engagement. Education meetings Use of existing systems Small local interactive discussion groups Audit and feedback Educational outreach visits	Improved quality of care for atrial fibrillation and TIA. Intervention was very cost effective, with savings of over £400 per patient

through interviews, consensus methods and educational meetings. Both studies found that engaging with local stakeholders to create a teamwork approach, not only facilitated tailoring of evidence-based guidelines but also provided what Wright et al. described as 'added bonuses', which included local commitment, partnership building and identification of local barriers and enablers. These factors were then utilised to inform the context tailoring process.

Context tailoring was aimed at addressing identified local barriers and involved elements such as: education meetings, identification of local opinion leaders, local interactive discussion groups, sharing local audit information, education outreach visits to reinforce key messages, discussions around implementation strategy (Wright et al., 2007), recruitment and training to assure diversity and cultural sensitivity, frequent meetings, home visits and workshops to continue guideline tailoring (Gallagher-Thompson et al., 2003). In order to overcome implementation barriers Wright et al. (2007) organised education meetings which used existing systems to promote guideline adaption. They also coordinated small, local interactive discussion groups to address local concerns and issues. Audit and feedback was shared with guideline users to aid discussion.

The perpetuation and adaptability of the tailoring process highlighted in Wright et al.'s (2007) and Gallagher-Thompson et al.'s (2003) studies suggests that researchers appear to revisit the tailoring process as new barriers to implementation arise, thus the tailoring process spans the implementation episode and is therefore iterative. This enables a flexible approach to implementation which allows the researchers to react to setbacks as they arise and tailor strategies to address potential barriers in action.

3:6:2 Borderline cases

Borderline cases are those that contain most of the defining attributes of tailoring, but not all of them. The borderline cases examined were often model examples of one aspect of the tailoring process but did not contain both aspects as in the model cases. Appendix 3:1 lists the borderline cases identified in this concept analysis of tailoring. The studies within the borderline case review fell into two categories; they either examined tailoring to adapt evidence-based guidelines for a particular context, or examined context tailoring in readiness for implementing evidence. There were eight studies in each category.

Most studies designed to tailor guidelines took place in the primary care sector (Bollini et al., 2008; Croudance et al., 2003; Graham et al., 2005; Harrison et al., 2005; Lobach, 1995; Poulsen et al., 2010; Schull et al., 2011). The majority of studies, with two exceptions, were tailoring for a group of professionals in a particular clinical setting. The exceptions were Abulkhair et al. (2010) who adapted a national cancer guideline for a specific geographical region in Africa, and Poulsen et al., (2010), who adapted an evidence-based parenting intervention also in Africa (Kenya) aimed at HIV prevention. The majority of the reviewed studies designed to tailor context also involved the primary care setting (Alanen et al., 2008; Flottrop & Oxman, 2003; Graham et al., 2004; Jans et al., 2001; Kirsh et al., 2008; Leslie et al., 2006); other studies took place in a variety of different settings, these included: an acute NHS Trust (Hamilton et al., 2007), a nursing home (Hutt et al., 2006) and the emergency department (Janssen et al., 2011).

The tailoring of evidence or evidence-based guidelines within the reviewed studies used several approaches these included: meetings, nominal group technique, content analysis of guideline recommendations, appraising quality of identified guideline using a validated appraisal instrument, audit of existing models of delivery, consensus building, group discussions, and reviewing current treatment policies. Context tailoring used similar approaches to gather information, but here the focus was upon the factors which influenced guideline adherence; or in order to design strategies to overcome barriers in preparation for guideline implementation. Again, approaches included meetings, focus groups, interviews, questionnaires, examination of case records, observations, education discussion groups, audit and feedback. Approaches in both categories were designed to ascertain the views of the individuals involved in the tailoring process; these individuals were often referred to by authors as 'stakeholders'.

Engagement with stakeholders was again seen as helpful in all borderline cases studied. Stakeholders predominantly fell into two categories, they were either individuals who the researchers believed had an expert knowledge with regards to the guideline content, or were professionals who would use the tailored guideline in their day to day practice. Most frequently the researchers selected stakeholders, but the selection process was not always made clear. Suitability for the role of stakeholder appeared to be driven by professional status or the environment where stakeholders worked. Furthermore, how their 'expertise'

was established is not discussed in the published studies. Stakeholders included professional experts, such as: doctors, psychiatrists, Registered Nurses, surgeons, chemists, microbiologists, senior clinicians, expert patient representatives and methodologists (Abulkhair et al., 2010; Alanen et al., 2008; Bollini et al., 2008; Croudance et al., 2003; Flottrop & Oxman, 2003; Graham et al., 2004; Graham et al., 2005; Hamilton et al., 2007; Harrison et al., 2005; Hutt et al., 2006; Lobach 1995), along with end users of the tailored guideline, such as: doctors, Registered Nurses and local professionals (Croudance et al., 2003; Hamilton et al., 2007; Harrison et al., 2005; Jans et al., 2001; Janssen et al., 2011; Leslie et al., 2006; Lobach, 1995; Poulsen et al., 2010; Schull et al., 2011).

Certain studies engaged opinion leaders (Abulkhair et al., 2010; Kirsh et al., 2008; Lobach 1995; Schull et al., 2011), others used guideline advocates (Croudance et al., 2003) or a champion (Hutt et al., 2006). In all cases these individuals were chosen as they were felt to be respected individuals with the ability to influence practice and or facilitate recommendation design that was more practical in daily use (Abulkhair et al., 2010).

This notion of creating a fit with day-to-day practices is an interesting one and one that was considered in several studies (Alanen et al., 2008; Bollini et al., 2008; Graham et al., 2004; Poulsen et al., 2010). Hutt et al. (2006) found that tailoring implementation strategies to address locally identified barriers and enablers has the potential to improve guideline adoption and the quality of care interventions. Promoting feasibility of guidelines can sometimes in itself create a barrier to implementation, as Jans et al. (2001) found that GP's questioned the validity of guidelines that were consensus based. Likewise, Graham et al. (2004) found that some Registered Nurses were less convinced by the evidence, but they nonetheless, advocate finding ways to fit the introduction of recommendations into the organisational agenda, whilst maintaining the fidelity of the original evidence.

The need to maintain the fidelity of the evidence or guideline when tailoring for a particular context was highlighted by several authors (Bollini et al., 2008; Croudance et al., 2003; Graham et al., 2005; Jans et al., 2001; Kirsh et al., 2008; Poulsen et al., 2010). Poulsen et al. (2010) emphasised the need to maintain the fidelity of the evidence-based intervention; they found that involving communities in the adaption of evidence-based interventions for

their particular setting achieved a good adoption and satisfaction rates, whilst maintaining the core elements of the evidence-based intervention.

Where the implementation of best practice guidelines was found to be ineffective, studies reported engagement with guideline users to identify barriers to guideline implementation and to enable the retrospective design of research and implementation strategies to address these barriers (Alanen et al., 2008; Flottorp & Oxman, 2003; Graham et al., 2004; Hamilton et al., 2007; Hutt et al., 2006; Jans et al., 2001; Janssen et al., 2011). Context tailoring identified barriers to implementing best practice, such as organisational structures, support from management, attitude and awareness, skills and training, staff development, role and responsibilities, workload and resources (Alanen et al., 2008; Hamilton et al., 2007; Janssen et al., 2011). This somewhat fragmented time frame for tailoring differs from the seamless transition of tailoring evidence and context demonstrated in the model cases.

3:6:3 Related cases

Related cases are instances of concepts that are related to tailoring, but do not contain all the defining attributes of tailoring (Walker and Avant, 2005). The related cases differ from the borderline cases in their use of tailoring attributes. The related cases have less comprehensive tailoring mechanisms, but are nonetheless in some way connected to the concept of tailoring. Appendix 3:2, displays the studies that represent related cases of tailoring within this concept analysis.

Related cases were connected to tailoring in several ways, such as: guideline tailoring using literature reviews (Ackermann et al., 2007), audit (Hickson & Hill, 1997; Hysong et al., 1998), interviewing practitioners (Lundgren et al., 2011; Vidal-Treca et al., 1999), setting up a guideline review committee (Montoya et al., 2011), or appointing researchers to create guidelines (Peleg et al., 2008). Related cases sought to examine factors influencing tailoring context by: introducing a fidelity framework to monitor adherence by participants (Chlan et al., 2001); using interviews, questionnaires and observations to seek clinician's views about guideline compliance rates (Hart & Morris, 2008; Helfrich et al., 2007; Jansen et al., 2007; Jones et al., 2007; Van Peppen et al., 2008) and by examining the role of champions in diffusing best practice guidelines (Ploeg et al., 2010). None of these methods adopted the more comprehensive attributes of tailoring as identified in the model or borderline cases.

Some studies in the related cases highlighted the need for tailoring guidelines for a particular context (Hysong et al., 1998; Van Peppen et al., 2008). Others identified poor compliance rates with guidelines (Hart & Morris, 2008). Whilst Jansen et al. (2007) called for a guideline for tailoring itself.

Context tailoring in the related cases identified similar barriers to implementing best practice such as: lack of awareness (Jones et al., 2007), resource constraints, workload (Helfrich et al., 2007; Jones et al., 2007; Maviglia et al., 2003; Van Peppen et al., 2008) paucity of evidence, and out of date guidelines (Jones et al., 2007).

The notion of fidelity was again raised in the related cases studies; where Lundgren et al. (2011) raised concerns with regards to involving key stakeholders, who would be the end users of an adapted guideline, in the tailoring process. They felt that engaging with end users risked diluting the original message and as a result the fidelity of the evidence (Lundgren et al., 2011). This challenges the findings of other studies where engagement with end users in adapting evidence-based interventions for their particular setting was seen as an effective method to evoke a sense of ownership and consequential adoption of interventions (Gallagher-Thompson et al., 2003; Poulsen et al., 2010; Wright et al., 2007). In an attempt to promote fidelity Chlan et al. (2011) introduced a treatment fidelity framework to monitor adherence of participants; they found that this facilitated a greater adherence to treatment framework.

3:6:4 Contrary cases

Contrary cases are cases that present clear examples of the lack of tailoring principles. Appendix 3:3 displays the contrary case identified during this concept analysis. The contrary cases in this study carry out implementation research without any aspects of tailoring. As a result, they found no significant difference in adoption of evidence-based practice (Crotty et al., 2004), or poor adherence to an evidence-based pathway (Tan et al., 2007). The suitability of the evidence base recommendations to the local setting was not addressed. In addition, researcher did not seek to examine or address local barriers and facilitators to implementing best practice in that particular context.

3:6:5 Summary of findings

The defining attributes of tailoring can therefore be summarised as:

- Tailoring should have two targets:
 - Evidence (research and/or evidence packages – e.g. guidelines)
 - And context, which includes organisational resources, structures, routines, culture as well as personnel
- Tailoring requires explorative, consensus building methods to:
 - Seek the views of key stakeholders in order to examine current practice and to create a fit between day to day activity and best practice guideline recommendations
 - Examine the factors that have the potential to influence implementation in order to tailor context
- Collaboration and engagement with the end users of tailored guidelines in order to:
 - Raise awareness
 - Obtain user buy in
- Tailoring seeks to creating a fit between the organisational context and implementation outcomes
- Tailoring is an Active and iterative approach, which interacts and reacts to practice needs/barriers as they arise leading to a potentially continuous process
- Tailoring should address challenges of ensuring fidelity of the evidence – core and peripheral, adherence, mechanisms of action .

3:7 Discussion

The analysis of the model, borderline and related cases of tailoring highlights some key referents for developing theory around the process of tailoring. The empirical referents identified within this concept analysis were: engagement, stakeholders, tailoring in action, feasibility, and fidelity. These empirical referents form the theoretical building blocks of tailoring and as a result should be analysed further using a more inductive analysis (Morse, 1995), in order to further unpack and theorise about tailoring phenomena. Table 3.3 summarises the findings of this concept analysis in relation to the defining attributes, the factors which make up tailoring; the antecedents the background elements which can influence tailoring; the possible consequences for practice; and finally the empirical referents for tailoring.

Table 3.3: Findings summary

Summary of findings: Patterns of tailoring			
Defining attributes	Antecedents	Consequences	Empirical referents
<ul style="list-style-type: none"> • Stakeholder involvement • Partnerships • Consensus building • Identifying gaps in service • Identifies barriers and enablers • Sympathetic to local context • Tailors evidence • Creating a fit with existing models of delivery • Maintain core elements of evidence • Address education needs • Opinion leaders • Multidisciplinary • Culturally appropriate 	<ul style="list-style-type: none"> • Teamwork • Involvement • Contextual influences • Custom and practice • Fit with local priorities • Knowledge and skills • Influences upon tailoring at local level • Relevance to practice • Levels of training • Belief in evidence • Communication networks • Evaluation mechanisms 	<ul style="list-style-type: none"> • Resources • Resistance • Motivation • Resilience • Cost effective • Service reorganisation • Financial constraints • Quality improvement • Risk of diminishing original evidence 	<ul style="list-style-type: none"> • Engagement • Stakeholders • Tailoring in action • Feasibility • Fidelity

3:7:1 Engagement

Engagement is a dominant theme in the tailoring literature. Effective tailoring requires collaboration with end users and relevant stakeholders to ensure their views are captured and utilised to facilitate a best fit with the local context. Engagement and collaboration with professionals, end users and other stakeholders can highlight the specific needs of a given setting in order to create a better fit with day to day practices, thus highlighting the relevance and usability of the tailored guideline. Effective tailoring of evidence-based guidelines requires an intimate knowledge of the intended clinical practice environment, engagement with end users from the practice environment is therefore a fundamental requirement of the tailoring process. The engagement of end users in the tailoring process increases awareness of the gaps in knowledge and increases understanding of the scope of practice of all disciplines involved, and can begin the process of dissemination of evidence to key personnel (Gibbons et al., 1994; Graham et al., 2002; Wright et al., 2007).

Strategies used to collaborate with stakeholders included: focus groups, interviews, questionnaires, outreach visits, and consensus building events. Engagement with local stakeholders to overcome identified barriers and tailor pertinent implementation strategies to the local setting forms the basis of context tailoring. Tailoring which encompasses the local context and addresses local influences can be used to adapt and implement best practice guidelines. Graham et al. (2004) stress that it is important to identify organisational barriers to change, and that careful tailoring of implementation interventions to overcome barriers and promote adopters is necessary.

Gallagher-Thompson et al. (2003), Poulsen et al. (2010) and Wright et al., (2007) believe that involving end users in adapting evidence-based interventions for their particular setting was an effective method to evoke a sense of ownership and consequential adoption of interventions. Graham et al. (2005) suggest that involving end users in tailoring raises health care providers' awareness of the evidence base and facilitates implementation. Cargo and Mercer (2008) believe that raising awareness about the underlying issue is a key aspect of engaging end users and other stakeholders in tailoring. Furthermore, adopting a collaborative approach can enable end guideline users to reflect upon their practices and the factors that interplay at a local and political level, in order to highlight barriers and enablers to implementation. Analysis of this data can enable researchers in partnership with local stakeholders to create robust locally adapted guidelines, which end users can implement into their day to day practices.

A lack of collaboration with professionals who are expected to use the tailored evidence in their day-to-day practices, and the service users whose healthcare experience is at stake, is therefore potentially problematic. Failure to engage with end users in the tailoring process often resulted in poor up take and impacted upon quality outcomes (Hickson & Hill, 1997). Guidelines implemented without local consensus can lead to a threat to professional autonomy and result in recommendations that fail to support decision making in practice, producing very limited, if any, definite impact upon care outcomes (Crotty et al., 2004; Tan et al., 2007). Evaluation of the views of end users and an awareness of the local context in order to establish barriers and facilitators for guideline adoption is seen as a key aspect of tailoring (Baker et al., 2010). Establishing the factors that influence guideline adoption can enable tailoring of the implementation mechanisms to fit with the local context.

Effective collaborations can result in what Realpe and Wallace (2010) describe as co-production. Co-production aims to address the problem of compliance with evidence-based guidelines and pathways by attaining involvement and agreement from all stakeholders through shared problem definition and the design and implementation of local solutions (Realpe & Wallace, 2010). Whilst in the literature co-production predominantly involves citizens and communities engaging in the planning and organisation of health services, it seems a useful model to engage any practice community in the process of tailoring guidelines for their particular context. This method may fit more within the realm of engaged scholarship, which focuses upon the engagement of the end users of research interventions in the research process and design (Van de Ven, 2007). Engaged scholarship involves a relationship that involves negotiation and collaboration between researchers and stakeholders where knowledge is co-produced on important questions and through testing alternative ideas to create pertinent solutions (Van de Ven, 2007).

3:7:2 Stakeholders

Identifying pertinent stakeholders seems to be a significant component of evidence and context tailoring. The studies within this concept analysis identified stakeholders as a mix of service providers, service users and service developers. Engagement with stakeholders to tailor evidence for a particular context was highlighted within the tailoring literature as good practice (Gallagher-Thompson et al., 2003; Graham et al., 2004; Wright et al., 2007). How stakeholders were recruited is unclear, for example in Wright et al.'s (2007) study the recruitment of patients in order to measure the impact of the intervention is explained, but how 'relevant stakeholders' were identified is unspecified.

The terms stakeholder and end users were often used in the literature. Determining what differentiates the two is difficult as end users were often used as stakeholders (Flottrop & Oxman, 2003; Graham et al., 2005; Harrison et al., 2005). For example; Graham et al. (2005) discuss the process used to adapt a leg ulcer guideline; they describe the stakeholders involved as key providers of leg ulcer care in the community. Nonetheless, stakeholders and end users were chosen for their insider knowledge of the context where best practice guidelines were to be implemented. End users in particular were found to enhance the adoption of evidence-based practice, especially as tailoring moves on to identify

implementation strategies suitable for the local context (Harrison et al., 2005; Graham et al., 2005; Wright et al., 2007).

The impact of key individuals, or insiders, in the tailoring of evidence, and their consequent influence upon context tailoring whether intentionally or not is an interesting factor. These individuals seem to bring a different dimension to tailoring, which highlights local issues and has the potential to create more robust tailored guidelines, which are acceptable to end users. Harrison et al. (2005) and Flottrop and Oxman (2003) concluded that collaboration with key stakeholders helped to identify barriers and generate ideas for tailoring interventions. Graham et al. (2002) suggest that the participation of all stakeholders in guideline adaption for local use also has the potential to identify and reduce barriers to the implementation of the adapted guideline. Tailoring therefore, seems to be most effective when a collaborative, engaging approach is adopted, which involves interactive enquires where end users and stakeholders are given opportunity to identify local contextual issues that can enhance or hinder implementation of evidence-based practices or guidelines. This perception that guideline tailoring can inform context tailoring suggests an interesting, symbiotic connection exists; one which has the potential to enhance implementation outcomes (Harrison et al., 2005; Wright et al., 2007).

3:7:4 Approaches to tailoring

3:7:4:1 Tailoring in action

The studies examined in this review used a variety of approaches to tailor evidence such as: meetings, nominal group technique, content analysis of guideline recommendations, appraising quality of identified guideline using a validated appraisal instrument, audit of existing models of delivery, consensus building, group discussions, and reviewing current treatment policies. Approaches to context tailoring included: meetings, focus groups, interviews, questionnaires, examination of case records, observations, education discussion groups, audit and feedback. The model cases used several approaches in a comprehensive responsive fashion, which spanned the duration of the implementation process. Examples of a comprehensive approach to guideline tailoring were proved by Gallagher-Thompson et al. (2003) and Wright et al. (2007). Tailoring within these two studies was multifaceted, with both adopting a collaborative, interactive, exploratory approach in order to engage with and

capture the views of the individuals either involved in implementing the guideline, or affected by the outcomes of successful guideline implementation or otherwise.

Gallagher-Thompson et al., (2003) and Wright et al. (2007) use tailoring throughout the implementation process. The longevity and responsiveness of the tailoring process highlighted within these studies is interesting and presents a more comprehensive depiction of tailoring. The researchers appear to revisit the tailoring process as new barriers to implementation arise; thus the tailoring process spans the implementation episode. This enables a flexible approach to implementation which enables the researchers to react to potential barriers in action.

This concept analysis raises some key questions such as; the notion of 'tailoring in action', that is whether the process of tailoring itself is a flexible implementation method? For example, does the very notion of end users of evidence-based guidelines getting together to tailor them for a particular setting raise awareness and lay down the foundation for the process of implementation. Which leads onto a question around is tailoring a time limited process, if so when does it start and end? Within the literature this is often unclear, but there are pointers to tailoring being a process which starts at adapting existing evidence and then flows on, whether intentionally or not, into the factors that influence implementation. In addition, the question of who influences tailoring remains, for example are outside influences such as researchers, managers and policy directives the driving force, or is it the internal players who will use the tailored evidence in their day to day practices. These key questions are worthy of further investigation in order to fully understand the scope of tailoring in implementation research.

3:7:4:2 Feasibility

Feasibility addresses the practicalities of the proposed evidence for implementation, which takes into account the fit with current practices. Guideline adaptations therefore, need to fit within existing models of delivery in the targeted setting (Harrison et al., 2010). A lack of fit with existing models of delivery can create user ambivalence and barriers to guideline adoption in day to day practices. The concept of feasibility is typically invoked retrospectively as a potential explanation for implementation success or failure. Baker et al. (2010) propose that tailored interventions to change professional practice are interventions

planned following an investigation into the factors that explain current professional practice and the reasons for resisting new practice (P:2). This concept analysis however suggests that tailoring offers a flexible interactive approach, which engages with end users to create a fit whilst adapting best practice guidelines and facilitates the tailoring of implementation strategies for a given context (Gallagher-Thompson et al., 2003; Wright et al., 2007).

This review indicates that tailoring was employed to enable researchers and practitioners to unpick the factors which influenced day to day activity and to examine ways to tailor the evidence to create a fit with day to day practices. For example; Gallagher-Thompson et al., (2003) used tailoring as a technique to facilitate the design of culturally appropriate interventions, by adapting existing evidence-based interventions to meet the special needs of racially and ethnically diverse family members with dementia. Wright et al. (2007) adapted guidelines which were then tailored to the local context by identifying gaps in service, barriers to good practice and educational needs. As a consequence, they concluded that the intervention had been feasible and very cost effective. Establishing the factors which influence guideline adoption can enable tailoring of the implementation mechanisms to fit with the local context. Indeed, Hutt et al. (2006) found that tailoring implementation strategies to address locally identified barriers and enablers has the potential to improve guideline adoption and the quality of care interventions.

A key concern when tailoring evidence-based guidelines is maintaining a balance between feasibility and fidelity. That is ensuring that the evidence is a good fit with the practice and organisational structures, whilst safeguarding against dilution and maintaining the credibility of the evidence during the tailoring process.

3:7:4:3 Fidelity

Fidelity of implementation is measured by identifying the extent to which the particular characteristics of a specific program are present when the program is implemented (Century et al., 2008). To ensure fidelity tailored guidelines must therefore preserve the integrity of the evidence-based recommendations, whilst recognising that organisational, regional or cultural circumstances may legitimately require important variations for guideline adoption (Harrison et al., 2010). This therefore creates a fundamental challenge for the process of tailoring guidelines. The literature seems somewhat divided as to how fidelity can be

maintained. Within the literature there is a concern that involving key stakeholders, who will be the end users of an adapted guideline, in the tailoring process risks diluting the original message and as a result the fidelity of the evidence (Lundgren et al., 2011). Nonetheless, the need to involve end users in adapting evidence-based interventions for their particular setting is seen as an effective method to evoke a sense of ownership and consequential adoption of interventions (Gallagher-Thompson et al., 2003; Poulsen et al., 2010; Wright et al., 2007). Furthermore, Lundgren et al.'s (2011) study, which examined how community-based addiction treatment organisations modified evidence-based practice, found that key stakeholders identified a conflict between national evidence-based guidelines and providing culturally appropriate services for the local setting. As a consequence, Lundgren et al. (2011) felt that extensive modification of evidence-based guidelines could result in poor patient outcomes. Indeed, this has been highlighted as a concern by several authors such as; Graham et al. (2004), Graham et al. (2005), Harrison et al. (2005) and Poulsen et al. (2010), who advise against over adaption of evidence-based recommendations, which has the potential to lose the original meaning, and as a result can impact upon quality and care outcomes.

In order to maintain fidelity of existing evidence-based guidelines Lundgren et al. (2011) proposed that tailoring of evidence should be achieved by researchers, rather than engaging with end users to tailor the evidence to local needs. This suggestion however, seems to contrary to the evidence emerging from the tailoring literature, which has a strong emphasis upon collaboration and indicates that engagement with key stakeholders and end users is a significant feature of tailoring. Indeed, Poulsen et al. (2010) found that involving communities in the adaption of evidence-based interventions for their particular setting achieved a good adoption and satisfaction rates, whilst maintaining the core elements of the evidence-based intervention. Ploeg et al. (2007) suggest that tailoring with different groups of stakeholders is the key to identifying best practice guideline implementation strategies that address barriers related to the individual practitioner, social context, and organisational and environmental context. Harrison et al. (2010) support collaboration with end users and stakeholders. They believe that evidence-based guidelines can be successfully adapted to the local context, but add that the process of tailoring guidelines must preserve the integrity, quality and validity of the evidence-based recommendations and follow a

structured approach. The need to involve end users in adapting evidence-based interventions for a particular setting therefore creates a challenge for researchers who are required to ensure the fidelity of the evidence is not diluted.

It is often unclear in the literature how fidelity of tailored guidelines is assured, some studies such as Wright et al., (2007) used existing audit and feedback systems, but found that these systems were often not fit for purpose. Graham et al., (2005) suggest the use of a guideline appraisal instrument, along with a content analysis of guideline recommendations. Century et al., (2008) propose that fidelity of implementation is measured by identifying the extent to which the particular characteristics of a specific program are present when the program is implemented. Detailed discussion of the validity and reliability of fidelity measure are rare within the implementation literature. Nonetheless, Carroll et al., (2007) propose a framework for measuring implementation fidelity, which focuses upon the factors that may influence fidelity, adherence and outcomes. Where the tailoring process may fit into this framework is difficult to ascertain, as potentially tailoring could be used throughout the implementation venture. Chlan et al. (2011) found the use of a fidelity framework useful as it facilitated greater adherence to the original treatment framework. The fidelity framework used within Chlan et al.'s study was itself tailored to fit with local need. Furthermore, they highlighted a need for fidelity framework monitoring to be an iterative process with vigilance to identify barriers as they arise and adapt implementation methods to enhance protocol adherence (Chlan et al., 2011). This suggests that Tailoring would sit well within this iterative monitoring process and enable examination and redesign in action to create guidelines and protocols, which fit into the evolving requirements of practice context.

3:8 Recommendations

Tailoring is an active, interactive process which takes place in practice. Research designed to gain further understanding of the tailoring process must therefore engage with practitioners and take place in in the field of practice. The main purpose of tailoring is to account for the contrast between the clinical practice within which it is situated, with a collaborative and changing nature, on the one hand, and the formal theories and models that underpin guidelines, on the other hand. There is a therefore, potential for “cognitive

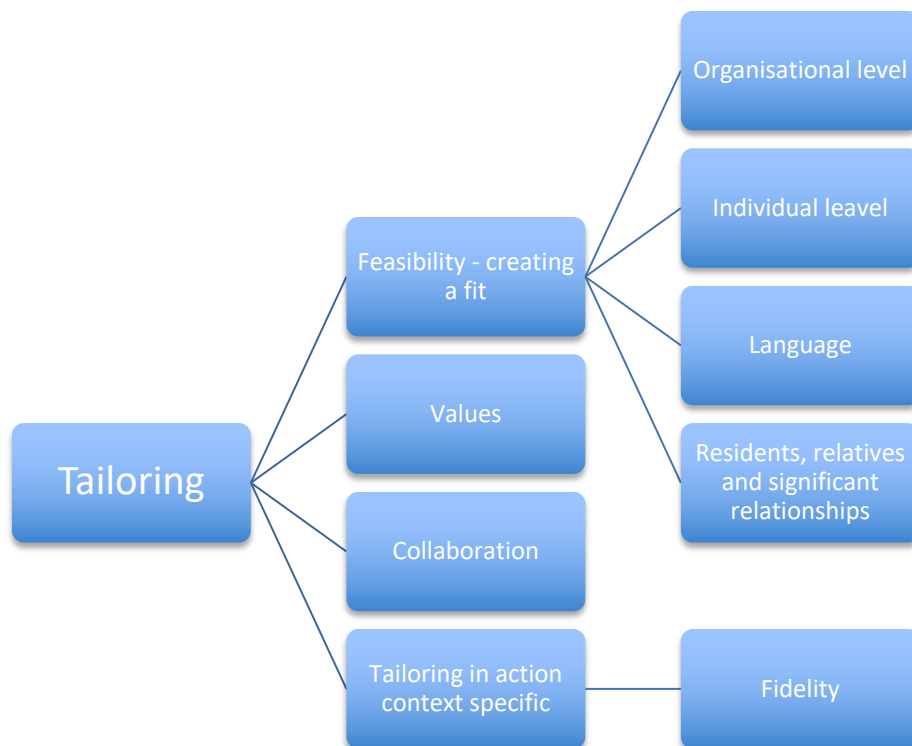


Figure 3.3: An illustration of Tailoring

dissonance” between implementing evidence-based guidelines and designing evidence-based guidelines. Guideline tailoring and context tailoring offer a collaborative, interpretive process to reduce this cognitive dissonance and create a fit for a clinical context.

Tailored interventions will be those that have been designed through consensus with local stakeholders, including end users. Data collection methods will have involved key stakeholders, managers and hands on staff. The successful tailoring of evidence to a specific context will have involved preservation of the integrity, quality and validity of the evidence-based recommendations following a structured approach. In addition, tailoring will include consensus with all key stakeholders in order to arrive at an agreed tailored evidence-based guideline for the given context.

Tailored implementation strategies will be those that have been designed to overcome identified barriers, and enhance enablers within the specific setting. Tailored implementation strategies will be designed and operationalised through collaboration with

end users. Local opinion leader will act as advocates and facilitators for the tailored implementation initiatives. Tailored interventions will require an environment of sustainability, where teams embrace new evidence and are able to tailor it to their local context.

A key concern when tailoring evidence-based guidelines is maintaining a balance between feasibility and fidelity. That is ensuring that the evidence is a good fit with the practice and organisational structures, whilst safeguarding against dilution and maintaining the credibility of the evidence during the tailoring process.

Vital steps which must occur if evidence is to be tailored to a specific context include: consideration as to what is to be tailored, for example a national guideline. The next step is an examination of the existing evidence regarding the proposed guideline or evidence to be tailored, towards establishing a need for local tailoring and the benefits of local adaption. In addition an investigation into previous guideline tailoring is required in order to establish what methods have been successful in similar cases.

An emerging framework for Tailoring Guideline Implementation which has the two targets of tailoring (evidence and context) can be seen in appendix 3:4 below. This framework provides a basic step by step approach to tailoring which encompasses the elements of successful tailoring which emerged from this concept analysis.

A logical framework for tailoring evidence-based guidelines in to a particular context can facilitate a robust process to ensure that the end product meets the needs of the particular context. Furthermore, tailoring implementation mechanisms and strategies to fit the local context is an essential process in order to give the adapted guideline a greater likelihood of being adopted into every day practices. This framework will be built upon during the course of this study in order to produce a framework to provide a guide to tailoring for implementation scientists.

Chapter 4

Study methodology and methods

4:1 Introduction

This chapter begins with the ontological and epistemological perspectives which guided the research methodology. The methods chosen to facilitate this approach will be discussed, in the second half of this chapter and will include the approach used to collect and analyse the data.

This research journey began by highlighting the concerns that residents with stroke living in care homes are not benefiting from the national stroke guidelines, as set out by the intercollegiate group on behalf of the Royal College of Physicians or the National Institute for Health and Care Excellence (NICE). The gap identified in the literature, concerning the application of available evidence into practice, led to the question of how care homes could be engaged to implement stroke best practices as set out in the national guidelines. The scoping review discussed in Chapter 2, which examined how the evidence base for stroke was being implemented, highlighted several interesting strategies. The notion of tailoring best practice recommendations for a specific setting was of particular interest, especially as the majority of best practice guidelines seem to focus in the main upon care in the acute sector. The concept analysis discussed in chapter 3 enabled a greater insight into tailoring and identified empirical referents. This study therefore, was designed to examine whether tailoring was a suitable vehicle to adapt and aid the design of implementation strategies to facilitate the implementation of stroke best practice recommendations for this context. And indeed, if a process map of tailoring could be developed, which could in turn add to implementation knowledge.

4:2 Methodology

4:2:1 Ontology

Grix (2001) defines ontology as 'the image of social reality upon which a theory is based' (p:26). Ontology therefore involves an enquiry about the form and nature of reality (Guba & Lincoln, 1994). It is this reality that defines a researcher and the approaches adopted to create knowledge. A positivist research perspective views knowledge as coming from an external, measurable reality (Howlett, 2013). The positivist ontology therefore, focuses upon a single objective reality and uses a structured approach to test hypothesis (Carson, Gilmore, Perry, & Gronhaug, 2001). At the other end of the continuum interpretivism is often viewed as an alternative to positivism, which uses an inductive theory building approach. In interpretive research therefore, knowledge is a social construct. A constructivist standpoint offers a paradigm that reflects individual or phenomenological perspectives, where co-existing multiple realities and interpretations are possible (Newman & Benz, 1998). Constructivists therefore, assume that the meaning of experiences and events are constructed by individuals as they engage with the world; who therefore construct the realities in which they participate (Charmaz, 2006).

Constructivism asserts that social phenomena and their meanings are continually being accomplished and evolved by social actors (Bryman, 2001, pp16-18). Knowledge acquired in this paradigm therefore, is socially constructed rather than objectively determined (Carson et al., 2001, p.5). The ontological position adopted within this study was informed by theories such as Anthony Giddens' theory of structuration (Giddens, 1984). Giddens maintains that society should be understood in terms of action and structure. As a result, Giddens believes that human agency and social structures are in a relationship with each other, and that it is the repetition of the acts of individual agents which reproduces the structure. Applied to healthcare settings, this suggests that the organisational achievements are only as effective as the sum of its parts; which includes the human agency of the healthcare team. Human agency and social structure interrelate, and people's everyday actions reinforce and produce social forces, which create a social structure (Giddens, 1984). When the human agency creates a social structure, with traditions, moral codes, and established ways of doing things that produce poor quality interventions and outcomes, as

was the case in Mid Staffordshire (Francis, 2013), the institution or organisation becomes unstable.

In order to understand the culture within an organisation, such as a care home, the researcher must examine the impact of the human agency with the purpose of interpreting the day to day customs and practices that make up the social structures. Giddens' view of society therefore, is of particular interest to healthcare implementation researchers, as it is only by examining practice contexts at a macro, meso and micro level (Pettigrew, 1998), that it is possible to establish real understanding of the factors that influence evidence use in practice.

Giddens believes that some degree of collective consensus is necessary to preserve social constructs and practices. He suggests that researchers need to listen to the dialogue of participants. Gibbons et al. (1994) suggest a Mode 2 approach, where knowledge is produced in the context of application using a transdisciplinary approach, which requires the participation of all stakeholders in knowledge generation. This enables a much greater diversity of knowledge production. The knowledge generation process is highly reflexive and requires a much greater dialogue between all participants. Generating and implementing evidence requires the involvement of knowledge producers, disseminators, traders and users (Kitson & Bisby, 2008).

For this study an interpretivist stance was therefore required in order to understand the 'what we know' about day to day care home routines and to establish the care home staffs' perspectives about interventions for residents with stroke. Furthermore, Morse (2006) suggests that interpretive researchers seek to establish who has the power, within a given context, to control the definition of evidence and the vehicles through which evidence can be put into practice. Grix (2001) suggests that if ontology is about what we may know, epistemology is about how we come to know what we know (p:27).

4:2:2 Epistemology

Epistemology is a way of looking at the world and making sense of it (Crotty, 1998). In general, epistemology embodies the assumptions made about the nature of knowledge, and

how we use, or do not use, knowledge in a particular context. Epistemology therefore, acts as a lens through which the researcher can explain the study's methodology (Kelly, 2010). Epistemology has its roots in philosophy and is concerned with the theory of knowledge and the ways in which knowledge of social reality is understood (Grix, 2001. P:27). Knowledge is fundamental to the epistemology of social inquiry. Polanyi (1958) challenged the positivist philosophers who separate objective knowledge from individuals who hold that knowledge. Polanyi (1958) distinguished between propositional and tacit knowledge. He suggests that propositional knowledge is the knowledge of both reason and gossip, composed of interpersonally shared statements, most of which were observations of objects and events. Tacit knowledge on the other hand, may also dwell on objects and events, but it is knowledge gained from experience with them, experience with propositions about them, and reflection (Polanyi, 1958).

Positivism is an epistemological paradigm that uses methods aligned to apply the natural sciences, and considers knowledge arrived at through the gathering of facts (Bryman, 2001, p:12). Positivism therefore, uses a deductive theory testing approach, which consequently adopts a quantitative research perspective. A positivist approach focuses upon methods of natural sciences, which are based on a belief in universal laws and insist on objectivity and neutrality (Holloway & Wheeler, 2002). The aim of this study was not to gather facts for facts sake, but to interpret the participants meanings around tailoring in action in order to develop theory to inform the implementation of evidence in this context. In other words, the study sought to establish care home staff's meanings in relation to how the best practice recommendations for stroke could be applied to their day to day practice and the application of tailoring to enable a fit to this context. An approach conceived within the positivist paradigm would therefore be incongruent with the purpose of this study. Thorne, Kirkham and Henderson (1999) however advise against unwarranted 'paradigm thinking', which they believe can restrict rather than inform research methods. A paradigm which enables the researcher to gather appropriate data to answer the research question, is nonetheless a fundamental factor when designing the research approach.

Constructionism, in concurrence with Giddens' theoretical perspective, assumes that the meaning of experiences and events are constructed by individuals as they engage with the world; who therefore construct the realities in which they participate (Charmaz, 2006).

Consequently, a constructivist approach focuses upon the contextual perspective, which enables the researcher to acquire a greater understanding of the culture and context, where stroke interventions are being delivered. This research paradigm provides a comprehensive theoretical perspective for this research enquiry, which aimed to understand how care home staff construct reality in concert with others within the care home context. This in turn would enable an understanding of how these constructs impact upon the day to day actions and interactions around stroke, and to move towards a consensus, whilst still open to new interpretations as further information is gathered. This approach enables the researcher to assemble local knowledge, using data collection methods designed to encourage care home staff to share their views and opinions. Denzin (2009) suggests that qualitative research should not be shoehorned into a specific paradigm, but should adopt a flexible approach, one that focuses upon understanding verses prediction. Crotty (1998) explains that 'different people construct meaning in different ways, even in relation to the same phenomenon' (P:9). It is the researcher's task to discover and interpret this meaning.

4:2:3 Case study

Stake (1995) proposes a case study approach which is orientated within a naturalistic, holistic, ethnographic and biographic perspective (p.11). Yin (1994) puts case study forward as a legitimate methodology to conduct inquiries into a theoretical proposition. Yin therefore, demonstrates a more positivist leaning in his perspective on case study (Crotty, 1998). "A case study is an empirical inquiry that investigates a contemporary phenomenon within its real life context, especially when the boundaries between phenomena and context are not clearly evident" (Yin, 1994, p13). Stake (2006) believes that qualitative case studies enable the study of experiences in real situations. Given that it is the context that shapes the process of tailoring and the consequent interpretation of tailoring activity, in this case the tailoring national stroke best practice recommendations for the care home setting, a case study method was and ideal choice for this study.

Stake (2006) believes that the power of case study design is its attention to the local situation and not how it represents other cases in general. Case studies therefore, are generalizable to theoretical propositions and not to populations or universes. The case study does not represent a sample and the investigators goal is to expand and generalise theories

(analytical generalisation) and not to enumerate frequencies (statistical generalisation). Stake (2006) describes an 'instrumental case study' where the purpose of the study is to go beyond the case itself. The case is of secondary interest and investigation facilitates an understanding of something else. Stake's case study method therefore, offers an interpretivist approach to examine the process of tailoring as an implementation strategy within the care home setting.

A case study approach enables the researcher to understand the influences of organisational structures within a given context, such as a care home, and to examine the context in which care is delivered (Stake, 1995). As one result relies on multiple sources of evidence, with data needing to converge in a triangulating fashion and as another result benefits from the prior development of theoretical propositions to guide data collection and analysis. Case studies therefore, can be based on any mix of qualitative and quantitative evidence. Yin (1994) believes that the case study as a research strategy comprises an all-encompassing method, with the logic of the design incorporating specific approaches to data collection and to data analysis. In order to be robust this 'design work' must continue throughout the data collection phase. As a result, the researcher can develop an understanding of how care home staff explain how things are, why they are, and how they approach tailoring and how they perceive the tailored recommendations could be implemented into day to day practices.

A case study can be exploratory, descriptive and explanatory. Yin (1994) suggests that the important element is to identify the type of research question. He suggests that research questions that seek answers to the 'how' and 'why' are likely to lead to the use of case studies. If the aim is to identify the factors that might influence an implementation intervention, then a case study approach is appropriate. Case study is preferred in examining contemporary events, but when the researcher cannot manipulate the relevant behaviour. Case study includes direct observation and systematic interviewing. The unique strength of the case study approach is its ability to deal with a full variety of evidence such as: documents, artefacts, interviews and observations (Stake, 2006).

Case study will facilitate the deliberate examination of contextual conditions in order to understand and build theory in relation to the phenomenon of tailoring. Stake embeds case

study in constructivism with the underpinning view that ‘knowledge is constructed, rather than discovered’ (Stake, 1995: p.99). This research study therefore, used Stake’s case study method, as it offered the desired qualitative, interpretivist approach.

4:3 Methods

This study aimed to examine tailoring in action to apply theoretical constructs of tailoring. In the first instance the objective was to examine and understand current practice in relation to stroke care in the care home context in order to plan tailoring in action in this setting. This was achieved by interviewing care home staff about their day to day experiences of delivering care for residents with stroke.

Another key objective was to close the gap between theory and practice, using tailoring as a vehicle to adapt best practice recommendations for the care home context.

4:3:1 Research approach

In order to structure the study a research design was required. A research design is the logic that links the data to be collected to the initial questions of a study (Yin, 1994). This research study used Stake’s case study methods, which used mixed methods to collect relevant data. Below is a flow diagram (Figure: 4.1) of the research design.

In order to examine tailoring and to develop theory to explain this phenomena, the case study enquiry enables the researcher to unpack the complex and distinctive situation that exists in, for example, care home environments, in which there will be many more variables of interest than data points. Furthermore, the focus of the study was to unpack care home staff activity and behaviours, rather than examining the care home staff as entities. Indeed Stake (2006) suggests that within a multicase study there will be a binding concept, that holds the cases together (p:9), in this study it was the examination of tailoring in action. Tailoring in action was the conceptual infrastructure for building this thesis.

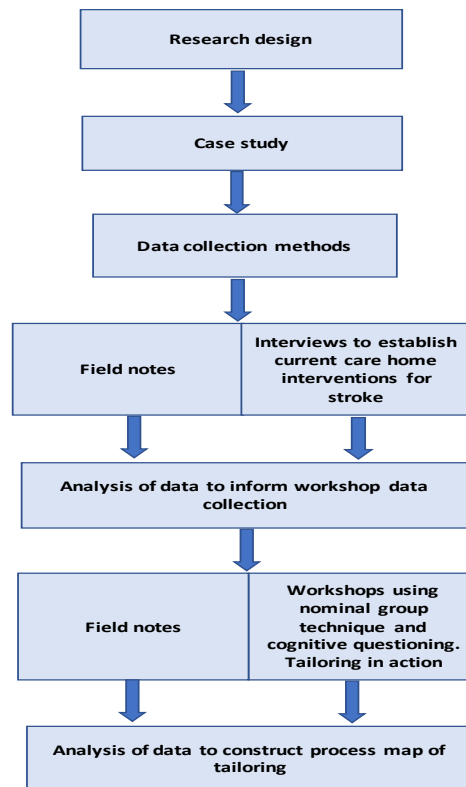


Figure 4.1: Research design

Stake (2006) explains that the how and why type questions deal with operational links needing to be traced over time in order to understand the factors influencing day to day practices. All too often these ‘how’ and ‘why’ questions are ambivalent and need clarification. In this case how do care home staff perceive current interventions for stroke and if they would engage in tailoring best practice recommendations to create a fit to their every day practices? The why questions relate to the factors influencing the implementation of evidence-based stroke interventions; such as why is the current evidence base for stroke not being implemented? Along with why would tailored recommendations be implemented, or not, in this context? A case study approach enabled examination of the factors that might influence tailoring and implementation of evidence-based practice in the care home setting.

A qualitative understanding of the case requires the researcher to engage with the care homes in order to experience the activity of tailoring as it occurs in context (Stake, 2006). The key for this study was to enable the care home staff to articulate their views in order for

the researcher to establish meaning from their narratives, rather than the researcher's observations and applied meanings.

4:3:2 Field notes

Field notes were recorded to keep a diary of the researcher's experience and to record valuable context information, which was wider than the focus of the data collection (Phillippi & Lauderdale, 2017). This helped to create a picture of the context and was valuable when unpacking factors in the discussion of findings. It is essential to the success of the case study that the researcher works hard to ensure all the evidence that emerges is reported fairly (Stake, 2006), field notes helped with this.

Filed notes were recorded following interview and workshop data collection and were, where possible recorded at the end of the day. They provided valuable contextual information. Field note excerpts are weaved into the discussion sections in chapters 5 and 6 to enrich and expand understanding of tailoring in action in the care home context.

4:3:3 Engagement with care homes

Effective tailoring of evidence-based guidelines requires an intimate knowledge of the clinical practice environment being studied, in this case the care home setting. Implementation literature indicates that where there is little or no collaboration or engagement with local staff outcomes seem to reflect poor implementation uptake. This was demonstrated in Tan et al.'s (2007) study, where a care pathway was introduced without engagement of local stakeholders and without any attempt to tailor implementation to the local context. Adherence to the stroke care pathway was found to be poor. Lack of collaboration with professionals who are expected to use proposed pathways or guidelines in their day-to-day practices, and the service users whose healthcare experience is at stake, is potentially problematic. Indeed, collaboration with professionals and key stakeholders is an emerging theme within the implementation literature. Effective collaborations can result in co-production as described by Realpe and Wallace (2010). Co-production aims to address the problem of compliance with evidence-based guidelines and pathways by attaining involvement and agreement from all stakeholders through shared problem definition and the design and implementation of local solutions (Realpe & Wallace, 2010). Engagement with care staff from this practice environment was a fundamental to this

study, as was the collaboration between care home managers and the researcher to coordinate data collection schedules, which created minimal disruption to both care home staff and the day to day running of the care home and facilitated shared ownership of the research venture.

It was essential as a researcher to be able to adapt and respond to the needs of the care home managers and staff. Initial researcher field notes, from introductory meetings with care home managers, reflected upon managers expressing their dislike of questionnaires, as they felt this was not the best way to engage with them (Researcher field notes: 14/01/2013). Furthermore, Sivell, Prout, Hopewell-Kelly, Baillie, Byrne, et al. (2015) suggest that there is potential for a power imbalance between the participants and the researcher and that the location of the data collection is a key factor. Convening the interviews and workshops in the care home setting helped to balance the power between care home staff and the researcher. In the care home environment, the care home staff could be themselves and more in control of the situation. As well as the location of the data collection, Anyan (2013) suggests that factors such as gender, socioeconomic status, ethnicity and professional background can impact upon the care staffs' willingness to share their views. Roberts (2007), therefore believes that researchers should develop genuine person-centred relationships with participants. The use of active listening skills and encouraging care home staff to share their views reflected the value the researcher put on their contribution, and also served to put the care home staff at ease, which enabled them to share their views and to build effective relationships throughout the duration of the study.

4:3:5 Recruitment within the care homes

In traditional scientific discovery knowledge generators are separate from the communities who use the theories and knowledge generated and the spread of knowledge is linear and sequential (Kitson & Bisby, 2008). In order to tailor best practice recommendations for the care home setting it was imperative to engage care home staff in the process.

Recruiting care homes proved to be a challenge. Difficulties engaging care homes in research is not a new concept. The Enabling Research in Care Homes (ENRICH) group provide guidance with regards to engaging care homes in research. They forewarn researchers about the transient nature of care home staffing, often as a consequence of the

low pay offered in this care sector (ENRICH, 2016). Laying the groundwork and creating and maintaining a climate of trust was therefore essential (Kayser-Jones, 2003). Furthermore, gaining trust was an important factor highlighted in the scoping review of the stroke implementation literature (Damschroder et al., 2009; Luker & Grimmer-Somers, 2009; Wright et al., 2007). Developing trust and engagement from care homes began with the managers, spending time meeting them and explaining what the project was about. Nonetheless, the rapid turnaround of staff meant that one care home pulled out as the manager had moved to another care home outside the area. The Royal College of Nursing (RCN, 2012) found that this often happens and that 17% of care home managers were in post for less than six months. These factors make engaging care homes in research studies problematic.

Twenty-eight letters were sent to care homes within the geographical recruitment catchment area inviting them to participate in this study. Inclusion criteria was that the care home accepted and cared for residents following a stroke. Initially, four care homes responded and expressed an interest. Following meetings with the care home managers, five expressed an interest to engage in the project. One home manager did not attend meetings and was not contactable. Another home withdrew after only a few weeks as the manager had moved to another home and the interim manager did not want to engage the home in the study. Recruiting care homes proved to be a challenge. Following communications with collaborative networks, a local health board practice development nurse helped with recruitment, and another two homes agreed to participate. Collingridge Moore, Froggatt, Sowerby, and Payne (2016) experienced similar recruitment problems and reported that care home managers were either, not contactable, too busy to discuss the study or were unsure of the benefits of taking part.

Four care homes engaged in the project, but only three care homes collaborated throughout the entire project. The views and insights from the care home staff generated the tailored recommendations and enabled close examination of the process of tailoring in action. The participating homes were given pseudonyms in order to maintain their anonymity; they were:

The Willows, a Nursing home registered to provide care for up to 32 persons to include ten residential dementia care and twenty two nursing places. The home manager is registered with the Care Council for Wales.

The Sycamores, registered to provide personal or nursing care to 94 older persons aged 65 years and over. With up to 88 nursing care places. Up to 48 younger adults with physical disabilities may also be accommodated.

The Beeches, is a registered nursing home for persons aged 65 years and over and can accommodate up to 33 persons, with 21 places being registered to provide nursing care (CSSIW, 2011).

The Oaks, registered to provide care for 77 people over the age of 65 years and four under the age of 65. It is divided into three units, providing nursing, personal care and dementia care.

4:3:6 Recruiting participants

In the first instance, the research project was introduced to the staff within the participating care homes using a rolling programme in each care home, in order to capture as many care home staff as possible, including night staff. This involved a 20-minute presentation by the researcher to explain what the project involved and the nature of participation required by individuals, with opportunity for questions. The 20-minute rotational sessions were attended by a maximum of fifteen and a minimum of two care home staff members throughout the months of January and February 2013 in the two larger participating care homes. The newly recruited care homes received their presentation at times convenient to the care homes throughout the months of March and April 2013. These care homes were smaller care homes and as a result between two and four staff attended the presentations, with an overall total of 16 care home staff attending.

The rolling programme of presentations to introduce the research venture to, and engage with staff was flexible in nature to ensure that all care home staff had the opportunity to attend. Evening sessions were delivered to enable attendance by night staff, and attendance was excellent. Attendees were mostly care assistants and Registered Nurses but some management, domestic and support staff were able to attend. Overall, from all four

participating care homes a grand total of approximately 120 care home staff attended the presentation-rolling programme.

On completion of the introductory sessions and following liaison with care home managers, they reported a great deal of interest from their staff, and indeed this was also evident during the presentations and following question and answer sessions. In addition, each care home identified a champion, whose role was to support the research venture within the care home, and form a link between the research team and the home.

Maintaining the momentum once care homes have agreed to engage in a research project also created many challenges, as did recruiting participants. The rolling programme of events in each care home enabled a wider engagement opportunity with all care home staff. These recruitment and awareness raising events, also served to break down barriers and enabled relationships to be built. Whilst the care homes were not known to me prior to the study, my district nursing background definitely helped to reduce potential barriers and expedited the building of trust and the collaboration required to carry out this project.

Meetings with managers and the introductory rolling programme of events proved invaluable and aided recruitment. It was also important to maintain and develop relationships throughout the data collection period. This was achieved by a professional, but warm approach towards care staff. The researcher drew upon skills as a nurse to effectively communicate and engage with care home staff. In addition, education and teaching skills were used to disseminate information about the project and to trigger the care home staffs' interest. All comments and questions were received with due regard, and conversations outside of the data collection window were energetic and empathetic. The staff who attended these events, often in their own time, seemed motivated to engage. This was very encouraging given that the RCN (2012) found that staffing levels and difficulties in recruiting and retaining staff in care homes often led to low morale.

4:4 Data collection

4:4:1 Interview data

Data was collected through individual face to face interviews with care home staff, which included care assistants, activities coordinators, Registered Nurses and managers.

Interviews formed the first phase of data collection and were designed to chart domains of

practice in relation to stroke care, along with examining how care home staff were supported, or otherwise, to acquire new knowledge and skills.

Everyone attending the introductory sessions were given information letters and invited to attend an interview. In order to engage the care homes in the research study and to facilitate their involvement, care home staff were asked to contact the care home manager if they were interested in taking part in the research and the subsequent interview. The care home managers had agreed to coordinate the interview schedules and to provide a suitable room for the interviews to take place. In total 48 interviews were completed with care assistants, senior carers, Registered Nurses and senior nurses.

Interviews were arranged around the normal running of the care home and participants were interviewed in a familiar environment with no out of pocket expenses required. Whilst it was hoped that a minimum of five care staff per home would engage in the research project and consent to be interviewed, in reality, the response from care home staff was overwhelming and in one home alone some 20 plus care assistants and Registered Nurses volunteered to be interviewed; a breakdown illustrating interview participants can be viewed in table, 4.1 below. This was far greater than expected but was one of the acceptable consequences of engaging and empowering care homes to participate in the data collection process. All staff who volunteered were invited to be interviewed, as this enabled valuable practice of interviewing technique and ensured data saturation.

Table 4.1: Interview participants

Care home	Participants role	Number of interview participants
Oaks	Registered Nurse	n=2
	Manager	n=1
	Senior carer	n=3
	Care Assistant	n=12
	Care Assistant/Domestic	n=1
Sycamores	Deputy Matron	n=1
	Registered Nurse	n=6
	Care Assistants	n=11
	Senior carer	n=3
	Activities Co-ordinator	n=1
Beeches & Willows	Registered Nurse	n=2
	Care Assistant	n=5

The semi-structured interview schedule was underpinned by the International Classification of Functioning (ICF) (impairments, activities and participation) (WHO, 2001) and Burton's (2000) description of the nursing role (care provision, care management and therapeutics). The original interview question schedule, please see appendix 4.1 was piloted in one of the participating homes, using a group interview with three care staff. Feedback with regards to the interview schedule was positive and the interview schedule was adapted following the pilot. The wording and structure of each question was discussed, and alterations were made. The adapted schedule following piloting can be seen in appendix 4.1.

The interview questions focused upon the participants role and their views of the impact of stroke on the resident's day to day functioning and their health and well-being. Questions were also asked about specialist roles and collaboration with services outside of the care home setting. A full interview schedule can be viewed in appendix 4.1.

Interviews took place in all four participating care homes between February and May 2013. The interviews were guided by a semi-structured interview schedule and took on average between 20 to 30 minutes to complete. Field notes were used to record observations and elements of conversations outside recorded interviews. Field notes will be referred to in Chapters 5 and 6 to facilitate analysis and discussion of the study findings.

4:4:2 Consensus workshop data collection

For the second and third phases of data collection three care homes engaged: *The Beeches*, *The Oaks*, and *The Sycamores*. Data collection workshops were arranged in collaboration with care home managers and took place in the care homes in order to create minimum disruption to care home routines and staffing levels. The care homes provided a suitable room for the workshops, where staff would be comfortable and away from the workplace. Consent was obtained from each participant attending the workshop and opportunity to ask questions was provided. The workshops were well attended and two of the care homes managed to facilitate the release of interested staff members for both workshops, which enabled staff to engage in the tailoring all recommendations tailored.

The consensus building workshops focused upon the process of tailoring stroke best practice recommendations for the care home context. Linking data from the interviews with

care home staff enhanced this data collection process as it informed workshop data collection and enabled the researcher to communicate with participants in a more therapeutic fashion. This in turn facilitated a greater depth of data collection, which helped to uncover the theoretical constructs of tailoring in action.

Using consensus building ensured that all workshop participants were able to engage in the tailoring of the stroke best practice recommendations. Moreover, this process highlighted how these recommendations would, or would not, fit with day to day care home practices. They were held in the individual care homes at times indicated by the care home manager as most suitable. Prior to the workshops the relevant intercollegiate stroke best practice recommendations were forwarded to the care homes, for staff to make themselves familiar with the recommendations to be tailored (Minas & Jorm, 2010). Cabana et al. (1999) found that a lack of awareness and lack of agreement with guidelines were key barriers to guideline adoption in practice. The main purpose of consensus methods was to define levels of agreement between care home staff in relation to the suitability of the stroke best practice recommendations for their care home setting. Fink, Kosecoff, Chassin, and Brook, (1984) suggests that consensus methods offer a structured meeting, which can provide an orderly process for obtaining qualitative information from target groups who are most closely associated with the care setting. Francke, Smit, DeVeer, and Mistiaen, (2008) found that easy to understand guidelines were more likely to be implemented in practice. Consensus building therefore, offers the opportunity to tailor best practice stroke recommendations for the care home context, which can create a better fit with care home cultures and capitalise upon the accumulated experiences of care home staff (Minas & Jorm, 2010).

The consensus approach used adapted the nominal group technique. The nominal group technique was developed by Delbecq and Van de Ven (1971). They suggest that this type of consensus building enables individuals with differing views to engage in a discussion for generation of ideas; for example the development of clinical guidelines. Nominal group technique combines quantitative and qualitative data collection in a group setting, where idea generation and problem solving are combined in a structured process (Gallagher, Hares, Spencer, Bradshaw, & Webb, 1993). This process is designed to enhance group

member participation in order to make the best use of available information in relation to the collective wisdom of the participants (Murphy, Black, Lamping, McKee, Sanderson, et al., 1998).

Heine, Lehman, Peng, and Greenholtz. (2002) suggest that being part of a group means that the presence of others may lead group members to evaluate themselves in relation to how other members of the group may view their input. This in turn may influence the data collected. In order to avoid this, the first step in the nominal group process is to ask all participants to list individually and without discussion their own ideas on the topic for investigation (Fink et al., 1984). This method was used in the first workshop, but proved to be unproductive with care home staff, who seemed uncomfortable with this remit and seemed reluctant to write anything down, and embarrassed by the silence, as this extract from field notes indicates:

‘Did not seem to want to write comments. Care staff appeared uncomfortable with working alone to score recommendations, very embarrassed, looking at each other, reluctant to score. Were more engaged when discussing as a group – may need to re-think this?’ (Researcher field notes: 02/12/2013).

It was essential that the researcher was reflexive and flexible and can adapt to the situation encountered. Bryman (2006) suggests that the researcher needs to adopt a flexible approach to data collection in order to ensure participants feel able to share their experiences. Moreover, an understanding of the participants and context is essential. Many staff working in care homes are female workers who work part-time or flexibly; they are often paid very close to the National Minimum Wage (ENRICH, 2016). Staff turnover can affect the stability of the working environment (ENRICH, 2016). Luff et al. (2011) suggest that researchers should not assume that care home practitioners automatically have research appropriate skills. Furthermore, Luff et al. (2011) believe that research in care homes requires a balanced and compassionate approach, where inter-personal and emotional skills will be as important as an understanding of research methods.

A change to a more inclusive group discussion was adopted, which used the facilitation of brain storming (Michie, Johnston, Abraham, Lawton, Parker, et al., 2005) to establish the workshop participant’s views on the following:

- a. Do residents with stroke have (**recommendation domain, for example bladder and bowel management**) goals?
- b. Who assesses their (**recommendation domain**) goals, when and how?
- c. What training do they have?
- d. What types of targets are set to achieve (**recommendation domain**) goals?

Care home staff were far more receptive with this approach and readily shared their views. The data gathered from these initial discussions is discussed in Chapter 6, (6:2).

In order to unpack the care home staff views around the best practice recommendations, workshops, which adopted a cognitive interview type format, were used to gain an insight into the care home staffs thinking when completing their Likert scoring (Drennan, 2013), and to explore care home staffs views around each recommendation's fit with the care home context. Cognitive interviewing can facilitate an evaluation of the quality of responses to survey questions (Beatty 2004:45), which in this case involved scoring specific stroke best practice recommendations. In addition, cognitive interviewing can highlight misunderstandings around health literacy (Drennan, 2013). This process of questioning enabled the researcher to unpick the care home staff responses, and to adopt an improvised approach to further determine the care home staff views around the specific recommendation statement. Enabling the care home staff to express their thoughts and views in a proactively interviewer guided interaction created a more intensive workshop interview, which allowed free flowing discussion (Beatty & Willis, 2007). Although the nominal group technique alone would not have enabled rich data to emerge, it was nonetheless an ideal vehicle to generate awareness and debate about the stroke best practice recommendations. This debate was further unpacked using cognitive questioning to enable the researcher to understand the impact upon day to day working in this context and the impact tailoring best practice guidelines might have. The use of nominal group technique and cognitive questioning therefore proved to be a successful method to gain consensus and to gather the care home staffs views of each recommendation and their perceived relevance to their day to day practices. Issues covered within the group discussions are illustrated in table 4.2 below.

The use of cognitive interview discussions to establish what influences staff choices when identifying elements of a national guideline for tailoring to the local context, can safeguard the integrity of the tailored guideline to the particular context. In addition, cognitive discussions can highlight misunderstandings and language issues with the questions and or guideline recommendations in the consensus approach which can be modified to enhance the reliability of the data acquired through consensus methods. This approach was

Table 4.2: Cognitive questions as applied to the care home context

Feasibility – fit with care home context:	<ul style="list-style-type: none"> • The particular recommendation was appropriate for care home residents with stroke? • Did the recommendation relate to their current practice, and if so in what way? • Do they believe implementing the recommendation would enhance care for residents with stroke? • Who did they believe should carry out the recommendations with their residents?
Consequences – impact upon care home culture and day to day running of home:	<ul style="list-style-type: none"> • What would these recommendations mean to: <ul style="list-style-type: none"> ○ Them? ○ Their team? ○ Them day to day? ○ Residents? ○ Resident's family?
Fidelity:	<ul style="list-style-type: none"> • Are the recommendations written in a clear way that all care home staff can understand? • Would you like to alter any of the language used? • What would these personal activities of daily living recommendations look like in day to day practice in your care home?
Implementation – barriers and enablers:	<ul style="list-style-type: none"> • What if anything would you need to adapt or change? • What things might stop you doing (recommendation) with care with residents? • What things might help you to do (recommendation) with care with residents? • How do you think staff within your care home would react to these recommendations?

particularly useful in this context and enabled all participants to share their views. Likewise, redistributing the draft tailored guideline to enable second consensus further enabled collaboration and consolidation of the tailored guideline to the local context. Furthermore, insight gained and themes from the interview data analysis were used to further develop and enhance the workshop data, by providing real life insights into day to day care home interventions for residents with stroke. Indeed, data analysis was happening throughout the whole process of informal and formal engagement with care home staff. This in many ways reflected the researchers nursing background, where problem solving on the hoof is embedded into every day actions and interactions. This in turn led to a very reflexive approach towards the researcher's experience of engaging with care homes and examining their views about the stroke best practice recommendations, and their engagement in the

tailoring process. Once again reflecting previously developed nursing skills, where the Registered Nurse assesses and adapts to the client's needs and personality traits in order to enable meaning full interactions.

Specific stroke best practice recommendations were scored using a Likert scale by care home staff to identify the relevance of each recommendation to the care home context. An excerpt of this can be seen below in figure 4.2 below. This however, only enables a snap shot of the workshop process, as this does not demonstrate the wealth of data recorded during the cognitive questioning used to explore the care home staffs understanding of each recommendation and the relevance to day to day practice within the care home. This data emerges from the workshop transcripts of the recorded discussions and is explored in depth in chapter 6.

	Stroke best practice recommendation 6.24 Bowel and bladder impairment	Rating 1 to 9 with 1 being least relevant to residents living with stroke in your care home and 9 being most relevant. Please indicate your choice by circling the relevant number									The Beeches: Individual care home consensus result scores ■ score before cognitive interview ■ score following cognitive interview									Total relevance score	
i.	A - All wards and stroke units should have established assessment and management protocols for both urinary and faecal incontinence and for constipation in stroke patients.	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8	9 n=3	27 = 100%
ii.	B - Patients with stroke who have continued loss of bladder control 2 weeks after diagnosis should be reassessed to identify the cause of incontinence, and have an ongoing treatment plan involving both patients and carers. The patient should: <ul style="list-style-type: none">Have any identified causes of incontinence treatedHave an active plan of management documentedBe offered simple treatments such as bladder retraining, pelvic floor exercises and external equipment firstOnly be discharged with continuing incontinence after the carer (family member) or patient has been fully trained in its management and adequate arrangements for a continuing supply of continence aids and services are confirmed and in place.	1	2	3	4	5	6	7	8	9		1	2	3	4	5 ■ n=1	6	7	8	9 ■ n=2 ■ n=3	■ 23 = 85% ■ 27 = 100%
iii.	C - All stroke patients with a persistent loss of control over their bowels should: <ul style="list-style-type: none">Be assessed for other causes of incontinence, which should be treated if identifiedHave a documented, active plan of managementBe referred for specialist treatments if the patient is able to participate in treatmentsOnly be discharged with continuing incontinence after the carer (family member) or patient has been fully trained in its management and adequate arrangements for a continuing supply of continence aids and services are confirmed and in place.	1	2	3	4	5	6	7	8	9		1 n=1	2	3	4	5	6	7	8	9 n=2	23 = 85%
iv.	D - Stroke patients with troublesome constipation should: <ul style="list-style-type: none">Have a prescribed drug review to minimise use of constipating drugsBe given advice on diet, fluid intake and exerciseBe offered oral laxativesBe offered rectal laxatives only if severe problems remain	1	2	3	4	5	6	7	8	9		1 ■ n=1	2	3	4	5	6	7	8	9 ■ n=2 ■ n=3	■ 23 = 85% ■ 27 = 100%

Figure 4.2: Likert scoring of recommendations before and after cognitive questioning.

4:4:3 Data analysis: interviews

Forty-eight interviews were completed with care assistants, senior care assistants, Registered Nurses and senior nurses. Interviews took place in all four participating care homes throughout February, March, April and May 2013. Field notes were used to record

observations and elements of conversations outside the recorded interviews. Field notes highlighted some interesting factors relating to knowledge acquisition and use in relation to practice in general and especially in relation to the care of care home residents with stroke. Excerpts from field notes were identified within the data analysis and selected excerpts are used to enhance the discussion in chapter 6.

In order to prepare for the consensus workshops, where stroke best practice recommendations would be tailored, the interview data analysis sought to identify potential influencing factors upon the process of tailoring in this context. The interview data provided an insight into the participants role within the care home and their views of the impact of stroke on the resident's day to day functioning and their health and well-being. Data also enabled analysis of the influences of services and service providers outside of the care home setting. Analysis therefore, concentrated upon some key elements within phases 1-3 of the Knowledge To Action process (KTA) from Graham et al. (2006). Data therefore, sought to identify change agents (phase 1); factors which might influence adapting the stroke best practice recommendations (phase 2), and the identification of barriers and enablers to using the tailored recommendations in day to day practice within the care home (phase 3).

Thematic analysis was used to analyse the data obtained from the interviews and workshops. Thematic analysis offers flexible, theoretical freedom, which can provide a rich and detailed account of the data (Braun & Clarke, 2006, p:78). The thematical analysis approach taken within this study to unpack the interview data followed Braun and Clarke's (2006) phases of thematic analysis. The process used the steps described in table 4.3, which was adapted from Braun and Clarke's (2006) framework.

Themes were identified in terms of their relevance to answer the research question. Charmaz (2014) suggests that what the researcher sees in the data relies upon prior perspectives (p;132); these perspectives were informed by the literature review and the concept analysis. This did not however, exclude themes, which emerged using an inductive approach. The verbatim transcripts were reviewed line by line in order to identify patterns of meaning and issues of potential interest (Braun & Clarke, 2006), to enable the identification of emerging codes in order to interpret what was happening in terms of stroke

Table 4.3: Phases of Thematic Analysis, adapted from Braun and Clarke (2006, p:95)

Phase	Description of the process
1. Familiarising yourself with your data:	The interviews were transcribed verbatim. The researcher read and re-read the data, noting down initial ideas in the margins.
2. Generating initial codes:	The transcripts were then coded to identify interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes:	The potential codes were collated and grouped to start to identify potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes:	The themes were then checked to see if they worked in relation to the coded extracts and the entire data set generating a thematic 'map' of the analysis, (figure: 4.2).
5. Defining and naming themes:	Theoretical coding (Saldana, 2009) was used to systematically link subcategories to a core code in order to refine the specifics of each theme, generating clear definitions and names for each theme (figure: 4.3).
6. Presenting findings in context:	The findings were then presented within the thesis using a selection of vivid, compelling extract examples. Interview findings are presented and analysed in chapter 5, and workshop findings are presented and analysed in chapter 6.

interventions (interview data) and tailoring stroke best practice recommendations for this context (workshop data). Identifying preliminary codes enables a deeper level of understanding, whilst presenting opportunities for rapid analytical development (Charmaz, 2014). Coding enabled the organisation of data into meaningful groups (Tuckett, 2005). Codes enabled the construction of themes, which were broader and were where the interpretative analysis of the data occurred (Braun & Clarke, 2006). Saldana (2009) explains that theoretical coding integrates and synthesises the categories derived from coding and analysis to create a theory (p.164). The resulting core codes therefore, consisted of all the products of analysis condensed into a few words that framed the key theoretical building blocks within this study (Strauss & Corbin, 1998: p.140).

Initially a thematic map (this can be viewed on page , figure 5.) enabled the organisation of data into meaningful groups (Tuckett, 2005), and the construction of themes, which were broader and were where the interpretative analysis of the data occurred (Braun & Clarke, 2006). In the final thematic map data analysis focused upon an approach put forward by Braun and Clarke (2006), which sought, in the first instance, to reflect the reality of stroke interventions in the care home context in order to inform the consequent reality of tailoring stroke best practice recommendations in this context.

4:4:4 Data analysis: workshops

Findings from the care home interviews helped with the design of the consensus approach used in the workshops, to tailor the stroke best practice recommendations to the local context. The need for a greater awareness of the intercollegiate stroke recommendations was highlighted within the interview data and reinforced the value of consensus workshops, which were designed to unpick specific recommendations. The interview findings also highlighted a need to provide information prior to the workshops in order for the participants to familiarise themselves with the recommendations. The recommendations to be tailored were therefore e-mailed to the care home managers a week prior to each workshop event. For the second and third phases of data collection three care homes engaged. The three care homes which participated in this phase were: The Beeches, The Oaks and The Sycamores.

Data analysis was a central evolving, iterative process within this research project, which informed design for subsequent data collection and analysis. Observations and field notes helped to focus the research journey, with particular emphasis upon the researcher's relationship and interactions with care home staff when tailoring recommendations.

Excerpts from field notes are weaved through the findings and discussion sections in chapters 6 and 7. Initially recorded transcripts were listened to in order for the researcher to become familiar with the data. Recordings were then transcribed verbatim. This was a lengthy process, which often involved revisiting the recordings to check meaning and accuracy of the written record.

An initial coding framework was designed (Appendix 4:2), which was informed by care home interviews and concept analysis of tailoring (Richie & Spencer, 1994). The key focus of the framework was unpacking factors which influenced tailoring in the care home setting. The framework therefore, sought to capture information around the impact of care home culture and the day to day running of the home upon tailoring stroke recommendations for this context. Also, how care staff viewed a fit or focus within the care home for the tailored recommendations, and the impact of resources upon tailoring. In addition, the concept analysis of tailoring identified collaboration and key stakeholders as a key influence upon evidence use and implementation (Wright et al., 2007), these factors also emerged as

influential during interview data analysis, and as a result the impact of these factors upon tailoring was examined. Inevitably, any implementation research focused research will also draw out potential barriers and enablers. Conversations around barriers and enablers creates an open forum where deeper issues can emerge, which help the researcher form a more comprehensive insight into the factors that influence day to day care of residents with stroke.

Inductive data analysis was therefore essential to examine themes and to draw out new themes. Indeed, several new themes emerged, such as 'Values', 'History', 'risk' and 'responsibility'. These initial themes were identified as factors influencing tailoring and stroke interventions in the care home context are illustrated in data network at influences the process of tailoring in the care home setting? Constructing meaning from care home staff narratives. Eliciting the moral values care home staff express towards tailoring best practice recommendations for residents with stroke. An illustration of the data analysis journey can be seen below in figure 4.3.

Initially verbatim transcripts were indexed to identify referents to thematic framework. Referents were recorded in the margins or highlighted within the text and the appropriate framework referent number identified. Construction of the framework draws upon information gained from interview data analysis and concept analysis of tailoring (Richie &

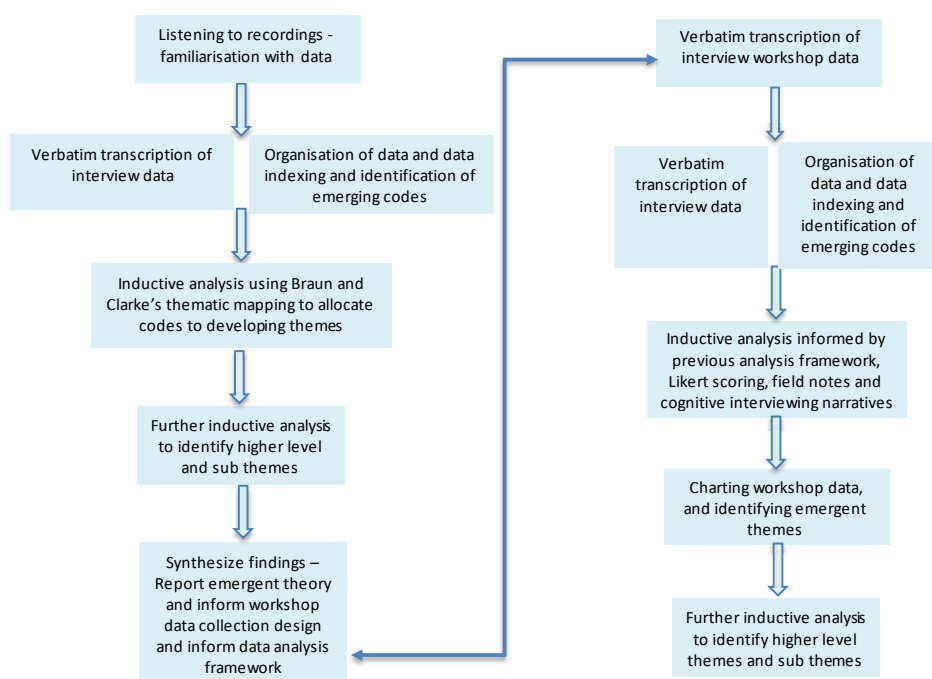


Figure 4.3: Data analysis journey

Spencer, 1994). These factors enabled the identification of tailoring characteristics in the care home setting (framework version 1, appendix 4:2). Once indexing of the transcripts was complete data from each care home was charted. This enabled ordering and grouping of the individual cases, which helped identify patterns of experience and or behaviour (Richie & Spencer, 1994). Once the framework was populated with data from the workshops more inductive analytical themes emerged (framework analysis version 4:3). These refinements represent the diversity of experience and attitudes of care home staff to tailoring the best practice recommendations. Richie and Spencer (1994) explain that refining a thematic framework involves logical and intuitive thinking, which involves making judgments about meaning and the relevance and importance of issues.

Verbatim transcripts were reviewed and relevant data was mapped to the coding framework – when all the data had been sifted and charted according to core themes, the researcher pulled together key characteristics of the data in order to map and interpret the data set as a whole (Richie & Spencer, 1994). Here the analyst defined concepts, mapped the range and nature of phenomena, created typologies, found associations and developed

strategies. During the charting of data memos and network maps were made of emerging ideas, these included notions around: permissions, values, complex co-morbidities', stroke specific recommendations, management influences on coproduction. This process enabled a redesign of the framework characteristics and facilitated the mapping range and nature of these phenomena.

A review of the charts and research notes, enabled comparisons and contrasts around the perceptions, accounts and experiences of care home staff to emerge. These patterns and connections help to create explanations within the data. Discussions with the researchers supervisor helped to ensure reliability and to avoid missing valuable meanings within the data. Eventually key overarching themes emerged, which are illustrated and explored throughout chapter 6.

4:4:5 Construct validity

Stroke best practice guidelines not currently being implemented in care homes, as a result residents do not receive evidenced based stroke interventions on a day to day basis. Little evidence has been gathered around the factors that influence practice change in care home setting. This study aims to use tailoring to adapt stroke best practice recommendations whilst examining the contextual factors that interplay to affect the use (or non-use) of the recommendations in day to day practices. Establishing operational measure for the concepts being studied meant designing data collection methods that engaged with and sought the views of the care home staff influencing the delivery of stroke interventions was essential. The data collection methods in this study included, interviews, consensus building workshops, and field notes. Data analysis adopts an interpretive stance in order to understand care staffs' perspectives in the context and circumstances of their working

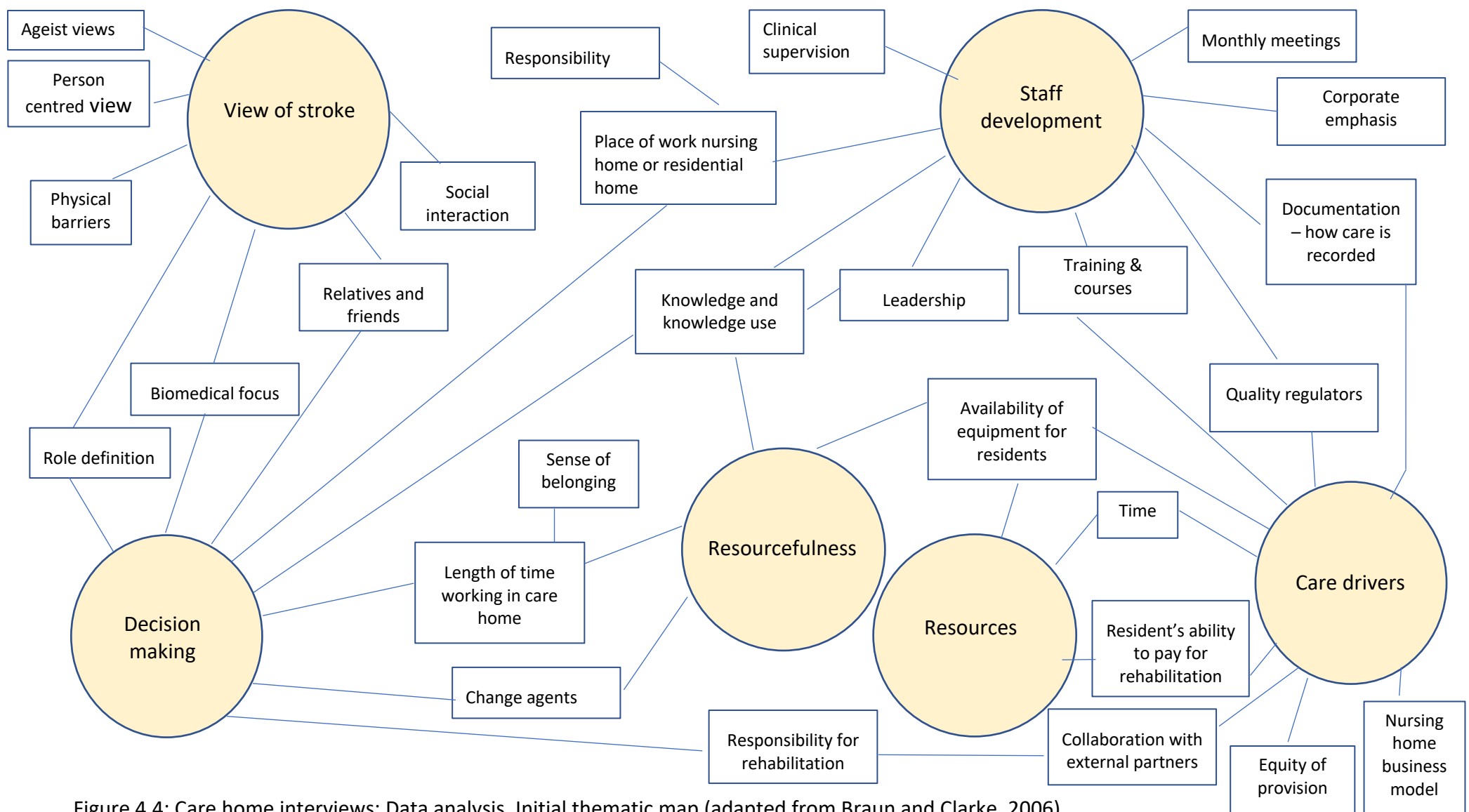


Figure 4.4: Care home interviews: Data analysis, Initial thematic map (adapted from Braun and Clarke, 2006).

environment. In addition, the researcher adopted a real time and reflexive approach to field notes in order to capture observations, thoughts and feelings with regards to data collecting events and interactions with care home staff.

4:4:6 Internal validity

Coproduction and consensus was used to tailor stroke best practice recommendations. Engaging care home staff in this study raised their awareness and enabled them to develop recommendations for stroke that were relevant to their particular care context; this is discussed in more depth in chapter 5.

4:4:7 External validity

The need for external validity has previously been viewed as a major barrier in doing case studies (Riege, 2003). Given that case studies rely on analytical generalization, the investigation sought to identify the components that were significant in this practice context and the care home staff behaviours that produced them. The aim was to generalise a particular set of results to a broader theory and not to replication of populations involved in the study. The theories generated about implementation of the stroke best practice guideline should be generalizable. Using more than one care home setting will enhance external validity and enrich the emerging theories.

4:4:8 Reliability

It is essential to demonstrate that the operations of a study, such as the data collection, can be repeated with the same results. The researcher ensured that all documentation was kept sequentially, and processes were clear to enable replication by other researchers, or at least to enhance the reliability of the study in relation to the constructs related to qualitative research quality. Data collection and analysis procedures are clearly mapped out and can be replicated. Researcher reflections identify and explain the benefit of adaptations to nominal group technique and the use of cognitive interviews to expand meaning and understanding of the research participants views in relation to the specific recommendations used within the workshops. The steps taken in this research were robust and transferable. Study methods have been clearly thought out and explained in order to

allow other researchers to examine the strengths and weakness of the approaches used and the resulting theory.

4:5 Ethical considerations and permissions

Ethics are rooted in a philosophy of morality and humanity, where decision making impacts upon the dignity and identity of individuals. The discipline of ethics focuses upon standards and conduct, and for researchers the emphasis is upon ensuring methods and procedures are designed to respect and ensure the safety of participants (Fouka & Mantzourou, 2011). To ensure the safety and anonymity of research participants, University ethics approval was sought; and was granted on the 26th September 2012 (please see approval letter in appendix 4:3). Data collection took place in the participating care homes, with care home staff. This was a position of privilege and was developed as such, schedules with the care home managers to suit the care home were always agreed in advance and reporting in on arrival at the care home was always maintained. Memorandums were designed between the researcher's university and care homes; these lay out strategies for reporting any concerns. The potential for disclosure and observation of poor practice was considered and the memorandum ensured there were robust reporting mechanisms to raise concerns (please see appendix 4:4). An individual memorandum of understanding for each care home was signed by the care home manager and the head of the researcher's academic school. The memorandum of understanding was therefore agreed by all parties. This ensured respect and provided clear mechanisms for escalating concerns.

As a registrant with the Nursing and Midwifery Council (NMC) it was imperative that when engaging in any research activity that has the potential to illicit information about practice and factors that impact upon the lives of service users, such as care home residents, that the researcher adheres to the NMC Code and ensures the safety of all involved. Within this study adherence to the NMC Code ensured that confidentiality was maintained, and that via the application of an agreed memorandum between each care home and the researcher any areas of concern could be addressed. The memorandum did prove effective during data collection when an interviewee mentioned feeling that the care home did not have the equipment required to meet the needs of one resident and that the interviewee felt that the dignity of the resident was put at risk. These concerns were raised with the care home

manager who assured the researcher that the equipment was available within the care home, but following this escalation the manager met with all of the care home staff to ensure that all staff were aware of the equipment and had training with regards to its appropriate use.

The memorandum of understanding was therefore effective, as the researcher used this tool to escalate this concern, which enabled the care home manager and staff to work together to address this training need. Escalating a concern during the first data collection intervention had the potential to alienate the care home manager, but the researcher had a professional accountability to safeguard the public and raised the matter in a timely and sensitive manner. As a result, the care home manager and researcher maintained a professional relationship and a mutual respect, which resulted in the care home remaining in the study until its conclusion.

University ethics committee approved letters (Appendix 4:5) inviting care home staff to participate, were distributed within each care home. These letters explained about the project and data collection, and were handed out within the care home during the introductory rolling programme. Prior to being interviewed, and immediately before each interview, candidates were given an interview information sheet (appendix 4:6). Before commencing data collection, the researcher enquired as to whether the candidate had read the interview information letter and obtained written consent for the interview or workshop (appendix 4:7). Participants were able to withdraw at any stage.

All data collection activities were coordinated in partnership with care home managers and took place in the care homes in order to create minimum disruption to care home routines and staffing levels. The care homes provided a suitable room for the interviews and workshops, where staff would be comfortable and away from the workplace. Despite offering the option of telephone interview, all care home staff preferred to be interviewed face to face. Consent was obtained from each participant attending and interview or workshop and the opportunity to ask questions was always provided.

4:5:1 Data management

Interview data and workshops were audio recorded, and transcribed verbatim. All data was stored on a secure, password protected University computer to which the researcher had sole access.

Chapter 5

Findings: care home interviews

5:1 First phase data analysis: Examining existing care home practices

This chapter will present the analysis of the interview data relating to current stroke care practices in the care home context and will use a selection of compelling extract examples to explain the theoretical themes. Data was analysed, as discussed in chapter 4, to examine the existing care home context in relation to interventions for residents with stroke, and to explore how staff obtain information about stroke. Data from interviews was used to chart domains of practice in relation to stroke in the participating care homes. Initial data analysis highlighted the thematic map in Chapter 4, figure 4.4, which was further examined to identify higher level themes (Figure 5.1). Two overarching themes emerged, which in turn had an impact upon ‘responsibility for stroke rehabilitation’ in this context.

The first theme to be discussed, ‘decision making’, is illustrated below:

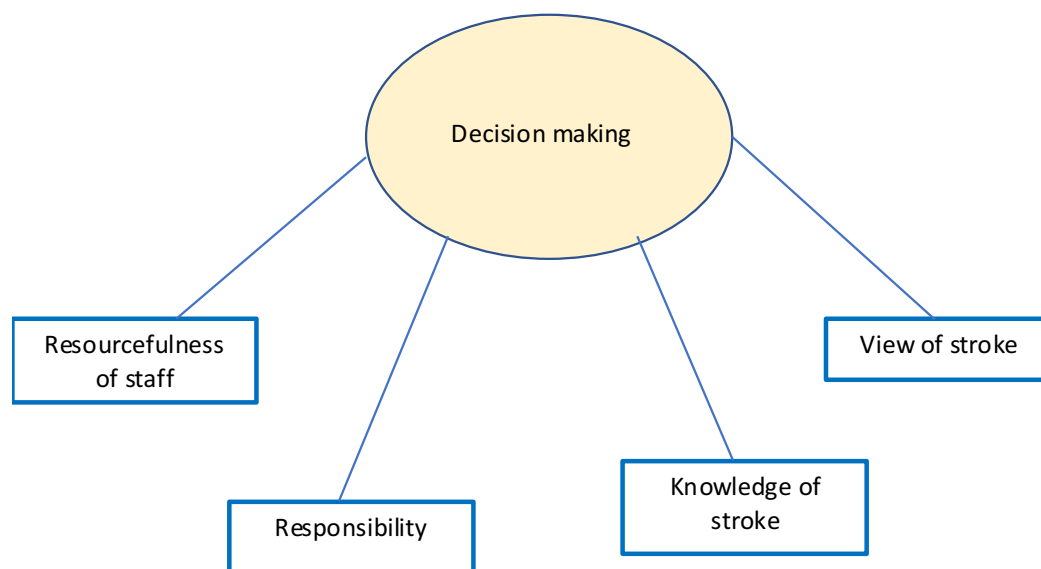


Figure 5.2: Decision making

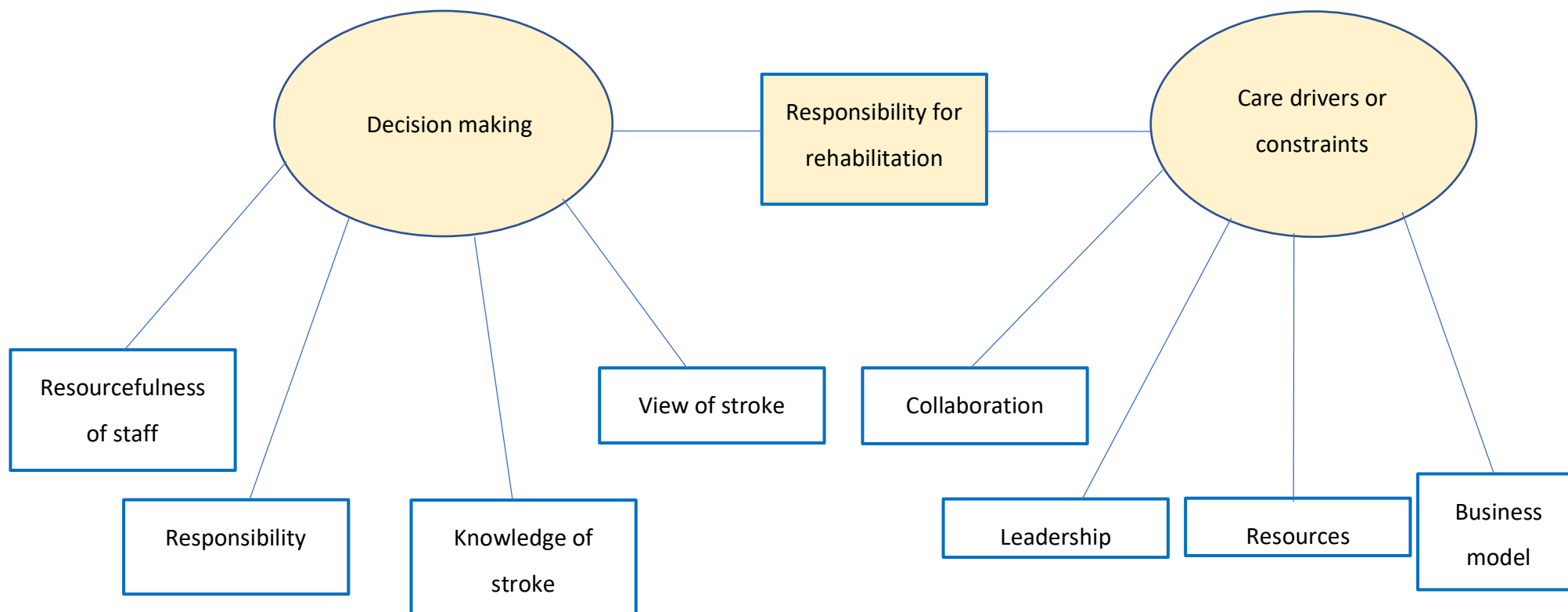


Figure 5.1: Data analysis, final thematic map: key factors influencing stroke interventions in the care home setting (adapted from Braun and Clarke, 2006)

5:1:1 Decision making

The complexity of decision making was key to the resident's stroke journey and the types of interventions they received within the care home. Decision making in the care homes was influenced by many factors. These factors were broken down into the subthemes of: resourcefulness of staff, responsibility, knowledge of stroke, and how care staff viewed stroke.

5:1:2 Resourcefulness of staff

Care home staff often demonstrated resourcefulness, in that they developed work arounds in order to deliver interventions for residents with stroke. This was often driven by a desire to build good relationships with residents and to promote social interactions. In addition, there was also an emphasis on the need to enable the resident to be as independent as possible. Care staff interviewed, whilst acknowledging they were often very busy emphasized the need to spend time with residents who had needs related to stroke. One Registered Nurse interviewee explained:

“Just giving them the time to express their feelings and not for them to feel rushed, I also say to the care staff make sure you don't rush them take time to express because a lot of the time they have lost communication and it is and you can see them and you say no give them chance, let them express themselves, because if we don't from the beginning that is another thing in time they won't progress they are just the person with a stroke and they will go into themselves or they won't talk to that person, because they don't understand them but is always giving them time” (14th February 2013, interviewee 2).

Care home staff showed initiative and resilience when describing how they overcome the perceived lack of resources for residents with stroke. One Registered Nurse explained how promoting resident's independence with eating was achieved:

“Unless they get referrals to an OT but that has barriers in its self because they're in a care home, they're not apparently ...what's the word...they're not entitled, apparently not entitled so the same equipment, they'd have to fund it themselves. Where as if they were in their own home, it would be with the NHS. But here they have to be self-funded so a lot of them

can't afford to do that. We have some from previous residents that we use but aren't perhaps always ideal for that particular person, but we do have a few things that we try" (28th February 2013, interviewee 1).

This statement also indicates the frustration that appeared to be felt by care home staff at the perceived inequitable support for care home residents. It highlights the motivation of staff to adapt and facilitate resident's needs by whatever means possible to overcome the restrictions of limited resources. This statement does however raise questions about comparative needs, such as why are care home residents not treated in the same way as other health service users, just because of their place of residence? It also raises questions about reasonable responsibility of the organisation to supply equipment for residents who have the residual effects of stroke.

The resourcefulness of staff and their desire to respond to the needs of residents with stroke was an important factor , as was their ability to connect with the residents and their families. As one nurse manager explained:

"We encourage the staff to be close to the residents not to just look at it as a job, feeding and dressing, washing, if you've got time go and sit with them, it's never 'oh you haven't got time to sit around go and tidy some cupboards' you know" (27th February 2013, interviewee 3).

In addition, staff interviewed suggested that relatives and friends of residents were encouraged to get involved in their care and to help staff understand the residents' particular like and dislikes. The friends and relative unique understanding of the resident seemed to be valued by care home staff, and input was encouraged, as in the example one interviewee described:

"A friend came in yesterday to see this lady and she got her a book stand that goes on the bed and she can actually just about flick the pages herself, that was a good idea. I didn't think of that one but she did because she knows that person thoroughly enjoys magazines and books and she's also brought in a Kindle" (27th February 2013, interviewee 3).

There is a possibility however, that work arounds can mask the organisational responsibilities with regards to supplying the necessary equipment to meet the needs of residents who have stroke care needs.

5:1:3 Responsibility

Staff roles within the nursing and residential care units seem to influence the day to day organization and care delivery. Responsibility was an interesting concept, which in the care home context was quite complex. For example, Registered Nurses interviewed highlighted giving out medications and collaborating with other agencies as a key part of their role responsibilities; the following narrative being a typical example:

“I’m a nurse, I work on days. It involves giving out the medications, being responsible for ... the carers on my shift” (13th February 2013, interviewee2).

Registered Nurses interviewed highlighted giving out medications as a key part of their role. This reflects a study by Burton (2000) who found that the nurse’s role in stroke was often concerned with tasks associated with the patient’s journey through the health care system, which often diverted them from a focus upon individualised stroke rehabilitation needs.

Care staff often felt that they were the team members who got to know the resident and were able to talk to them about their concerns or specific needs. As one care assistant said:

“I always say to them ‘If you need somebody to talk to you can always talk to me’, because if they trust you they’re going to talk to you more than ... say, one of the nurses, if they don’t know the nurse very well, they’d always talk to the person that they trusted if they needed to” (13th February 2013, interviewee1: carer).

Some of the Registered Nurses interviewed also indicated that it is often the care assistant who forged therapeutic relationships with the residents. The Registered Nurses interviewed seem to value this and were keen to highlight the collaborative working relationships between Registered Nurses and care assistants in the care home setting. One interviewee summed this up with the following statement:

“Carers input is just as valued as the nurses and often more so, they notice more. They notice half the things, I mean with the terminal care they’re the ones who come and say ‘so-and-so’s not looking at all well,’ they notice it before we do, even the care support the cleaning staff,

they come and alert you to problems, it's all valuable. It's not 'oh you don't know anything, you're not a nurse,' we don't run like that" (27th Feb 2013 interviewee 3: nurse).

Other care assistants seemed to indicate their role was to carry out the tasks allocated by the Registered Nurses. One carer stated, "*we do as we are told to do*" (14th March 2013, interviewee 2). Indeed, part of the Registered Nurse's role responsibility was to monitor the care assistant role. As this Registered Nurse explains:

"Making sure that the carers feel that they know what their role is and they're meeting their roles as carers and if they're struggling in any way then they would come to us. It's quite good here for that, for support" (7th March 2013, interviewee 4: nurse).

Overall, carers working on the nursing units, that is a unit that is registered to provide nursing care, seemed to rely upon instruction and information from the nurses to complete the required tasks involved in delivering day to day care for residents; this was also highlighted in the responses received pertaining to how carers accessed knowledge and information about stroke.

This response potentially raises questions around the resident's voice and person-centred care, as care assistants have the most contact with the resident, yet their insight into the individual care needs for stroke interventions seem to be driven by the Registered Nurses' instructions. If the Registered Nurse does not engage with the resident on a day to day basis and at a personal level, it is unclear whether or how they can ascertain the resident's views and needs in order to plan and deliver person centred care using the evidence base for stroke. There is potential for the resident's voice to be diluted or lost within the Registered Nurse, care assistant hierarchies; this is worthy of further investigation but goes beyond the scope of this study.

Care assistants working in the residential units seemed more autonomous and to have more of a decision-making role; they used their knowledge and experience to organize and deliver care. As a result, residential unit care assistants were more likely to seek

information about stroke or any other care issues for themselves. One interviewee from the residential unit explained that they collaborated with:

“Doctors, physiotherapists, the team. Sometimes we go to ALAC (Artificial Limb and Appliances Centre) in the hospital, you know, for the electric wheelchairs or things like that. We work a lot with the hospital as well, and ... like District Nurses, things like that, yeah” (21st Feb 2013, interviewee 3).

Care assistants working on residential units, where resident receive social care interventions and any health care is delivered by outside services, seemed to be aware of and collaborated with several outside agencies. Others expressed, and valued collaboration with Speech and Language Therapist (SALT), General Practitioner (GP), Occupational Therapist (OT) physio. Whilst, care assistants working on the nursing unit seemed less aware of external organisations and other agencies and relied upon the qualified nurse for any collaborative interventions, as one carer put it:

“We go straight to the nurses” (29th January 2013, pilot interview)

Another carer, during interview questioning made the following responses:

*INT: And do you collaborate with any other professional groups to deliver Stroke care for these residents?

**RES: I don't know, because we get all the information off the nurses.

*INT: Okay. So you don't personally engage ...

**RES: No. (13th Feb 2013, interviewee 1).

*(*INT = researcher interviewer; **RES = respondent)*

5:1:4 Knowledge of stroke

When asked if they follow any specific Stroke care guidelines were followed interviewees suggested that the care delivered was quite generalized:

“No, we just follow the ... Roper-Logan-Tierney model ...” (13th Feb 2013 interviewee 2).

None of the care home staff interviewed mentioned the national intercollegiate stroke guidelines when asked about stroke. Thus, indicating that they were not knowingly using the national stroke guidelines in their day to day practices.

In the nursing units the Registered Nurses seemed to hold the key to how knowledge was used as they allocated care tasks to the care assistants. The care assistants working on the nursing units often seemed happy to follow instructions and did not seem to feel the need to seek out knowledge for themselves. As one care assistant interviewed put it:

“Between physio and the nursing staff and then we get told if there is anything to do with regard to repositioning or anything like that”. (6th February 2013, interviewee 6).

When asked how they found information about stroke answers ranged from ‘asking nurses’ to the ‘Code of Conduct’. As one Registered Nurse explained:

“Erm, obviously Code of Conduct, legislation, current legislation that comes out, keeping abreast with new, NICE guidelines, can’t think now off the top of my head” (7th March 2013, interviewee 4).

Most interviewees stated that they accessed the internet for information. Several respondents relied upon the resources within the care home, this was especially the case with the two larger care homes, where staff had a dedicated room with policies, books and internet access. As one interviewee stated:

“But here we have everything, and we’re made aware by the courses so we’re able to provide better care” (6th February 2013, interviewee1).

The graph below (Fig:5.2) highlights the different ways care home staff sought information about stroke. The data displayed indicates the number of care home staff and how or where they accessed information about stroke.

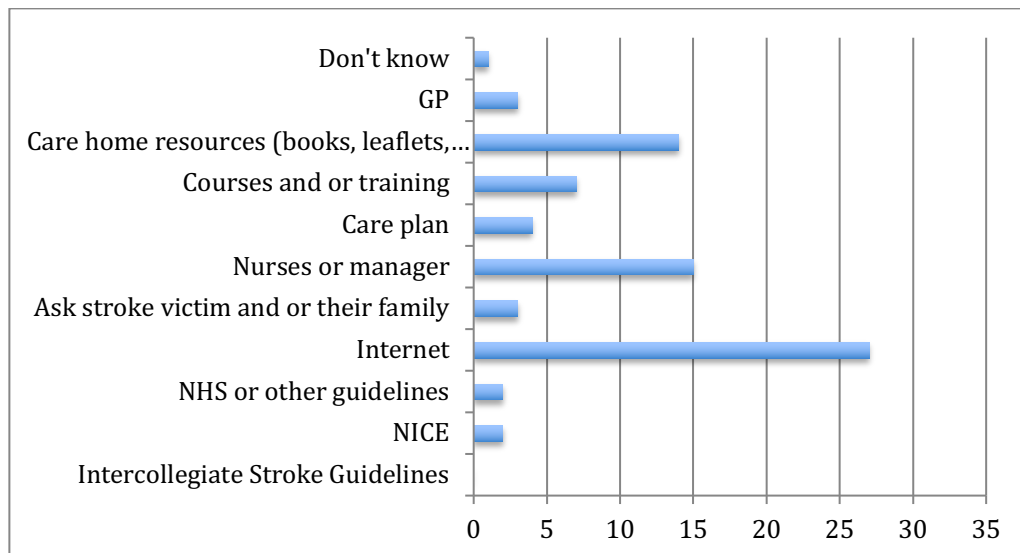


Figure 5.2: How care home staff found information about stroke

Most care home staff interviewed, 77% (n=27) reported using the Internet to get information about stroke. Several, 43% (n=15) would ask their unit manager or Registered Nurse. This was particularly the case for care assistants working on the nursing units. None of the staff interviewed stated that they currently used the intercollegiate stroke guidelines, a couple said they would look at NICE guidelines (n=2), but on further questioning they were unclear as to how this information would help them care for residents with stroke. Similarly, 20% (n=7) of the staff interviewed said they would get information about stroke from training or courses on offer, but respondents were unclear as to how the information gained on courses helped them to care for residents with stroke. Only 9% (n=3) of the respondents said they would ask the resident with stroke or their family for information about their stroke. A lot of care home staff seemed to rely upon the resources provided within the care home for information about stroke, these resources were often found in a designated space and consisted of books, leaflets and relevant policies and procedures. Only one interviewee stated they did not know how to get information about stroke.

Other respondents mentioned government and national information resources:

“We could get NHS guidelines; I have got some at home, the NICE Guidelines, but I’m not sure if it’s NICE anymore, I think they’ve ... but you can get ... we have information here” (7th February 2013, interviewee 3).

But this response appears vague and the respondent did not seem to be aware of how these guidelines might influence care delivery, suggesting that they were aware of the existence of NICE guidelines, but were not clear as to whether or not they were implementing them in practice. This narrative suggests an element of awareness, rather than evidence informed practice.

The majority of care assistants stated they would get information from the Registered Nurses: “Could ask the nurses or internet” (24th April 2013 interviewee 2). This suggests that the nurses are an often-used source of knowledge or information, or perhaps that some care assistants defer to the Registered Nurse rather than take responsibility for their own knowledge development.

One interviewee stated that they would get information about stroke from talking to the residents:

“Talking to the resident themselves, because every ... everyone’s different, you know, just because one Stroke person has it that way, they might have it a different way, so I think that’s the best way for me personally” (21st February 2013 interviewee 3).

Communication to establish residents’ needs and likes and dislikes was often hindered by their lack of ability to communicate following their stroke leaving care staff unable to reassure residents. Indeed, the impact of stroke upon the resident’s ability to communicate following their stroke seemed to be a major issue for care staff and the residents themselves. As one interviewee stated:

“A lot of the time, residents we’ve got upstairs, it affects their speech. So they ... they feel that we don’t understand them, you know, so they don’t want to talk to us, they don’t want to talk to other residents, sometimes their family, they don’t want their family to come in. They become depressed. You know, they don’t want to do the same things they used to do before a Stroke, they don’t want to watch the same programmes, because they just want to sit by themselves” (21st February 2013, interviewee 3).

Care home staff suggest that the residents themselves often appeared to be frustrated with their lack of ability to communicate, and care staff often expressed frustration at the lack of help available for these residents. One interviewee summed this up:

“We have a couple of people who have had strokes at a younger age who have no speech what so ever which causes them to get very frustrated and very unhappy with their lot. They don’t really get much care physio wise or anything else because when they come they say they’ve reached their full potential” (14th March 2013 interviewee 1)

Furthermore, the lack of communication between some residents who had had a stroke and staff, coupled with the resident’s frustration that led to some care assistants reporting that they were afraid of some residents. One senior carer explained:

“We have got one gentleman who has had a real, what do you call them full stroke left him with one-sided weakness – no speech, very difficult to communicate with him. Very frustrated gentleman, comes out sometimes as aggressive, some of the staff are frightened of him” (29th January 2013, pilot interview).

This fear of residents has the potential to hinder the care assistant’s ability to interact and care for the resident and lead to further frustration and low self-esteem for the resident with stroke. Care assistants interviewed did however, explain that they often communicated with resident’s families to ascertain what the resident might like or dislike and what their particular interests were, as one interviewee explained:

“I think again for people who have had a severe stroke and it has affected their speech can go and then not able to communicate but if they can a lot better because then you get to know through them and their family what their interests are and you can involve them more which takes away the feeling of being isolated” (6th February 2013, interviewee 6).

Nonetheless, interviewees also suggested that stroke and an inability to communicate also affected the resident’s ability to interact with their family and friends:

“They just become very withdrawn, you know, they don’t really want to ... because a lot of the time, residents we’ve got upstairs, it affects their speech. So they ... they feel that we don’t understand them, you know, so they don’t want to talk to us, they don’t want to talk to other

residents, sometimes their family, they don't want their family to come in" (21st Feb 2013 – Interviewee 3).

"His partner comes in and helps with washing his hair and showering he won't let any of us do it for him. He is lucky he has still got her really because he can get quite violent with her at times, but I suppose that is a barrier she has overcome" (29th Jan 2013 pilot interview).

Individualised care interventions for residents with stroke require effective communication in order to understand the resident's needs.

5:1:5 View of stroke

Interviewees reported that all types of generalist care were delivered for residents with stroke. These interventions included management of continence; this was usually with continence products such as pads. Other interventions were related to personal hygiene and skin care, as one interviewee explained:

'Everyday they have a thorough good bed bath, showers, we have some really good cream named XXXX (product name) which is really good for protecting the skin, so obviously regularly repositioning them if they are in bed or in the chair, hoist them every few hours to relieve the pressure" (24th April 2013 interviewee 1).

Staff interviewed often demonstrated a pride in the standard of care delivered to protect and promote resident's skin care with one stating:

"We don't tend to have people here that have pressure sores occurring, which is really good, we've got preventative measures here" (March 7th, 2013, interviewee 4).

Most of the staff interviewed, when discussing physical care, mentioned skin care, with regular checks, repositioning and the use of creams being used to protect the resident's skin.

Dietary needs were also highlighted, many interviewees stated that often residents who had been affected by stroke required swallow assessments, some care home managers had staff trained to carry out these assessments, others relied upon outside agencies such as Speech and Language professionals.

Day to day care was on the whole delivered by the care assistants but checks such as daily observation and assessment of the skin for signs of damage, known as pressure area checks were performed by the nurse on the nursing units. As the following care assistants explained:

“Daily pressure area checks are done by the nurses. (6th Feb 2013, interviewee 6)

“If there are any issues we always refer it to the nurse and get them to come and check their skin” (13th Feb 2013, interviewee 1).

Furthermore, interviewees were aware of stroke specific interventions related to one-sided weakness and the moving and handling requirements associated with this. The special dietary requirements for residents with stroke, related to their inability to swallow were also highlighted, along with communication impairments. These findings suggest a biomedical view of stroke which focuses upon physical functioning.

Most Interviewees did however, emphasize the need for residents to be socially active, many interviewees highlighted the role of the activities coordinators within the home. All participating homes had activities coordinators. The care home staff interviewed emphasized the importance of actively involving residents in activities to stimulate them socially, as one interviewee explained:

“We try to get people to social activities to try and improve their mental wellbeing, and socialize, that helps a lot of people” (7th February 2013, interviewee 3).

Another interviewee felt that these types of activities helped to develop the resident’s relationship with the care home staff:

“Stimulation for them in the daytime like activities programmes and the banter that goes on between the staff and patients” (29th January 2013, pilot interview).

On some units the staff engaged in activities with residents:

“Staff do activities but we also have 2 activities coordinators here, who do the whole home, but on the dementia unit the staff do the activities

twice a day as well, just to keep them stimulated really” (6th March 2013, interviewee 3).

Some care home respondents acknowledged that not all residents could attend and participate in activities and some homes had solved this problem by encouraging staff and or activities coordinators to perform activities on a one to one basis:

“We have one gentleman that he has had a stroke he comes to participate in the quiz but he is contracted that much now that it is unsafe to go and get him up so we go in the room and take the quiz book so that he can still do activities. Good to keep the brain stimulated” (24th April 2013, interviewee 1).

Potential barriers to stroke rehabilitation and social integration were evident, these barriers were related to the care home staff views of stroke rehabilitation and age. Data analysed indicated views of age as a barrier were an external and internal barrier to engaging residents in rehabilitation. Several participants highlighted that they felt age was as a factor for residents receiving or not receiving stroke interventions from external partners:

“Because of age it is a waste of resources used elsewhere or if they are in home they are being looked after and they are not in the community” (29th January 2013 pilot interview).

“The physios come back out after a few months, to see how they have got on but the majority of the time the exercise is usually stopping the person contracting any more but they have got to that stage unfortunately which is quite sad and I always think like a twenty-year-old person they would have the treatment much sooner and would not put on a waiting list” (24th April 2013 interviewee 1).

When explaining about why she felt that stroke services did not follow the resident into the care home one care assistant felt that acute services had the “Attitude that they are in a home or they are getting old.” (29th Jan pilot interview)

Other responses seemed to suggest that the care staff themselves felt age was a factor when providing interventions for residents with stroke:

“They could have an exercise programme, but that doesn’t seem to work much here because a lot of the time we do have older residents, it’s not usually younger ones” (7th Feb 2013 – Interviewee 3).

“It depends on the individual and the age group that they are, think the younger the person is it affects them – it is worse for them because if they have had an active life before and all of a sudden they are struck down the effects can be quite devastating” (14th Feb 2013 interviewee 2).

“Maybe if they were mobile could we try and promote like a ... exercise routine or try and ... it depends on their age as well.” (7th Feb 2013 interviewee 3)

One interviewee’s response indicated that care assistants could relate to younger residents with stroke more easily as they remind them of their own morbidity or that of siblings, by stating:

“I find it difficult at times, one young person in their 40’s and I can spend a lot of time with that person because I have a brother similar age and I go in there” (14th Feb 2013 interviewee 2).

This focus upon age, rather than the resident’s individual needs has the potential to create a barrier to stroke best practice interventions in the care home context.

5:2 Care drivers or constraints

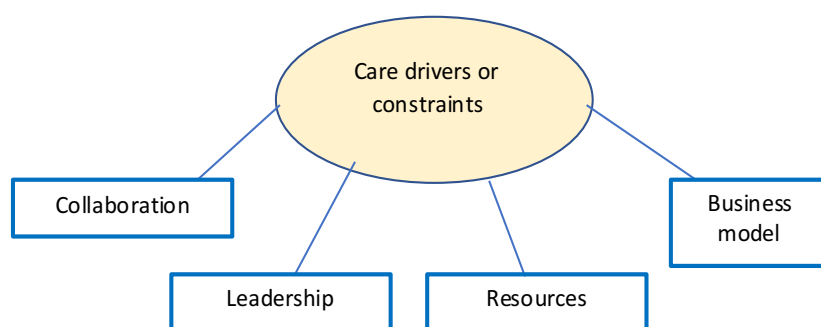


Figure 5.3: Care drivers and constraints.

5:2:1 Care drivers or constraints

Any change in practice will require an awareness of the factors which might enable or restrict the implementation of stroke best practice. Several drivers and constraints emerged from the interview data.

5:2:2 Collaboration

Care home staff often engaged with other professionals to deliver care interventions, as this interviewee explains:

“Yes we do have direct access to Speech and Language therapist team and we think if anyone has any problems we refer them to them and they come in and I am trained to do their swallow assessment, I know if they need anything different. We do have access to the SALT team and the dietician, we will refer if need” (26th April 2013, interviewee 1).

Some interviewees indicated that these specialist services were relatively easy to engage with:

“Stroke mainly for swallowing issues we liaise a lot with speech and language therapists, they’re available quite easily, we can refer direct, some of us have been on a training course and we can refer” (27th February 2013, interviewee 3).

Whilst others indicated that the waiting time for residents with stroke was often too long:

“We can do referrals because we have been trained we can fully refer. Straight away to speech and language therapists but for some it is only awaiting time – waiting time too long, if they have some concerns – it is just the time” (28th February 2013, interviewee 6).

The values of links with the District Nursing (DN) team were expressed within one residential unit; as this care assistant explains:

“If we have got any concerns any redness in the pressure areas, dryness, rashes, skin thin sometimes knock it – skin tear, so that all goes through the district nurses which I must admit at the moment are being very good with us. Scores review, pressure areas, pressure relieving

equipment, lucky we have a good district nurse team and the staff well informed and they know what to look for” (29th January 2013, pilot interview).

Often interviewee’s felt that physiotherapists and Occupational Therapists (OT) seemed reluctant to provide interventions for stroke rehabilitation in care homes, as this Registered Nurse explains:

“With this lady I look after we have been quite lucky we had OT out give her an ankle brace and palm protected quite quickly done – but it is an effort to get them here.” (29th Jan pilot interview).

Staff reported feelings that physiotherapists seem to give up on care home residents or suggest that if they are in nursing homes interventions should be provided by the home. This care assistant explains her view:

“Not a lot of help for aftercare – you are in a home, biggest problem which makes me angry – they have got dementia and I have actually had a physiotherapist saying I am discharging that lady because she is too violent!” (29th January 2013, pilot interview)

Whilst another respondent indicated that it was a lack of understanding by other professionals of the resident’s disease process that led to them not receiving rehabilitation:

“Maybe if my lady had not got dementia and after she had had her stroke, if she had gone home she may be better looked after” (March 6th 2013 interviewee 1)

Another interviewee expressed frustration at the lack of collaboration between the acute services and the care home sector:

“It was only in the acute setting but it has got to be something out in the community for it to continue because it is like as if I feel that they come out and they say well you are not in my hands now you are in the nursing home and it is their problem” (14th February 2013, interviewee 2).

Care home staff suggested that there is a lack of understanding of what care homes can realistically offer residents in terms of stroke interventions. Furthermore, care staff suggested that acute sector staff did not always value their expertise.

5:2:3 Leadership

Leadership traits displayed by care home managers were quite diverse. One manager did not want to risk upsetting staff and sought their permission to engage in the project. On arrival at this care home on the agreed interview date, field notes record that this manager had not arranged an interview schedule with staff, as the following field notes excerpt illustrates:

‘No schedule arranged, manager unaware of who was happy to be interviewed’
(Researcher field notes: 24/04/2013).

A couple of staff on duty when asked by the manager were keen to be interviewed, the researcher therefore agreed to return later that day. Staff who were interviewed were told to use one of the resident’s bedrooms which felt inappropriate, researcher filed notes record:

‘Interviewing in a resident’s bedroom – feels wrong...’ (Researcher field notes: 24/04/2013).

When questioned with the care home manager they said there was no meeting room in the home. This manager was again contacted by telephone and once again field notes recorded that:

‘Manager had forgotten to ask staff, manager said staff were interested, but had changed their minds’ (Researcher field notes: 26/04/2013).

This servant leadership style appeared to be aimed at retaining the workforce, rather than developing the resident’s experience. This care home manager indicated that some of the staff did not see the point in taking part in the research; although the reasons for this were not clear. Further contact was made and on this occasion the manager had again forgotten to ask staff if they would be prepared to be interviewed (Researcher field notes: 26/04/2013). During the rolling programme, several staff from this home expressed an

interest. But the manager indicated that although staff were keen, they had changed their minds; no further interviews were scheduled for this home.

In the two larger care homes, several staff commented upon the fact that they felt theirs was the best care home during initial meetings. During interviews care home staff from the two larger care homes seemed to have a sense of 'family' or 'belonging' within the care home. The following comments were made:

"It's part of our culture here to improve their dignity, choices, what they want to eat, dress, do if they want to get up or stay in bed or those type of things, the staff encourage them to make those decisions themselves" (28th February 2013, interviewee 1).

"I think we create a good environment in here, we're very friendly and we make sure we look after them, we keep families involved, we're all quite close to the families as well in here" (6th March 2013, interviewee 5).

"Here, we try and include them in everything, if they want to" I think here we provide good quality care" (6th February 2013, interviewee1).

"I think being here doesn't make them as socially isolated because they have a lot of company and a lot of staff going to them. And I think ... sometimes, although a nursing home isn't the ideal situation, I think for a lot of people it's the best, and it's better than being at home on their own just with their partner. Because they're getting more social interaction here than being stuck at home" (7th February 2013, interviewee 3).

We have senior carers that have been here for a long time (7th February 2013, interviewee 3).

Registered Nurses interviewed highlighted giving out medications and collaborating with other agencies as a key part of their role. Care staff on the other hand often felt that they were the team members who got to know the resident and were able to talk to them about their concerns or specific needs. As one care assistant explained:

"When you have been here a while you get to know your person, you get to know how they like to be positioned." (14th February 2013, interviewee 2).

Some of the Registered Nurses interviewed also indicated that it was often the care assistant who forged therapeutic relationships with the residents. The nurses interviewed seem to value this and were keen to highlight the collaborative working relationships between Registered Nurses and care assistants in the care home setting. One interviewee summed this up with the following statement:

“Carers input is just as valued as the nurses and often more so, they notice more. They notice half the things, I mean with the terminal care they’re the ones who come and say ‘so-and-so’s not looking at all well,’ they notice it before we do, even the care support the cleaning staff, they come and alert you to problems, it’s all valuable. It’s not ‘oh you don’t know anything, you’re not a nurse,’ we don’t run like that” (27th Feb 2013 interviewee 3: nurse).

Other care assistants seemed to indicate their role was to carry out the tasks allocated by the Registered Nurses. One carer stated:

“We do as we are told to do” (14th March 2013, interviewee 2).

The two larger homes had resource centres where staff could access up to date guidelines and information. One home had a training room for staff. Most staff interviewed from these care homes were aware of these resources.

All staff interviewed felt that they could approach the home manager and that the manager would support their learning needs.

Most staff interviewed stated that they received some form of supervision, this seemed more structured in the two larger care homes where staff stated they had regular clinical supervision meetings and regular team meetings. One interviewee explained that: “We have two monthly supervisions” (28th Feb 2013 interviewee 1). Clinical supervision was with an allocated supervisor, usually a senior member of staff.

The two large care homes had staff meetings once a month, where staff could voice concerns or highlight practice issues, one interviewee described them as discussing:

“Just general things to do with the home, and then if we’ve got any issues we can bring them up” (13th Feb 2013 – Interviewee 1).

Further information was provided by another interviewee who explained that:

“They just like discuss ... what’s gone on over the month and what they need to change, whether there’s like ... if there are any complaints or anything like that” (13th Feb 2013 – Interviewee 3).

Staff in the two larger care homes felt their home manager was supportive and that they were encouraged to access training. As one interviewee stated:

“We’ve got a really supportive manger so if we need any help or extra training then they’re approachable and they’re pretty good here for supplying courses, so that’s good. The carers are well trained, everybody has to do NVQ level 2 and level 3 is encouraged so a high percentage have done level 3” (7th March 2013, interviewee 4).

There was an emphasis upon management and leadership in the two larger care homes.

One interviewee explained that:

“The residential management team, team leaders and that have done level 4 NVQ in care and management. So we promote through training and monitoring, evaluation of the care and clinical supervision of the staff to identify problems. They have regular appraisals the staff, every 2 months” (14th March 2013, interviewee 1).

Some of the Registered Nurses interviewed stated that they engaged in the link nurse system operated by the local health board to educate and update Registered Nurses in specialist areas of care. One interviewee stated:

“We have link people for tissue viability and for incontinence, infection control, so we have a link for all these things, palliative care. There’s not a link for stroke available I’m afraid” (14th March 2013, interviewee 1).

5:2:4 Resources

Finding the time to attend to resident’s individual needs was sometimes problematic as this interviewee indicated:

“I think time is sometimes a problem in a home because it’s a very busy environment but then the staff here are caring and compassionate and I think that they do the best job that they possibly can in providing emotional support. Spending time with them, I have to activities

organisers as well and part of their role is spending one to one time with people who are not able to join in with you know bingo or quizzes etc. They spend time just in their room trying to chat or read a paper or play a bit of music with them whatever so that's something that we identified about 5 months ago and that's what made me take on another activities organiser so there was more time for this. On the nursing unit in particular, you do get a lot of people all in their rooms you know" (14th March 2013, interviewee 1).

Interviewees often felt that interventions for residents with stroke could be improved, but felt that stroke and rehabilitation services were not available in the care home sector, especially the nursing home sector, with Registered Nurses suggesting that outside agencies did not understand the role of the care home and had unrealistic expectations as to what the care home could provide for residents with residual impact of stroke. As one Registered Nurse explained:

"Usually, unless families are willing to pay for it, they don't really get it. Or ... and it's been a trouble ... I know a person that ... it took a lot of time ... he was having one week of physio, but then it took a lot of time to get extra funding for him to be able to have extra. And that's that window of opportunity that's totally getting lost" (7th February 2013, interviewee 3).

There seemed to be an uncertainty as to where the line sits between generalist and specialist stroke care, as another interviewee seemed to suggest that Registered Nurses working in the acute hospital sector had more opportunity to gain specialist knowledge, and gave the following example:

"Nurse in hospitals, specialize in different subject... better knowledge of a certain illnesses, unfortunately we're not like that even though we try to treat them (*residents with stroke*)."

(29th Jan pilot interview).

Why care home staff might feel that acute sector nurses have more opportunity to gain knowledge of specialist subjects/conditions is unclear, but perhaps another interviewee's response may help to shed some light on the possible reasons:

"I don't think I am a very confident person really, when the family of stroke patients ask questions, sometimes I feel why did I not know more about that and I go and look on line and look somewhere and say I will go and look for you, not quite sure. Always room for improvement,

nobody is perfect, like I say with stroke so many changes – lot of younger ones day by day care is changing, changing for the better” (14th February 2013, interviewee 2).

This statement seems to suggest that whilst care home staff are motivated to find information they may not know where to find it or how to find credible, reliable evidence, such as the Intercollegiate Stroke Working Party (2012), or the NICE (2013) guidelines, to inform their practices. Nonetheless, there is evidence of self-awareness and a desire to seek answers.

Some interviewee’s expressed concern around the misconceptions regarding what care homes can offer stroke survivors:

“Yeah because ... there’s certain people who sort of get missed as soon as they come here, but I don’t know if that’s because they believe that we’ve got physio...” (7th February 2013, interviewee 3).

Other interviewees felt that once in a nursing home residents did not receive the same interventions for their stroke as in the acute sector, as one explained:

“Me personally think they get a lot more in hospital and sometimes I find that they can slip through the net when they come here because they have come to a nursing home – end of” (14th February 2013, interviewee 2).

‘Definitely, once in care home it seems like a closed door to them, and they don’t have any chance of reaching their full potential because they don’t have support services for them’ (26th April 2013, interviewee 1).

This perceived inequity between acute service provision for stroke and care home provision could create a potential barrier to resident’s stroke rehabilitation.

5:2:5 Business model

Interview data suggests that the care provided on a day to day basis was aimed at meeting residents’ needs, but was often quite generalist and planned to meet Care and Social Services Inspectorate Wales (CSSIW) standards. As one interviewee explained:

“We have the national service framework usually is in there, a lot of what we offer is set by CSSIW who uses the National Service Frameworks” (28th Feb 2013 interviewee 1).

Interviewee’s in the smaller homes did report having team meetings but staff did not seem to feel they could discuss care related issues in the meetings, they reported a more corporate feel to the meetings, with one interviewee commenting:

“We have staff meetings, but that does not tend to be about the care” (24th April 2013, interviewee 2).

Another participant explained that the meetings were focused upon the home owner’s agenda, stating:

“If we do have any meetings it is usually with the owners of the home and it is just for them to air their moans and groans about the home. More corporate stuff” (26th April 2013, interviewee 1).

Some interviewees explained that rehabilitation was influenced by the resident’s ability to pay, as one explained:

“Would physio come into this – because it stops when they come in because it has to be paid for when they come in to a private home. Like in hospital they would get physio for free and when they come here that would be stopped, not stopped they would have to pay for it themselves because it is private” (14th Feb 2013 interviewee 3).

A potential strength within the care homes was the opportunity for staff to discuss care issues. Several interviewees stated that their care home held regular meetings where care and other issues could be discussed. The following statements reflect this:

“We have staff meetings, but that does not tend to be about the care” (24th April interviewee 2).

“We have monthly meetings which all sorts are raised, information comes down, it could be about the company as well, and any sort of issues around clinical matters they’re raised and there’s plenty of opportunity, it’s done in a discussion form, carers input is just as valued as the nurses and often more so” (27th Feb 2013 interviewee 3).

Other interviewees questioned the value of their staff meetings, stating that:

“If we do have any meetings it is usually with the owners of the home and it is just for them to air their moans and groan about the home. More corporate stuff” (26th April interviewee 1).

One of the larger care homes held monthly meetings with staff, yet despite this one respondent indicated the following:

“We have a monthly meeting here, but ... I tend to ... I tend to stay on the floor”.

When asked by the researcher why they avoided the monthly meeting the response was:

“Too much talking. They just like discuss ... what’s gone on over the month and what they need to change, whether there’s like ... if there are any complaints or anything like that” (13th February 2013, interviewee 3).

This indicates a potential barrier to change, as despite the care home manager creating forums where staff can openly discuss any concerns or reflect upon the care delivered, some team members avoid these types of discussion forums and this would need to be taken into account when identifying barriers and planning implementation strategies.

During an induction event for care home stroke champions, one participant suggested that the competition between care homes was often fierce, and this individual felt that the need to create a corporate image often got in the way of inter-care home collaboration opportunities, especially between management level staff.

As this field note excerpt, following reflections of a conversation with one care home manager, explains:

‘XXXXXX (care home manager) explained that care homes have to compete with each other, and as a result managers are very wary of discussing problems or needs they may have within their care home as this might be seen as a weakness. She indicated that this made managers very isolated’ (Researcher field notes, December 2012).

Nonetheless, engaging in research and practice development studies, such as this study, offers managers the opportunity to collaborate.

5:3 Discussion

An understanding of the interview data was essential as this could then be used to plan workshop data collection in order to tailor the stroke best practice recommendations for this care context.

5:3:1 Decision making

Tailoring stroke best practice recommendations and preparing to implement them into day to day care home practice involves active decision making, therefore it was vital to unpick this theme to establish what influenced decision making in the care home context. It was clear from the interviews with care home staff that their time is limited and their day to day routines revolve around meeting residents' basic human needs. Resources are limited, but the majority of the staff interviewed expressed positivity towards the venture, with an emphasis upon enhancing the care experience for residents with stroke.

The care home staff were keen to engage in the project; the number volunteering to be interviewed highlighted this. Care home staff were aware of the inspectorate requirements and strove to ensure these standards were met. None of the current CSSIW care home standards relate to rehabilitation or reaching maximum potential for residents who have had a stroke. As a consequence, this is not necessarily a priority for the care home when allocating available resources.

5:3:1:2 Resourcefulness of staff

Findings indicated that care home staff were often motivated to adapt and facilitate resident's needs by whatever means possible, to overcome the restrictions of limited resources. This person-centred focus lends itself to tailoring best practice recommendations for this care setting, as care home staff can apply their unique insight of residents and the care context into the tailoring process.

These findings do however raise questions about comparative needs, such as why are care home residents not treated in the same way as other health service users, just because of their place of residence? Comparative need occurs when the characteristics of those already in receipt of a service have similar traits to those not in receipt. Where two similar

populations could potentially have access to a particular service, the population not in receipt of the service is considered to be in need (Bradshaw, 1972). A report by the Royal College of Nursing (2011) suggests that one reason maybe that residents “are being admitted with more severe and complex care needs, but with inadequate funding allocated to meet their needs as both social care and Continuing Health Care (CHC) eligibility criteria are being tightened” (p.4). The latest stroke care guidelines disseminated by the Intercollegiate Stroke Working Party (2016), state that “at present people in care homes rarely receive any ongoing rehabilitation or equipment provision by the NHS despite this being their main domicile. Reducing dependency as far as is possible and improving the quality of life for people with stroke whatever their place of residence is an important and compassionate objective of community provision for people with stroke” (Intercollegiate Stroke Working Party, 2016: Recommendation 2.17, p:32). Inequitable provision in the care home setting has the potential to limit the care homes ability and resources to tailor and implement stroke best practice recommendations. The resourcefulness of staff and their desire to respond to the needs of residents with stroke was nonetheless, an important factor when planning to tailor stroke best practice recommendations for this sector.

5:3:1:3 Responsibility

Nurses interviewed highlighted giving out medications as a key part of their role. This reflects a study by Burton (2000) who found that the nurse’s role in stroke was often concerned with tasks associated with the patient’s journey through the health care system, rather than a focus upon individualised stroke rehabilitation needs. Nonetheless, findings indicated that the care home staff followed instructions from the nurses and that the nurses were instrumental to any changes in day to day routines. This transactional approach to leadership and care delivery has the potential to impact upon tailoring stroke best practice guidelines. The data analysed here suggests that it would be essential to involve the Registered Nurses in the tailoring process, as they appear to be the main drivers for change in the nursing home setting. Chang, Jones and Russell (2013) however, found that a lack of authority and responsibility can create a barrier to change in the care home context; suggesting that staff at all levels should be engaged in processes to

develop and implement best practice recommendations. On the residential care units the senior carer and carers appeared more autonomous and happily took responsibility and made care decisions and collaborated with outside stakeholders. It is essential therefore, that consensus workshops are made up of care home staff of all levels.

5:3:1:4 Knowledge of stroke

Some interview participants indicated a fear of resident's who were struggling to deal with the impact of stroke. This lack of understanding with regards to the impact of stroke has the potential to hinder the carers ability to interact and care for the resident, and lead to further frustration and low self-esteem for the resident with stroke. The RCN (2012) found a lack of training and education for care home staff outside mandatory training. Findings also indicated that none of the care home staff interviewed were aware of the intercollegiate stroke best practice recommendations. This indicates that care home staff were not knowingly implementing these recommendations into their day to day practices for residents with stroke. The planned tailoring workshops offer a good opportunity to build upon this level of awareness.

5:3:1:5 View of stroke

Interview data suggests that the interventions for stroke were not specifically designed to address the resident's needs in relation to stroke, but were of a general nature, and often seemed to focus upon physical functioning. Findings suggest a bio-medical view of stroke which focuses upon physical functioning related for example, to one-sided weakness and the moving and handling requirements associated with this. And the special dietary requirements for residents with stroke, related to their inability to swallow. Baseman, Fisher, Ward and Bhattacharya (2010) found that the relationship of physical function to social integration after stroke was a key factor, and that a focus upon physical functioning alone would be insufficient to address the rehabilitation needs of people who have had a stroke. Consequently, a biomedical approach to care has the potential to limit the tailoring of the best practice recommendations, as a biomedical view of an individual's needs can limit interventions to physical functioning at the expense of addressing the social needs a person has to function holistically in their environment (WHO, 2001).

Some care home staff were unable to communicate effectively with residents who had had a stroke, and some were reported to be frightened of displays of frustration from residents with stroke. A report by the RCN (2012), suggested that recruitment and retention of staff issues in the care home context, often meant that care home staff struggled to access more specialist training, such as communicating with people following a stroke. This lack of understanding of the impact of stroke could create barriers to implementing the best practice recommendations; as McGitton et al. (2012) suggests that effective communication with people who have had a stroke is vital, and results in less agitated patients and less stressful interventions for staff.

Some study participants suggested that age, rather than the resident's individual needs created barriers to stroke best practice interventions in the care home context. Similarly, a review carried out by the Centre for Policy on Ageing (2009), found ageist attitudes in care homes, which led to poorer quality of care in care homes for older people. These attitudes were linked to stereotypical assumptions about older people. If the staff do not see older people as individuals, who have the capacity for rehabilitation and stroke specific interventions, then they may be reluctant to implement these practices. This in turn has the potential to impact upon tailoring stroke best practice recommendations for this care context.

5:3:2 Care drivers or constraints

An examination of the drivers and constraints within the care home context prior to tailoring stroke best practice recommendations was necessary to establish factors that might influence care staff engagement.

5:3:2:1 Collaboration

Care home staff reported good relationships and collaboration with the district nurses. Goodman, Robb, Drennan and Woolley (2005) found that district nurses were the most frequent visitors to care homes, and that care home staff and district nurses often reported good relationships. Interview data suggested a feeling of frustration for care home staff at the perceived lack of support for care home residents and the seemingly unequal service offered by other agencies. Access to physiotherapy and occupational

therapies was inconsistent, and the nursing home staff felt that they were often unable to offer these services to residents unless they were able to pay. The Chartered Society of Physiotherapists (2015) support these views and report that there seems to be a lack of clear responsibility around rehabilitation between care homes and health trusts. A situation where care home residents do not receive services in the same way as other health service users, just because of their place of residence, has the potential to limit stroke outcomes. Stroke best practice recommendations however, propose that “People with stroke living in care homes should be offered assessment and treatment from community stroke rehabilitation services to identify activities and adaptations that might improve quality of life (Intercollegiate Stroke Working Party, 2016: recommendation: 2.17.1A, p32). Clarity around rehabilitation responsibility, and the need for worthwhile collaboration, which sees the residents needs as central to success is required.

5:3:2:2 Leadership

Findings suggest that subjective factors such as values, beliefs, culture and language all emerged as important concepts that have the potential to influence tailoring in this context. Furthermore, management styles might help to explain how these negotiated orders are held together, for example, some managers did not want to ‘upset’ staff. This reflects findings from The RCN (2012) review of care home staffing, which highlighted that one errors were being overlooked by management so that staff do not leave (P:5). Other managers actively encouraged staff to engage, in the extreme example staff participation was ensured by inserting interview schedules into their daily routines.

Despite reporting support from care home management, the ability of the care home staff to access credible evidence to inform their practice around stroke was quite weak. Tailoring a national stroke guideline for this setting has the potential to help raise awareness about what evidence is and how care home staff can tailor stroke best practice recommendations it to their care home context.

5:3:2:3 Resources

Time and resources emerge as an influencing factor to the adoption of a task orientated focus upon care. Several care staff interviewed felt that time pressures influenced the type of care delivered for residents with stroke. This was a key finding in a 2010 Royal

College of Nursing policy unit (RCN) policy report about care homes under pressure. The report found that staff shortages and a lack of time influenced the quality of care the residents received. The RCN (2010) also found that care home staff did not have appropriate equipment to cater for residents' diverse and complex needs. These factors also came to light in the interview transcripts and was often linked to expressions of frustration both with the lack of equipment and the perceived lack of collaboration from other professionals. These factors have the potential to create barriers to tailoring best practice recommendations as they raise issues with regards to the feasibility of tailoring best practice recommendations to this context. Timing and venues of consensus workshops require robust planning, which reflects sensitivity to the day to day running of the care home. The process of tailoring the best practice guidelines also offers the care home staff ways to challenge and address some of the issues highlighted in the interviews, and to examine different ways of working to create a better fit.

5:3:2:4 Business model

An organisation is enacted by people developing particular work practices rather than existing objectively and independently of social action (Turnbull-James, 2011). Care homes are often viewed as places of long-term treatment and therapy dominated by the biomedical model that values efficiency, consistency, and hierarchical decision-making (Brownie & Nancarrow, 2013). The RCN (2012) reported that due to staffing shortages, one respondent said the home felt like a 'conveyor belt', and many other respondents also felt that they were unable to offer personalised, patient-centred care that provided for patients' social and emotional needs (p.15). Furthermore, a lack of funding, time, and workplace culture creates systemic barriers to evidence-based practice in care homes (Chang et al., 2013). It will be interesting to see if the business model within the care homes has an impact upon tailoring the stroke best practice recommendations.

The interviews highlighted several key factors which might impact upon the care home staffs' enthusiasm to engage in consensus workshops to tailor the stroke best practice recommendations. These factors will form an initial data analysis framework to help the researcher unpack care home staffs engagement in tailoring in action as defined by the workshop data, they include: staff resourcefulness and the impact upon day to day care

home life, people, who they are and how they care home staff and the interventions they deliver, along with the influence of internal and external stakeholders on day to day care home business.

Chapter 6

Findings: care home tailoring workshops

6:1 Introduction

This chapter will present the data findings from the care home staff consensus workshops. The workshops were organised to tailor national stroke best practice recommendations; and to examine tailoring as an implementation strategy. Consensus workshops sought to engage staff in discussions around how they perceived the stroke best practice recommendations could be applied to the day to day care in the care home. This enabled an insight into the roles enacted by the care home and staff on a day to day basis and influenced the way they engaged in the tailoring process. The workshops also provided an insight into the influence of the organisation and internal practices on the tailoring of stroke best practice recommendations. Workshops also enabled participants to become familiar with the stroke best practice recommendations whilst engaging in tailoring them to the care home context.

This data analysis section forms two part. The first examines how the language of the intercollegiate stroke best practice recommendations were unpicked. The second part provides an in-depth analysis of the narrative data recorded during the tailoring process in order to build theory around the tailoring process and to examine tailoring in this context.

6:2 Arriving at consensus and the impact of language

In the two care homes where attendance was on a more self-selection basis, staff seemed to share perceptions (Damschroder et al., 2009) of the importance of tailoring the recommendations for their context. Making comments like

“We need to put that right...” (Senior carer: The Oaks, second workshop).

The role of leadership and autonomy in engagement is worthy of further investigation, as it has the potential to impact upon staff engagement in the tailoring process.

Participants were given a list of stroke best practice recommendations and were asked to rate the intercollegiate recommendations on a Likert scale of 1 (least applicable to the

care home environment) to 9 (most applicable to the care home environment) were used. Care home staff participating in the workshop were asked to complete their list scoring of recommendations individually. In order to achieve consensus, the results (Appendix 6:1) were reviewed to establish to identify which, if any, of the intercollegiate stroke best practice recommendations care home staff felt were relevant to their care setting. Hasson, Keeney, and McKenna (2000) describes this as a technique employed to enhance effective decision-making, where individual opinions are transformed into group consensus. All participants were given the 2012 intercollegiate stroke best practice recommendations for care homes/goal setting, personal activities of living, bladder and bowel management, further rehabilitation, anxiety and depression.

This method proved an effective way of ensuring care home staff became familiar with the stroke best practice recommendations; but the scoring method in this context was not felt to be reliable. This was due to some care home staff scoring all recommendations an 8 or 9 as they felt that the residents should have the best care, indicating that care staff may have viewed these as aspirational; as one carer explained:

“Well I have done 9’s for all of them because I think they should have everything”
(Beeches, first workshop –goal setting; carer).

Furthermore, although consensus methods enabled the care home staff to individually score recommendations whilst supported by the researcher, it became evident during discussion that care home staff did not always fully understand the recommendations. In order to facilitate clarity and worthwhile consensus, scores were discussed, and during this stage some care assistants explained that they did not understand the recommendations. The researcher was able to discuss the recommendation meanings by involving all workshop participants. These discussions around meaning and relevance to the care home setting enabled some care assistants to revise their scores as their understanding of the recommendations became clearer. The group were then able to move on to discuss each recommendation, and care assistants were able to alter language and disregard recommendations that they felt were not relevant to residents, or were outside their control and were the remit of other professionals. This adapted approach was more akin to a nominal group technique consensus format (Rycroft-Malone, 2001).

Further explanations around the way the care staff scored the recommendations might be found in the health literacy literature. As some staff struggled with the terminology and language used in the intercollegiate recommendations. Workshop participants expressed confusion and lack of understanding around some of the intercollegiate language, for example when discussing one of the recommendations for daily activities:

“For patients with residual dressing problems” (Researcher)

“What does that actually mean?” (Carer)

“It just means that they can’t dress” (Nurse)

Similarly, mid-way through the discussion around ‘goal setting’ a carer explained:

“But now I understand your goals, so now I understand it but half an hour ago you were saying goals and I thought what the hell is she talking about!” (First workshop transcript, p. 19, goal setting: carer).

6.2.1 Discussion

The narratives identified within the above findings demonstrate how easy it is to create barriers to implementation with language and terminology; as if people do not understand what is being said they are unlikely to implement the evidence successfully. Higgins, Parker, Keatinge, Giles, Winskill, et al. (2010) found that a lack of familiarity with the language used in research articles can alienate clinical staff. Furthermore, Majid, Foo, Luyt, Zhong, Theng, et al. (2011) propose that inadequate understanding of the research jargon used in publications creates barriers to evidence implementation in practice. Health literacy is an emerging field but already the potential impact in relation to how understanding of the evidence messages around health and the ability to apply this is emerging (Berkman, Davis, & McCormack, 2010). Cavanaugh (2011) explains that health literacy is a broad concept including more than individual levels of intelligence, but rather a specific skillset that involves a variety of methods to communicate and interpret health information with unique demands, depending upon the person and their setting.

Building a rapport with participants was a crucial component of this research study as supported by previous authors, such as Sivell et al., (2015) and Roberts (2007). The researcher’s diary or field notes reflect interactions with care homes, whilst the audio recordings captured verbatim the interviews and workshop conversations. It is during

these discussions that the relationship between the care home staff and researcher develops. Care home staff were encouraged to share their views and ask questions. Very often questions were asked by workshop participants to clarify meaning of the intercollegiate recommendations. It is imperative as a researcher that you avoid influencing participant's responses, this was a challenging dilemma in these circumstances. The researchers teaching and education skills often came to the fore, providing strategies to engage the participants in addressing their own questions as a group. For example; asking other care home staff participants what they understood by the recommendation was a good way to generate discussion, rather than the researcher answering the questions, but this was not always possible as some elements of the language left the whole group dumbfounded. Where possible the explanations provided along with the recommendation in the intercollegiate guidelines (RCP, 2012) were used, and example of this was recommendation 6.36 'Emotionalism', which the guideline defines as 'Emotionalism is an increase in emotional behaviour (crying or, less commonly, laughing) following minimal provoking stimuli' (Royal College of Physicians, 2012, p:115). At other times, lay terms were used in replace of more academic language. Whilst this ran the risk of researcher influence, it did nonetheless promote trust and enable the care home staff to engage with the researcher and kept the discussion alive. Furthermore, the use of cognitive questioning to unpack the participant's responses enabled more interpretative data to be collected, which will be discussed in the second half of this chapter.

Graham et al. (2010) suggest that practitioners will use some aspects of best practice guideline recommendations, whilst disregarding others. The consensus workshops enabled the tailoring of the stroke best practice recommendations by care home staff, which are applicable to the care home context. Once care home staff had decided a recommendation was relevant for their care home setting, they were encouraged to tailor the language used in order to ensure all care home staff implementing the recommendations would understand what was being introduced. A guideline developed or adapted by the target group enhances the success of implementation (Francke et al., 2008). The aim of this process was to tailor the language of recommendations whilst protecting the original meaning of the recommendation in order to embed them into care

home custom and practice. In order for this to happen recommendations have to be written in the day to day language of the care home. Message change does not therefore equate to a loss of fidelity, but rather a clearer message which is more likely to be accepted by the care home team. Message tailoring therefore, does not denote the original meaning is lost, but that clarity and usability is enhanced by tailoring. As a result, fidelity was not necessarily diluted by tailoring language for this particular setting, it developed the original message in order to ensure the care home staff understood what was required, and could then apply it to their context. Tailoring the language used within the best practice recommendations was therefore a better way to ensure the quality and useability of the health literacy within the care home context.

Fundamental terms such as *patient*, would therefore be changed to *resident* to create a better fit for the care home setting, and to promote care home ownership of, and engagement with, the recommendations. Interprofessional responsibilities were also highlighted during recommendation tailoring, and language change around these issues was necessary in order to clearly identify care home staff's responsibilities and actions. The original and tailored recommendations can be seen appendix 6:2.

6:3 Workshop findings

Findings will be displayed using visual interpretation 'Networks', which were utilised in order to determine the variables for analysis (Miles, Huberman and Saldana, 2014) in relation to tailoring best practice recommendations in the care home context. Miles, Huberman and Saldana (2014) explain that 'networks' fit well when using a case study approach and help the researcher to illustrate complex interrelationships between variables, as a collection of points connected by links, which are designed to highlight patterns of participant actions, events and processes.

The theory building through emerging themes from the data will be discussed in turn, beginning with 'feasibility':

6:3:1 Feasibility

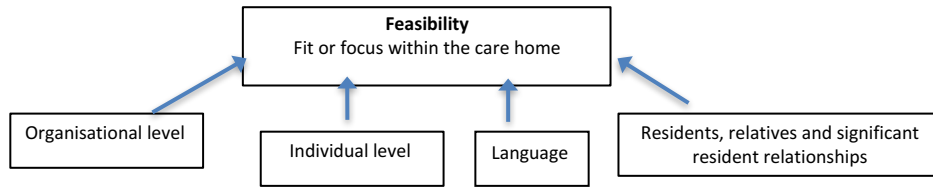


Figure 6.1: Feasibility

The higher level complex theme of feasibility can be unpacked by examining the sub-themes, as follows:

6:3:1:1 Feasibility

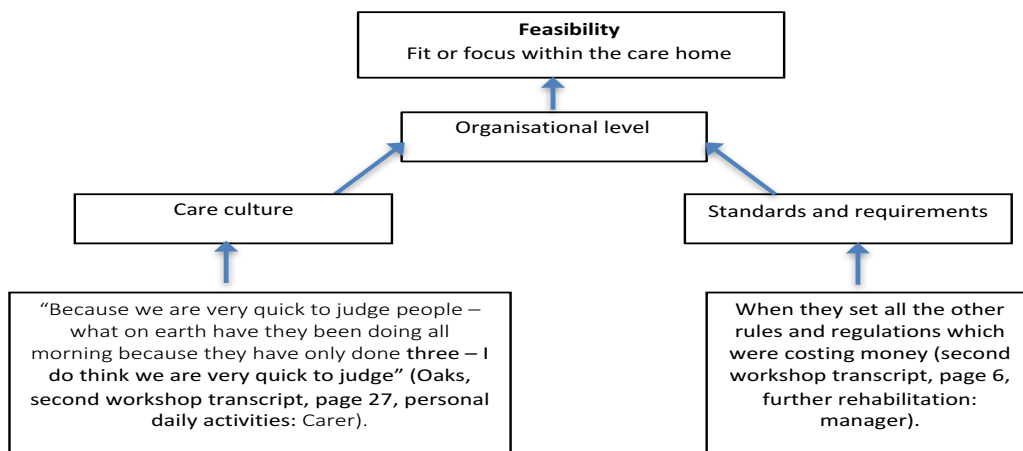


Figure 6.2: Feasibility: Organisational level

6:3:1:1:1 Care culture:

Care home staff often seemed entrenched in the day to day routines and this resulted in a task driven culture. Kitsen et al. (1998) suggest that often people who are asked to accept new evidence and ways of working often find themselves working in an environment that is task driven. This also emerged as an influencing theme within the research data and

was often reported by care home staff who felt they only had time to deliver fundamental care, as one Registered Nurse explained:

“Really speaking we are actually only making sure they are clean, being fed and not in pain and looked after” (The Beeches, first workshop transcript, p. 23, goal setting: nurse).

These ways of working have the potential to act as a barrier to tailoring best practice recommendations, as any variation from routines is seen as time consuming and a threat to the norm

“Not being disrespectful but we would not have the time” (The Oaks, first workshop transcript, p. 23, goal setting: nurse).

Just as a focus upon tasks has the potential to limit tailoring, when examining feasibility this theme emerges again in the shape of routines and rituals. A focus upon industry, rather than individual resident’s needs, has the potential to create a culture which values routines and ritual tasks, can impact upon the quality of person centred care the resident with stroke receives. In addition, care staff indicated that there may be a fear of being judged as avoiding industry, if spending time with residents.

“We don’t have the time, we would love to have the time but we don’t get it; (name omitted) likes to do their hair, likes to take them to the hairdresser and sometimes very rare, you do not have time to do that, and get to know them, we haven’t got time” (The Beeches, first workshop transcript, p. 23: carer).

“It is not knowing what that person has actually been doing they you know it does not mean that she has been outside having a cigarette does it? She could have been spending a little more time with the patient, but I think looking at something else that has been coming up with all the ‘powers’ that be up there we do actually have to now put in our care plan if a patient does need extra time spent during activities of daily living” (Oaks, second workshop transcript, personal daily activities p. 27: Manager).

Some care home staff seemed to promote hierarchies within the care home. This raises a concern with regards to exclusion rather than inclusion putting the tailoring process at risk. The following narratives highlight this:

“Yeah but does that include cleaners and kitchen staff because we don’t want them interfering in what we do. Maybe carers and nurses – that will

separate us from them” (Beeches, first workshop transcript, p. 16, consensus methods, carer).

“Is there a call for them being involved – no they shouldn’t be involved” (Beeches, first workshop transcript, p. 16, consensus methods, nurse).

Staff in some care homes felt residents who had had a stroke were treated differently because of their age.

“I also think it depends on what age you have your stroke. The girl who was interested in the group, the young carer who had had a stroke herself and actually has moved on and work in the hospital, she had all the help she needed to regain her life after she had had her stroke. It is not the case with older people” (First workshop transcript, p. 8, goal setting: manager).

Some care assistants however, seemed to suggest that they felt older people were not the focus of the tailoring workshops, as this care assistant suggests:

“As long as they are comfortable, happy and clean. But that is the elderly, but I know we are doing about strokes and all the younger people. What we are doing today, we are not doing about them ...” (The Beeches, first workshop transcript, p. 19, goal setting: carer).

A focus upon age, rather than rehabilitation potential can create a barrier to tailoring the stroke best practice recommendations and limit the resident’s individual potential.

6:3:1:1:2 Standards

Staff reported a history of documentation that identified individual need, but that these mechanisms had been replaced during organisational changes made to encompass identified risk and policy factors. These changes included the introduction of Intentional Rounding. Intentional Rounding was introduced following the Francis inquiry and is a structured process whereby nurses carry out regular checks, usually hourly, with individual patients using a standardised protocol. These hourly checks are usually to re-position, assess pain, personal needs and placement of items. The empirical evidence of its effectiveness is poor (Kings College, 2012). These changes were often designed to ensure minimal standards were met. Some care home staff felt this hampered individualised care, as this nurse explains:

“The carers used to write things that they had done and then we would write a paragraph (sentence or two) what we had done (carers had given medicine) and then that was stopped and now we have the **rounder** chart and the care plan being reviewed daily, in the past. But because of time restraints we were finding that people were copying things. Now we have got **rounder** charts it is quicker” (Sycamores first workshop, p. 18: Nurse)

“We keep that in the care plan and every day the rounding plan is put in the care plan and every week we have loads of these now they are put in their file” (Sycamores first workshop, p. 19: Nurse).

Care plans were reported as the mechanism for setting care standards and as a possible vehicle for implementing the tailored recommendations. Field notes recorded post workshop conversations where staff discussed how they were sharing learning from the workshops and adapting their care plans for residents to reflect this. Staff mentioned raising awareness of aspects of the stroke best practice recommendations several times and talked about how they were revising their care documentation to incorporate and highlight the recommendations they had tailored. Care assistants reported that they took their instructions from the care plans, as this care assistant explains:

“It’s in the care plan; go to the toilet or catheterised...” (Second workshop, p. 26; Bladder and bowel recommendations tailoring: carer).

Some care home staff reflected upon how care plans used to be more person centred, but they felt that was not as visible now. Some care staff felt that the need to be risk adverse was having an impact upon how care was planned and recorded, as this narrative during a discussion about person centred goals explains:

Nurse: “Old care plan, yeah I was just thinking that. It would be goals?”

Manager: “You have to be careful nowadays; realistic achievement of goals.”

Nurse: “We can’t bring things like that in it...”

Manager: “Careful what you write. Got to sort that out!” (The Oaks, first workshop, p. 9; Goal setting recommendations)

Belief in evidence used in practice can influence tailoring and motivation to tailor recommendations. The care home staff often seemed to suggest that their knowledge of the resident was overlooked, and care was prescribed from afar by other professionals

who were not working with the resident on a day to day basis. This seemed to leave the care staff feeling a miss trust in the care regimens prescribed by outside agencies. Care staff also indicated that at times there seemed to be a lack of compassion in these prescribed interventions, as this Registered Nurse explains:

“Physio came and gave him a big list, double sided, and said do this with him four times a day. And as she is showing me what to do, he is doing all this (hand gestures) he doesn’t want it as she is hurting him, because it is so stiff. She is doing this with the shoulder (hand gestures), she is hurting him and he doesn’t understand, he can’t express his fear! She comes back in and says have you done...” (The Oaks, first workshop transcript, p. 4; Goal setting: carer).

Demonstrating compassion was a key factor for some care home staff, especially when they felt that the resident had a poor quality of life. Some care home staff expressed a sense of helplessness when caring for residents whose stroke had left them severely disabled, as this nurse explains:

“This little old lady can’t consent. Even the PEG lady said ‘why are we stuffing the tube down...’

This lady is not living she is existing, when she is choking she can’t ask for help she can’t move her own limbs, if her head goes back she can’t bring it forward, what a terrible, terrible thing to put this lady through” (The Oaks, first workshop transcript, p. 15; goalsetting: nurse).

The debilitating consequences of stroke seemed to have an emotional impact on care staff and made some question their own mortality and morbidity, as the following narratives demonstrate:

“If you have a massive stroke and end up like some of our patients here, would you want us to intervene, you would say no! no!, but if you have a massive stroke it is going to happen because you can’t tell us.” (The Oaks, first workshop transcript, p. 14, goal setting: nurse)

“I have warned my kids – I will come back and haunt them, I don’t want them to do it.” (The Oaks, first workshop transcript, p. 14, goal setting: manager).

6:3:1:2 Feasibility

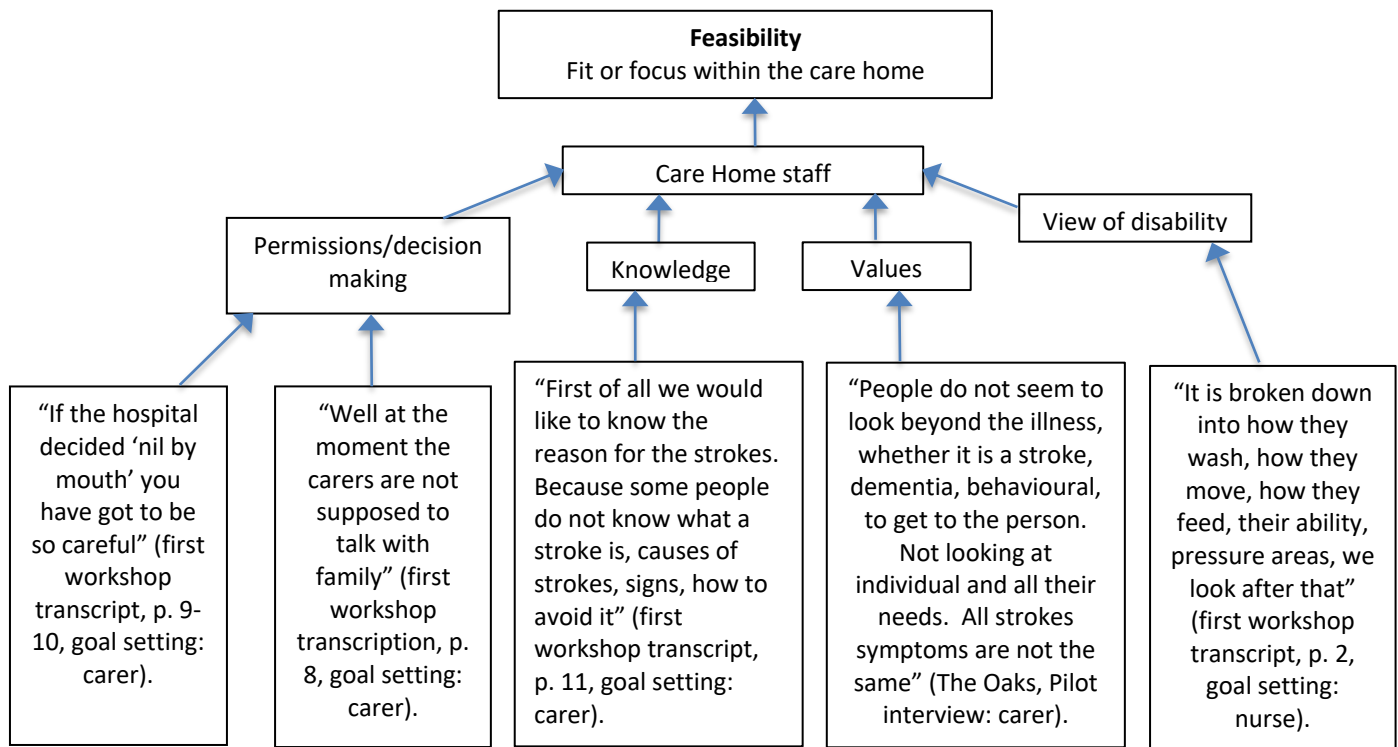


Figure 6.3: Feasibility: Care Home Staff

6:3:1:2:1 Permissions/decision making

Some care staff seemed to feel the care they could deliver was restricted by other professionals and they often seemed wary of the consequences of changing the care regimens of others. Furthermore, care home staff seem to suggest that limitations imposed by other stakeholder/professionals has the potential to restrict the scope of tailoring in the care home setting. A fear of the consequences as a result of transgressing from the regimen prescribed by other professionals was often put forward as a barrier preventing them from implementing best practice for residents. The following narratives suggest that deciding care interventions for residents with stroke was not always a collaborative process:

“I think there should be plans if they assess that they use a hoist at all times we are no longer allowed to try and stand them, not allowed, get into trouble it is very difficult to set any specific goals like that anymore.” (First workshop transcript, p. 2, goal setting: nurse).

A lack of collaboration with care home staff has the potential to disempower them and lead to inflexible interventions for stroke, which seems to reduce the resident’s potential post stroke rehabilitation choices.

6:3:1:2:2 Knowledge

The majority of the care home staff who attended the workshops were keen to know more about stroke. They felt they required more ‘training’, but were restricted due to resource implications, as these narratives explain:

“First of all, we would like to know the reason for the strokes. Because some people do not know what a stroke is, causes of strokes, signs, how to avoid it” (first workshop transcript, p. 11, goal setting: carer).

“We have had a bit through the Stroke Association but we cannot send everybody at once on courses. Three or four staff on it – that is it” (first workshop transcript, p. 11, goal setting: manager).

Care staff seemed unaware of stroke best practice guidelines, and whilst they expressed a desire to learn, their comments suggested that this process was not their personal responsibility.

“I would hate to make somebody worse, we need people to train us so we know what we are doing” (Beeches, first workshop transcript, p. 7, goal setting: carer).

“Usually we don’t get training we have to ask for it” (Sycamores, first workshop transcript, p. 9, goal setting: nurse).

Also, some care staff seemed unsure about whether they had had training or not:

“We have done stroke awareness before, haven’t we?” (Beeches, first workshop transcript, p. 29, goal setting: carer).

“No” (Beeches, first workshop transcript, p. 29, goal setting: carer).

“Thought we had” (Beeches, first workshop transcript, p. 29, goal setting: carer).

These narratives question the value of training. A more effective method of work based learning was explained by a carer who had moved from another care home:

“I can say XXXX if you worked here, how we work here – the carers do everything, and which I can understand. I worked in another care home, we had rehabilitation, we had physios coming in, I loved it because they showed us everything to do with certain people. I was shown, I knew what I was doing, but in here at the minute we haven’t been shown it...”
(Beeches, first workshop transcript, p. 30, goal setting: carer).

One care assistant however, felt that they should not have to learn more, because they were not paid well, whereas the Registered Nurses were educated and paid to reflect this. The following narrative highlights these feelings:

“I am on crap money. Yes, it is about the residents, cos it is, but I’m not bloody going to do training to be... I want it in my pay packet as well” (The Beeches, first workshop transcript, p. 28, goal setting: carer).

This care assistant was challenged by another care assistant who felt that:

“If you don’t want to learn – get out of the care system!” (The Beeches, first workshop transcript, p. 28, goal setting: carer).

This led to a discussion about the need for in-house training. Nonetheless, most care staff felt that they wanted to acquire an understanding of residents’ needs and consequent care. This care assistant sums this up:

“We need to know everything dementia, Alzheimer’s, stroke, swallowing difficulties, everything. We need to know because otherwise we haven’t got the tools, we can’t look after that person” (Beeches, first workshop transcript, p. 31, goal setting: carer).

A limited understanding around the scope of care has the potential to limit the scope of tailoring. Furthermore, workshop data suggests that within the care homes, the staff seemed to assume that rehabilitation of residents with stroke was someone else’s responsibility, often indicating that elements of stroke care were not within their scope of practice. This was evident when commenting upon the lack of physiotherapist and occupational therapist input.

“Don’t really do unless they have physio we don’t really do rehab. It just gets drawn into one big problem” (Sycamores, first workshop transcript, p. 12, goal setting: nurse).

“We see physio as being the rehab” (Sycamores, first workshop transcript, p. 12, goal setting: nurse).

“Then occupational therapist won’t come out. (Pause) G.P refers and they say they don’t come into private nursing homes. (Sycamores, workshop 2 transcript, p. 10; personal daily activities, referral to other professionals: nurse).

The lack of collaboration for stroke rehabilitation is an area for concern.

6:3:1:2:3 Values

Findings indicated that ‘Values’ was a key concept, which influenced tailoring and implementation of evidence-based practice. Care homes staff indicated that they felt it was important to value the individual, rather than focusing upon their stroke. Indeed, one workshop participant indicated that often a starting point for addressing values in the care home began by exploring care assistants’ views in relation to the elderly and discussing how elderly residents are individuals who have had similar experiences and aspirations in their youth, but were now at a different stage in their life journey. This workshop participant felt it was imperative that care home staff saw residents as people and not as just as older people:

“I think it is important to get the message across I am not just saying young staff –it is to everyone. Wrong word, wrong tone of voice, impatience it makes that patient feel, when they are so dependent on you, that they have lost their independence and dignity, we need to give it back to them as much as possible” (The Oaks, first workshop transcript, p. 14, goal setting: care home manager).

In addition, care home staff often struggled to apply condition specific recommendations to individual residents who often had complex needs with multiple co-morbidities.

“People do not seem to look beyond the illness, whether it is a stroke, dementia, behavioural, to get to the person. Not looking at individual and all their needs. All strokes symptoms are not the same” (The Oaks, Pilot interview: carer).

The notion of 'values' also applied to the care team themselves. Often care assistants seem to feel the amount of tasks performed within a given timeframe was valued over spending time getting to know the resident, as these narratives explain:

"Because we are very quick to judge people – what on earth have they been doing all morning because they have only done three – I do think we are very quick to judge" (Carer 1).

"We are" (Carer 2)

"It is not knowing what that person has actually been doing they you know it does not mean that she has been outside having a cigarette does it? She could have been spending a little more time with the patient, but I think looking at something else that has been coming up with all the 'powers' that be up there we do actually have to now put in our care plan if a patient does need extra time spent during activities of daily living" (Manager) (The Oaks, second workshop transcript, p. 27, personal daily activities).

Valuing current input from care team and mapping to tailored recommendations could enhance the impact and implementation of tailored recommendations.

6:3:1:2:4 View of disability

Some comments made by care home staff suggested that post stroke interventions were viewed in terms of physical functioning only, for example one care assistant explained that:

"Really speaking we are actually only making sure they are clean, being fed and not in pain and looked after" (The Beeches, first workshop transcript, p. 23, goal setting: nurse).

This narrative suggests a biomedical view of disability. Other comments however, suggested that care staff viewed quality of life more than biological functioning, but felt powerless to promote this view, as this nurse explains:

"But when somebody has had a very bad stroke and they end up with gastric feed or a PEG (Percutaneous Endoscopic Gastrostomy) we are not really able to participate in that decision" (The Oaks, first workshop transcript, p. 11, goal setting: nurse).

This Registered Nurse moves on to explain how distressing these decisions can be for the family, but that family decisions were not always fully informed:

“The relatives are so scared of losing mum/dad/whatever they do not realise the implication that they may never again be able to have a drink again, never eat again, they may possibly be bed bound, there are actual affects that a stroke has on somebody – no quality of life whatsoever. You know, and the decision has been made to keep that person alive by the relatives.”

This little old lady can’t consent. Even the peg lady said ‘why are we stuffing the tube down’...” (The Oaks, first workshop transcript, p. 11-12, goal setting: nurse).

Often the care home staff demonstrated empathy for the residents with stroke, and at times felt torn between the resident and the relative’s needs, as this Registered Nurse explains:

“It is harder for the family to accept what has happened to them and they tend to treat them like a child, although they have had a stroke a lot of them have still got it, they know what is happening to themselves” (The Sycamores, first workshop transcript, p. 17, goal setting: nurse).

Care home staff do nonetheless advocate for residents with stroke, and have to collaborate with other professionals in order to highlight their concerns with regards to quality of life issues, as this Registered Nurse explains:

“Once the tube is in, it is so difficult to stop, we have actually said now when the GP was here and everybody, we have actually said if XXXXXX is not a candidate to have a tube in her tummy that is fine, we have to decide what is in the best interest. What are we trying to achieve for this lady?” (The Oaks, first workshop transcript, p. 14, goal setting: nurse).

It is clear that the care home staff want to promote the resident’s quality of life, but often feel helpless when life prolonging intervention decisions are made. The consequences of these decisions seem to be a real cause for concern in some care homes.

6:3:1:3 Feasibility

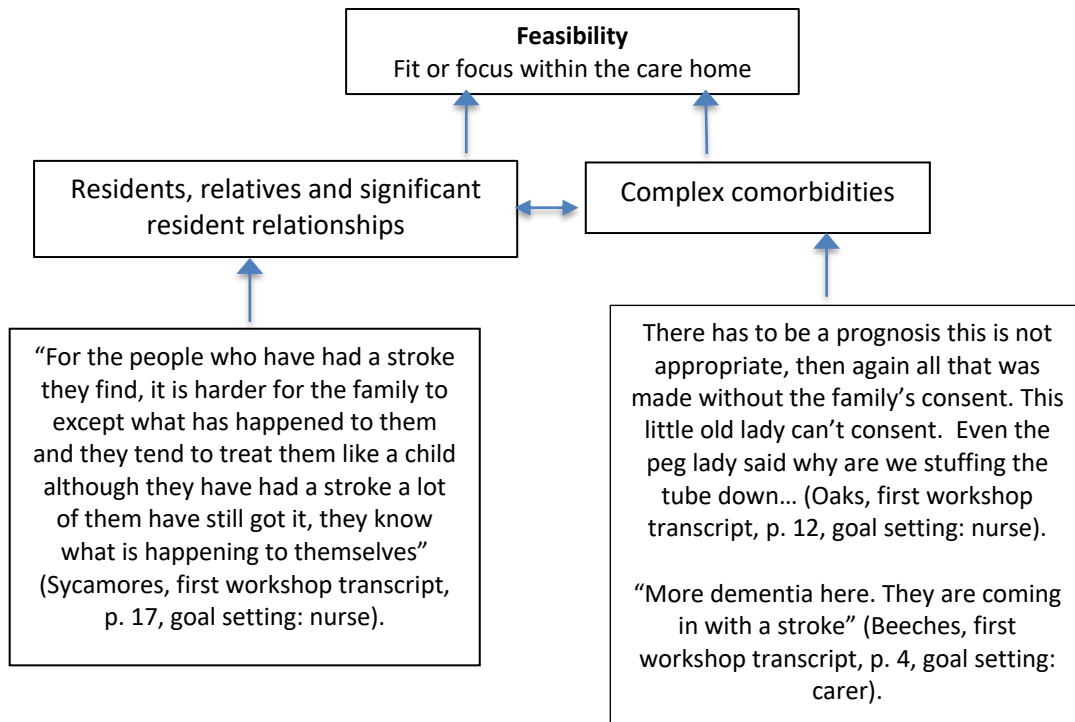


Figure 6.4: Feasibility: Residents, relatives. Complex comorbidities.

6:3:1:3:1 Residents and relatives

Data indicated that resident's expectations can create a barrier to care staff implementing evidence-based recommendations. As this care assistant explains the customer, service provider relationship can impede stroke rehabilitation:

"Sometimes they don't want to do anything, you know, they seem to be under the impression that they have come in to care – let them do everything that is why I am here" (Oaks, workshop 2, p. 2; personal daily activities: carer).

Expectations of residents can therefore, impact upon tailoring, and indeed upon the resident's motivation to rehabilitate following their stroke. Furthermore, the resident's view of living in the care home, and their expectations can also have an impact upon the resident, care staff relationship, as this care assistant explains:

“They are paying out of their pension – so I am paying for this and I want it yesterday, so it is more difficult” (Carer).

“Yeah” (Researcher).

“They are not all like that, are they?” (Carer)

“But it is like in life those that shout loudest get more!!!” (Manager)

“So shout – it’s right that is” (Carer) (Oaks, second workshop transcript, p. 24, daily personal activities).

This narrative also indicates that some residents may demand more of the care assistant’s time. Care staff often seemed ill equipped to deal with these dilemmas, but this also has the potential to restrict tailoring and the implementation of stroke best practice recommendations.

The emotional response of relatives to the impact of stroke, created dilemmas for care home staff. Dilemmas were in relation to the relatives’ expectations and a desire to keep their loved ones alive and to return them to their pre-stroke status. As this nurse explains:

“But is hard not to break their dreams. I kept saying wait and see if there is any improvement because I did not want to give her that straight. Time to move on, I think she has” (Sycamores, first workshop transcript, p. 18, goal setting: nurse).

Care home staff have to balance the resident’s needs and best interests with the expectations of relatives; these factors can also impact upon care home staffs’ motivation to tailor best practice recommendations. In order to commit to the tailoring process, the care staff will have to understand the evidence in the form of recommendations and be able to confidently discuss them with residents and their relatives. The consensus workshops were a good way to achieve this as they enabled the researcher and care home staff to unpack meanings and enabled care home staff to voice their opinions and concerns.

6:3:1:3:2 Complex co-morbidities

It is often hard for residents and sometimes care home staff who see the person, rather than the ‘stroke’. Care home staff often felt that all residents were different and as a result experienced stroke in their own unique way.

“Every individual is different, every individuals needs has different goals”
(The Sycamores, second workshop transcript, p. 9, activities of daily living:
nurse).

In addition, residents with complex co-morbidities make tailoring recommendations designed to be condition specific problematic, and again focus upon the ‘stroke’ rather than the individual resident.

6:3:1:4 Feasibility

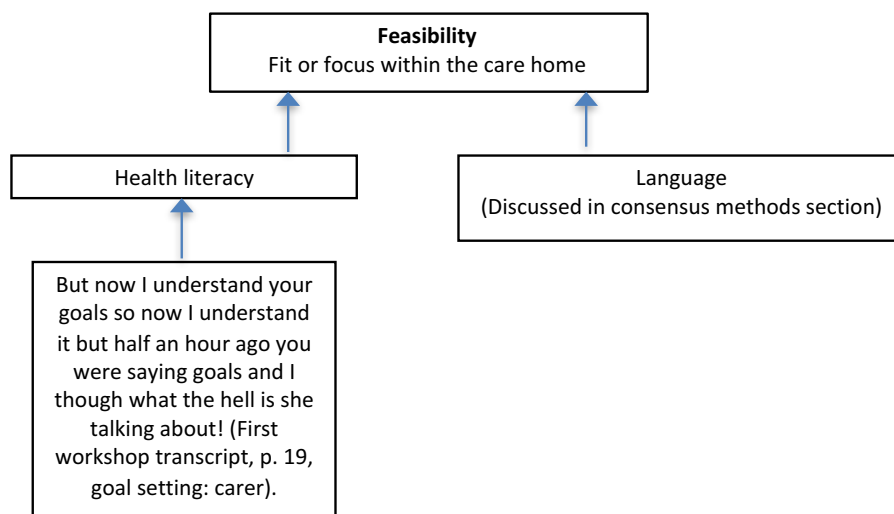


Figure 6.5: Feasibility: Health literacy and Language.

6:3:1:4:1 Health literacy

This aspect has also been explored during the analysis of the consensus methods, as understanding health terminology and health literacy is vital if national stroke recommendations are to be tailored for the care home context. But this understanding was not always present, and only through discussion did these health literacy factors emerge. Care home staff once they felt comfortable to have a frank and open discussion were able to highlight their lack of understanding, as this care explains:

“I think once we know it is a bit different, if we know what something means, it is just that we don’t come across it every day” The Beeches, first workshop transcript, p. 18, goal setting: carer).

6:3:2 Collaboration

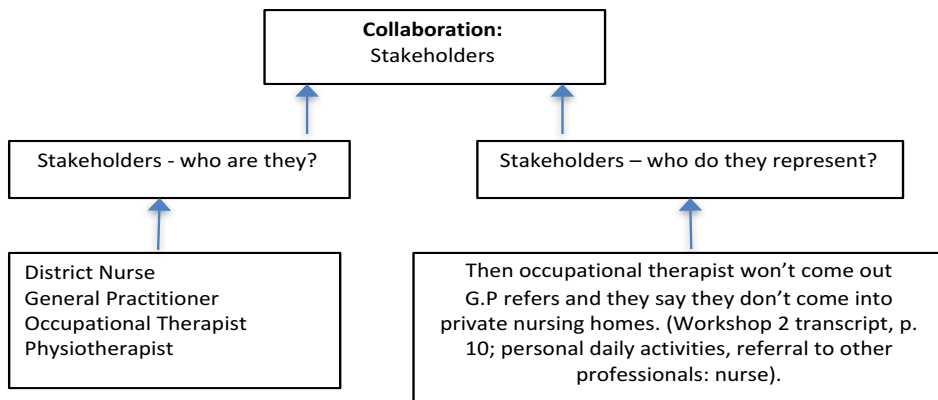


Figure 6.6: Collaboration.

6:3:2:1 Stake holders – who they are

Stakeholders identified by participants included, but was not limited to: district nurses, general practitioners, speech and language therapists, physiotherapist, occupational therapists, residents and their families.

Care home staff felt that some professional groups were more receptive than others to their involvement in decision making:

“I think district nurses would be quite receptive but GP’s maybe not because they are a different area. I think GP’s are a no, no” (The Beeches, second workshop transcript, p. 4, personal daily activities/implementing recommendations: nurse).

The impact of residents and families has been discussed throughout this data analysis section. As stakeholders, they were often viewed as customers, rather than partners. This

led to a more corporate approach to engagement, rather than a holistic needs approach, which aimed to coproduce stroke care interventions.

Other professional stakeholders, seemed to have separate organisational or professional agendas, which often led to misunderstanding rather than collaboration. An insight into this dilemma emerges from the following data analysis regarding who stakeholders represent.

6:3:2:2 Stakeholders – who they represent

Care home staff were motivated to deliver care that could enhance the quality of resident's stroke recovery, but often felt they lack the skills or were not involved in the rehabilitation process. They were keen to collaborate and learn from other professionals:

“But then you know physio really it should be ongoing to a certain extent and I see no reason why our staff can't be invited into a session with that resident before discharge so that we are given some guidelines, some training in what type of exercise would benefit them that person. You know again with OT the best way of letting this person do certain things safely, I think it should all change around and we should be involved in the discharge planning of patients, not just they have reached their full potential, there you go. Get on with it now and that's what we get” (Oaks, second workshop transcript, p. 14, further rehabilitation: manager).

“Yes, they should have some form of, like OT's coming in, physio show us how to do things, we don't seem to have anything like that here and I think we need it. Need physios to come in I think it would be rehabilitation – wouldn't it. Rather than them just coming into a care home and at the minute we are just a care home with elderly people” (The Beeches, first workshop transcript, p. 4, goal setting: carer).

Indeed, some care home staff felt under skilled and isolated, and were often afraid of causing harm, as this care assistant explains;

“Do really need to know what you are doing and with them coming out once to show you and go away, it is not perfect. Even yesterday I said to the physio reading it on a piece of paper how do we know if we are doing right? Frightened of hurting people you may been doing more damage, you don't know” (The Oaks, first workshop transcript, goal setting: senior carer).

The care home staff often indicated that other stakeholders were reluctant to collaborate with care homes;

“Then occupational therapist won’t come out. (Pause) G.P refers and they say they don’t come into private nursing homes. (Sycamores, workshop 2 transcript, p. 10; personal daily activities, referral to other professionals: nurse).

“We try and refer and they say they have already been seen. Some do it in their own time better than others. We try and refer but they say they have already been seen in hospital it is not appropriate” (Sycamores, workshop 2, p. 11; limitations with personal daily activities: nurse).

“OT no longer come in to nursing patients and that’s a new thing because they always did visit” (Oaks, second workshop transcript, p. 10, personal daily activities: carer).

Care home staff felt that stakeholders did not value their expertise, or their knowledge of the resident, as this Registered Nurse explains:

“We had a classic; gentleman came to us... Use of the toilet - Fallen off twice – had a stroke came from (name omitted) Ward, Stroke rehabilitation Ward – came to us, we are not using the stand aid cannot hold on, got no standing power ... Within a week his social worker came in and she saw is using the electric stand up and she said he has deteriorated in the five days since he came here, and I said no actually we feel it wasn’t safe to put him on, correct use of a stand aid you have got to understand the path, but she said it was assessed by the physio unit. I don’t give a ‘monkeys’ who he was assessed by I don’t feel it is safe!
I said he had fallen off the stand aid twice in the hospital, so there you go on your way...
You are battling – watch your back.
Big issue – stops people doing things. Going that extra mile
Sad really. Impact on patients” (The Oaks, first workshop transcript, p. 32-33, goal setting: nurse).

These narratives highlight the need for engagement and collaboration of all involved in implementing stroke interventions. Stakeholder appeared to be constrained by organisational boundaries, and as a result the resident and their rehabilitation potential was not the key care driver.

In addition to better collaboration in order to acquire work based learning and skills from other professionals, one care home manager felt that care home staff should be more engaged in the discharge process from acute sector to care home, in order to get a greater depth of understanding of the stroke intervention needs of the resident:

“But then you know physio really it should be ongoing to a certain extent and I see no reason why our staff can’t be invited into a session with that resident before discharge so that we are given some guidelines, some training in what type of exercise would benefit them that person. You know again with OT the best way of letting this person do certain things safely, I think it should all change around and we should be involved in the discharge planning of patients, not just they have reached their full potential, there you go. Get on with it now and that’s what we get” (The Oaks, second workshop transcript, p. 14, further rehabilitation: manager).

Other care home staff expressed frustration at the lack of collaboration between other professionals and the perceived lack of consistency in the advice given with regards to the resident’s rehabilitation, as this carer explains:

“They come out. There is the list you do! That’s what the community physio does. Then you don’t see then for six weeks! Then someone new comes in and they do something different and you think, well...” (The Oaks, first workshop transcript, p. 7, goal setting: carer).

These narratives further suggest that professionals seem focused upon organisational demands, rather than the person-centred needs of the resident with stroke.

There was also a notion of hierarchy within the relationship with other stakeholders, and often care home staff felt that they were unable to alter care regimens prescribed by other professionals, which led care home staff to express concerns with regards to making decisions about care, as this Registered Nurse explains:

“Got to be careful these day. Careful what you write. If the hospital decided ‘nil by mouth’ you have got to be so careful. Can’t do anything, but in the past, we would try a little bit on a piece and if we could see them swallowing we would work on it and call them back in when we got a bit of details – results. You are frightened of doing anything now.” (The Oaks, first workshop transcript, goal setting: nurse).

This insight further emphasises the need for collaboration when decisions about the resident’s care and abilities following a stroke are made.

6:3:3 Tailoring in action

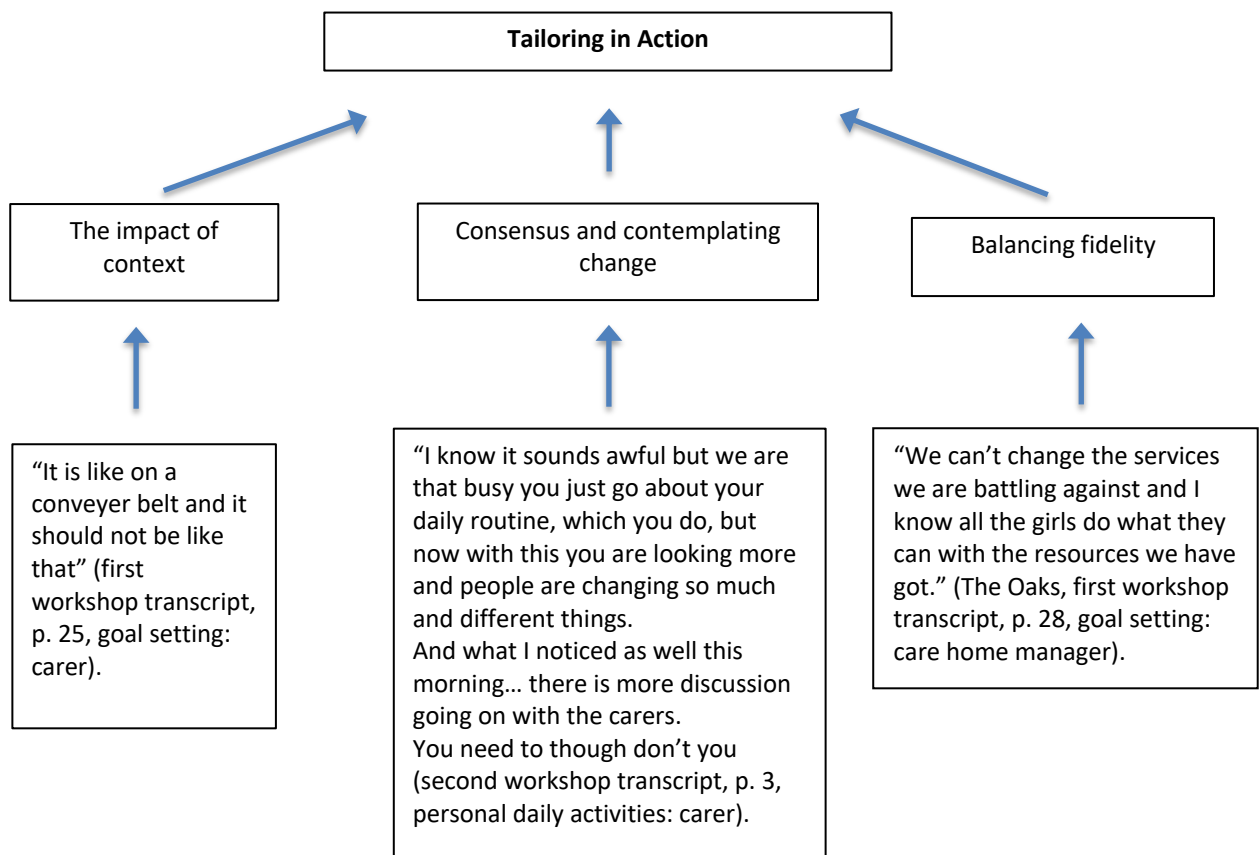


Figure 6.7: Tailoring in Action

6:3:3:1 The impact of context

The context in which tailoring takes place and the factors that interplay in that context have considerable upon the tailoring process and care home staffs’ motivation to engage. A perceived lack of resources, especially time resources, reduces motivation to tailor best practice recommendations

“Not being disrespectful but we would not have the time” (The Oaks, first workshop transcript, goal setting: nurse).

Analysis of the factors impacting upon tailoring in the care home context indicate that tailoring involves motivated leaders who adopt a transformational approach to change, co-production with care home staff, effective collaboration with all stakeholders. Also, leadership involved role models who promoted person centred care, an example of this was a care home manager who suggested the following;

“Wrong word, wrong tone of voice, impatience, it makes that patient feel, when they are so dependent on you, that they have lost their independence and dignity, we need to give it back to them as much as possible” (first workshop transcript, p. 14, goal setting: care home manager).

Leadership also played a crucial role in recruitment of study participants. All care home managers were motivated to engage in the study, and although not necessarily aware of their approach to leadership, all displayed different leadership traits when engaging staff. One manager was very wary of upsetting care home staff and did not want to participate until the care home staff had attended the rolling programme and agreed to go ahead. Other managers were more transformational and encouraged staff to engage, and enabled staff to attend and self-select. One manager told staff on duty to attend, thus removing the element of self-selection. These staff were still given the opportunity to opt out during the consent process, and those who remained were very guarded and often provided little insight into their role. Self-selected participants on the other hand spoke freely and very quickly built a rapport with the researcher.

Researcher field notes suggested that recruitment to the tailoring consensus groups may have influenced care staff readiness to share their views and as a consequence the data collected in relation to tailoring in action. In one care home, the manager was very enthusiastic and keen for staff to engage and sent staff on duty to the workshops; these staff were not given a choice, although they were happy to sign consent forms and to remain in the workshops, they were at times reluctant to engage in tailoring and share their experiences and views. Field note extracts comment upon: ‘very quiet staff, who were reluctant to engage and share their experiences’ in discussions about tailoring the evidence-based guidelines to their care context; and that ‘carers seemed to constantly defer to the nurse’.

As previously discussed the culture within the care home impacts upon the delivery of day to day care, but also influences the ability of the care home staff to engage with tailoring. Nonetheless, the care home staff seemed motivated to tailor the stroke best practice recommendations and there was evidence to suggest that they had been raising awareness throughout the care home.

6:3:3:2 Consensus and contemplating change

The consensus discussions to tailor the stroke best practice recommendations appeared to have raised awareness around the stroke best practice recommendations. During workshops, reflexive discussions took place with regards to how changes in the care homes had impacted upon care assistant's time and how legislation and revised local regulations were felt to impede rather than promote individual care. Some care homes had had discussions with staff not at the workshops in relation to creating a fit within their day to day routines in order to implement the stroke best practice recommendations. Some care homes were already considering how changes in practice might be implemented and identifying suitable vehicles for change.

6:3:3:3 Balancing fidelity

Often care staff felt that their residents were different and often had other conditions, which led to a complex set of needs, which often did not focus upon stroke alone. As a result, the debilitating consequences of stroke and multiple complex comorbidities has the potential to impact upon scope of tailoring recommendations. Care staff struggle with the concept of recommendations about a specific condition, when often the resident had multiple comorbidities, as these narratives explain:

“Some peoples stroke are different to each other” (The Oaks, first workshop transcript, p. 1, goal setting: carer).

“More dementia here. They are coming in with a stroke, so nine times out of ten, like xxxxx said, they can't compute because of the dementia.” (The Beeches, first workshop transcript, p. 4, goal setting: carer).

These narratives highlight the importance of a belief in the evidence, for example if the care home staff feel the stroke best practice recommendations do not apply to residents they will be less likely to engage in tailoring them to this context. In addition, this will

create a barrier to implementing recommendations into their practices. As a consequence, the tailoring process should be mindful of these potential barriers and ensure the process is inclusive, rather than exclusive of these factors. This in turn has the potential to reduce the fidelity of the original stroke best practice recommendations. Nonetheless, it is essential to create a balance, which respects fidelity, but focuses upon the care home context and the unique requirements that people residing in this context have.

As discussed earlier the customer, provider relationships also has an impact upon how the evidence base for stroke can be implemented. A need to balance the fee paying resident's expectations with their rehabilitation potential is complex and can create barriers to implementing the tailored best practice recommendations.

Belief in evidence used in practice can influence tailoring and motivation to tailor recommendations. Care home staff gave examples of when they had used evidence to enhance care and could as a result see the benefits,

“Because you look at that old lady over there we have had her treated for stress and depression but it didn't go into her care plan until after we said I am sure this lady is depressed and it was, oh dear, and there has been a huge improvement in her confusion and moods and everything else since she has had antidepressants, she is really happy now – settled” (Oaks, second workshop transcript, p. 7-8, depression and anxiety: carer).

This helped to rationalise the evidence-based recommendations and as a result the tailoring process. Using reflective practices and scenarios therefore, can help facilitate the tailoring process to create a fit for the care home context. Moreover, the enthusiasm to learn, displayed by the participating care home staff, enhances potential within tailoring process. Care staff expressed a desire to learn more about stroke in order to safely meet residents need, as these narratives explain:

“I would hate to make somebody worse, we need people to train us so we know what we are doing” (Beeches, first workshop transcript, p. 7, goal setting: carer).

“We need to know everything dementia, Alzheimer's, stroke, swallowing difficulties, everything. We need to know because otherwise we haven't

got the tools, we can't look after that person" (Beeches, first workshop transcript, p. 31, goal setting: carer).

Motivation to enhance stroke interventions for residents, and an enthusiasm to engage in this study suggests that care home staff have the potential to implement stroke best practices in this care context.

6:4 Chapter summary

This chapter presented findings which indicated that tailoring in the care home context was driven by the need to create a fit with day to day care home life. Initial data analysis provided an insight into day to day life in the care homes. Stroke interventions were quite generalised and care seemed to be organised to meet activities of daily living, with a focus upon biomedical functioning. Care home staff were often unaware of the intercollegiate best practice recommendations. Rehabilitation was often seen as someone else's role, and not the responsibility of the care home staff. Engaging care home staff in workshops to tailor stroke best practice recommendations enabled them to share their views with regards to the relevance for the care home setting. In addition, care home staff were able to identify influencing factors to the adoption of the tailored recommendations into their day to day practices. Analysis of findings uncovered three grand themes: feasibility, collaboration and tailoring in action, which were context specific. These grand themes were dependent upon several sub-elements, which together enabled the construction of a conceptual map of tailoring (figure 6:1).

Feasibility or creating a fit, was dependent upon several factors. Organisation level factors, where the day to day care home business and organisational standards influenced the ability of the care homes staff ability to tailor guidelines. Findings indicated that existing routines and standards had the potential to limit tailoring, and to create barriers to implementing stroke best practice recommendations. The corporate business model also had the potential to create a misfit with the resident's view of service provision and the need to rehabilitate and promote independence.

At an *Individual level* tailoring was influenced by care staff awareness of the best practice recommendations and their desire to seek and implement new knowledge. Care staff

appeared motivated to acquire knowledge, but did not always seem to see this as their responsibility. How care staff valued residents and each other also has potential to impact upon tailoring.

The salient language used within the care home, was the driving force behind the tailoring of the best practice recommendations. Care staff were uncomfortable with some of the written language used in the intercollegiate stroke best practice recommendations. A collaborative approach using group consensus, enabled care staff to ask for clarity and to tailor the language to their day to day parlance. This process also served to familiarise care home staff with the recommendations and enabled them to consider and discuss the factors that would influence their use in their care home setting.

Relationships with residents and their families was often mentioned by care home staff. Care home staff were keen to involve families, but at times seemed to be torn between the best interest of the residents and the families desire for their loved ones to recover. This has the potential to create a communication void, where tailoring could lose its focus.

The *values* held and expressed by care home staff seemed to influence their motivation to tailor the stroke best practice recommendations. And also to implement in their day to day practices. Some care staff expressed views that the recommendations did not apply to the elderly. Other staff expressed views suggesting that they were not valued or paid enough to develop the knowledge and skills to implement the best practice recommendations. Furthermore, care staff often felt that their expertise and knowledge of the resident was not valued by other professionals outside the care home.

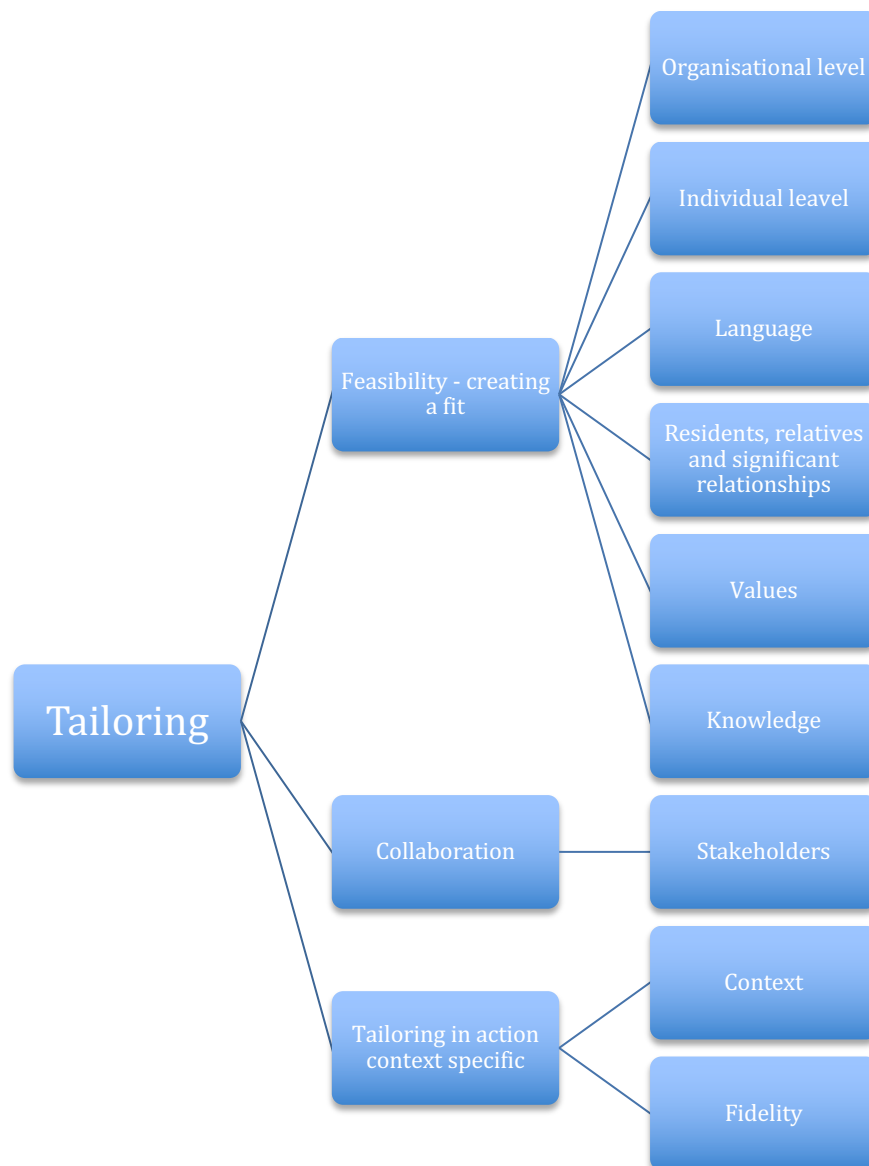


Figure 6.8: A conceptual map of Tailoring:

How care staff accessed their knowledge about stroke was often quite vague with the majority of staff saying they used the internet but struggled to add detail to this. Staff often indicated that training was not seen as their responsibility. Knowledge acquisition and use in practice differed for care assistants depended upon where they worked. Care assistants who worked on the nursing units suggested they did as the Registered Nurse instructed them to. Whilst care assistants who worked on the residential units seemed to actively seek knowledge to solve day to day problems.

Findings from this the consensus workshops and tailoring constructs will be further analysed in chapter 7.

Chapter 7

A process map of tailoring

7.1 Discussion

This study adds to implementation research knowledge by the creation of new knowledge about Tailoring in Action. This research examined the process of tailoring in action in a specific and hitherto under researched context; care homes. The resulting theory builds to a map of the tailoring process (Figure 7.2, p,193), whilst identifying the tailoring attributes required for tailoring to be executed in a given context.

Within this implementation study, the process of tailoring facilitated the questioning of current custom and practice in care homes through face to face interviews with care home staff. The interview findings and subsequent analyse in chapter 5 informed the data collection and analysis within the consensus workshops, where care home staff tailored existing stroke best practice recommendations to create a better fit to the care home context. The following discussion will draw these findings together to explore and build theoretical constructs of tailoring in action.

This discussion section unpacks, using study findings, the challenges faced when using tailoring in action to adapt evidence to coproduce implementation strategies that can maximise impact, whilst creating a fit with cultures and routines of the local context. The initial interview data generated during this research study created a picture of stroke care in the care home context, along with insights into the factors that might influence the readiness of the care home staff to tailor and implement evidence for stroke best practices. Furthermore, by introducing and adapting evidence, in this case national stroke best practice recommendations, this case study facilitated an in-depth examination of tailoring in action, and the factors that made up and influenced tailoring. The theoretical constructs of tailoring to advance knowledge of this approach within the field of implementation research will now be discussed in order to arrive at a process map of tailoring in action.

The specific Implementation of the tailored recommendations was not examined within this study, as the primary focus was upon the process of tailoring to a given context and preparing for implementation. Whilst this limitation is acknowledged, implementation within this study was not a one-off event, but rather a complex, reflexive journey which took time to prepare for and involved a multifaceted tailoring process before the final stage of implementation was attained. The following discussion sheds new light upon the process of tailoring in action as an implementation research mechanism.

7.1.1 Feasibility: creating a fit to the local context

The successful use of evidence is mediated by contextual factors including: workplace and organisational cultures, teamwork and day to day custom and practice (Rycroft-Malone et al. 2004; Kent & McCormack, 2010). One product of tailoring was the adaption of evidence to the local context to create a fit to day to day practices. Creating a fit involved tailoring to consider context specific needs and priorities, such as legislation, policies and resources (Harrison, Graham & Fevers, 2013). Findings indicated that several factors at 'organisational level' 'individual care staff level' can influence this process and as a consequence have an impact upon the successful outcome of tailoring or otherwise. In addition, the language used, the influence of residents, relatives and significant relationships, along with the values and knowledge held by the care staff further influenced tailoring and staff readiness to implement stroke best practice recommendations. These factors were integral to the construction of a conceptual framework for tailoring in action and are worthy of further discussion.

7.1.1.1 Organisational level

Within the field of implementation research the impact of organisational factors is already known (McCormack et al., 2002; Ploeg, Davies, Edwards, Gifford & Miller, 2007; Solomons & Spross, 2010). Analysis of the factors impacting upon tailoring at organisational level indicated that tailoring requires motivated leaders who adopt a transformational approach to change, co-production with staff, and effective collaboration with all stakeholders. Similar findings from the implementation research literature (Everett & Sitterding, 2011) support the need for transformational leadership, which has the potential to facilitate implementation efforts by promoting a strong climate for

implementing evidence-based practice and positive attitude toward adoption and use of evidence-based practice.

The impact of leadership within this research was evident when analysing the differing management approaches to engagement in tailoring in action during the course of this study. The approach of the care home manager to engagement influenced the level and type of engagement in tailoring in action from care home staff and consequent data collection. Most staff attending the workshops were happy to discuss their views when tailoring the evidence, but some seemed more reluctant. Tyler and Lind (1992) and more recently Storey and Holti (2013) suggest that team members will be influenced by the behaviour of leaders and often examine leader actions for information about what is expected and acceptable in team interactions. A transactional, more authoritarian approach has the potential to lead to a reluctance from team members speaking up and engaging in group discussions (Nembhard & Edmondson, 2006).

Discussion is vital to the process of tailoring in action to gain consensus in order to adapt evidence to a given context. Chen, Reid, Parker and Pillemer (2013) explain that the end users of the tailored evidence are likely to have insight into the concerns of participants regarding the program that are not apparent to researchers and program developers. Without free discussion, a tailored fit to the day to day working environment will be put at risk. The process of tailoring therefore, can only be enhanced if leaders create an environment where team members can share experiences and ideas in order to co-create evidence adaption to their day to day work context (Storey & Holti, 2013). Local leaders therefore, are best placed to minimise organisational barriers to tailoring in action by promoting collaboration (D'Amour, Goulet, Labadie, San Martin-Rodriguez, & Pineault, 2008).

True collaboration around the implementation of guidelines requires full engagement. Indeed, Dunham-Taylor (2000) found that the ability of staff to engage in effective group work decreased when leaders used transactional leadership. Engagement is thought to be higher in health care organisations where leaders create a positive climate for staff, so they feel involved (Dawson, West, Admasachew, & Topakas, 2011). Nevertheless, this transactional leadership approach did seem to ensure care staff carried out instructions in

terms of operational delivery. In addition, Wensing (2017) suggests that hierarchical power can help to increase the fidelity of practices which represent implementation of the best available evidence, whilst Aarons et al. (2015) suggest that transactional leadership can be effective in providing the support staff require to complete daily tasks. This style of leadership might therefore be very effective to ensure the day to day running of a care home, along with the implementation of the organisational agenda, especially given the transient nature of the care home workforce. The very nature of the care home workforce may create barriers to more transformational leadership styles, which appear crucial to supporting implementation generally, and tailoring specifically. Nonetheless, a study by Tourangeau, Cranley, Spence-Laschinger and Pachis (2010) examining leadership and working environment for staff in long-term care found that care homes were more likely to retain staff if they foster a positive work group cohesion, support and acknowledge staff accomplishments and minimise burnout. Whilst Castle and Decker (2011) found that consensus leadership style had an association with better quality in care homes. The leadership traits within a specific context therefore, can have an impact upon the process of tailoring (Tacia, Biskupski, Pheley & Lehto, 2015; Wensing, 2017).

Findings from this study do however indicate that tailoring in action, whilst challenging at times, is a good implementation process to enable the engagement of staff regardless of leadership and management traits but can nonetheless be influenced by the organisational leadership and management styles. Indeed, Wensing (2017) found that the role of managers was crucial when tailoring programs for chronic disease interventions. Practitioners and researchers using tailoring in action should be aware of these potential influences and modify consensus approaches to ensure they are sympathetic to the local context and to maximises staff engagement in the process.

Findings also suggest the influence of the care home business model, along with the influence of regulators and policy drivers was quite complex and meant that the residents stroke rehabilitation needs often were not necessarily a priority. This has the potential to restrict, rather than develop care home staff confidence to tailor stroke recommendations, as they seemed to focus upon inspection criteria, rather than specific best practice recommendations for residents with stroke. This potentially, puts the

tailoring of best practice recommendations outside the regulatory requirements at risk, and as a result, the quality of the resident's stroke interventions in jeopardy.

Organisational influences such as the need to be risk adverse, and local protocols designed to ensure minimal standards are met, also have the potential to hamper tailoring in action by diverting emphasis from stroke best practices to organisational targets. Furthermore, findings indicated that a history of change, which is perceived as less beneficial, such as historical documentation that identified individual need, being replaced by intentional rounding, as indicated in the findings, which delivers minimal standard care to all residents (Kings college, 2012). The evidence to support the implementation of intentional rounding however, has yet to be produced (Snelling, 2013). This example also highlights a barrier to tailoring, and indeed to implementation in general, of weak evidence, which end users cannot see benefits practice or residents (Rycroft-Malone et al., 2004). Furthermore, this routinized practice had the potential to limit the opportunity to tailor best practice recommendations to an individual resident's plan of care. These findings also infer the potential risk for drift between the agreed evidence used in practice and practice over time, where the evidence becomes diluted or replaced by the implementation of local protocols, which are not grounded in evidence.

A policy focus upon dignity in care, whilst important, meant that care homes often focused upon regulatory requirements, rather than the resident's stroke rehabilitation requirements, which seemed to reinforce routines and rituals, which led one staff member to describe the care delivered like a conveyer-belt. Regulators should consider integrating best practice recommendations for stroke into their inspection criteria, this would place an emphasis upon evidence-based practice, rather than more generalist criteria. These extended context issues highlight the complexities of a given setting and must be taken into consideration when tailoring in action in a given context. These findings do nonetheless, highlight the benefits of the pre-tailoring interviews to examine everyday practices prior to commencing the tailoring process. Tailoring in action can then move on to create a fit to existing models of delivery in the targeted setting (Harrison et al., 2010), in order to minimise user ambivalence and barriers to evidence adoption in day to day practices.

7.1.1.2 Individual level

During the analysis of the workshop findings it was evident that care home staff seemed to be motivated to implement learning from workshops, staff mentioned raising awareness of aspects of the stroke best practice recommendations several times and talked about how they were revising their documentation to incorporate and highlight the recommendations they had tailored. These actions and interactions highlight the value of awareness raising to enable staff to become more aware of factors which might influence implementation, as found by Perry and McLaren, (2003). Reflections from staff discussed during the workshops indicate that care home staff were considering mechanisms that could facilitate implementing the tailored stroke recommendations, such as negotiating with the care team in relation to what this might involve, which suggests that staff adopted tailoring in action to help them to consider the conditions within their work context and the social and physical environmental structures that needed to be in place in order to implement the stroke best practice recommendations (Middleton et al. 2011; Perry & McLaren, 2003; Wright et al. 2007). Using the workshops to help care home staff consider how they might implement the recommendations into their day to day practices required more than access to new knowledge, it required them to consider existing and necessary skills to integrate knowledge pertaining to the recommendations into the resident's care experience (Higgs & Jones, 2000). Indeed, this study would support the findings of Middleton et al. (2011) and Wright et al. (2007) who concluded that engaging with the end users of the new knowledge enabled them to tailor the knowledge for the local context, which in turn led to a more successful implementation of the evidence. This is a clear indication of the active nature of tailoring in practice and highlights that tailoring sits at the interface of evidence and context rather than being used merely as a tool to tailor evidence and establish barriers and enablers in a given context. Tailoring is therefore, a fluid multifaceted phenomena, which can be used as a one-off process or a series of processes designed to create the best fit between evidence and the care home real world context.

It is possible that some care home staff saw the best practice recommendations as an extra burden creating more work, or as a threat to their autonomy within existing working practices, as findings report several narratives with regards to a lack of time

(Damschroder et al., 2009). The lack of time resources was mentioned in all workshops, as was a focus upon day to day task completion. The Cavendish Report (2013) found that an emphasis upon the completion of tasks rather than individual need influenced the quality of care outcomes, as one interviewee commented:

“We value compassion and personal skills. But you can train that out of people if you insist too much of doing things in a certain way, feeding everyone at a certain time or taking everyone to the toilet after every meal is not respecting the individual or their dignity.” (Care home manager Cavendish Report 2013, p. 42).

Similar findings emerged from this data, which indicated that time and valuing tasks over individualised needs seemed to cause care staff frustration. A desire to address the current care culture is required in order to enable staff to engage fully in tailoring in action, as a failure to tailor current practices to enable adoption of evidence-based interventions for stroke, will reinforce a focus upon tasks rather than the resident’s person-centred stroke interventions.

Tailoring enabled care home staff to identify their existing practices and required knowledge needs. Many care assistants expressed a need for further training and education around stroke and the causes of stroke in order to deliver evidence-based care for residents with stroke. Care home staff also felt that training and education around stroke should be based in house and deal with the needs of residents, and not necessarily be guideline driven. Excerpts from field note reflections record conversations about how care homes could access e-learning. The care home staff did not like the idea of e-learning packages or studying in their own time. These findings have implications for planning how care home staff engage in education and training and the way they develop their knowledge and workplace cultures. This aspect, highlighted whilst engaging in the tailoring process points to a wider, additional context specific output of tailoring.

7.1.1.3 Language

Language and health literacy has the potential to promote or restrain implementation (Lambert et al., 2014). The use of, and often misunderstanding of, healthcare language has the potential to create barriers to tailoring stroke best practice recommendations and also to limit resident’s outcomes (Easton, Entwistle & Williams, 2013). Whilst often

reported as a barrier for patients, findings indicated that language, or a misunderstanding of terms used within best practice guidelines, can create a barrier to staff engaging in tailoring. Care home staff narratives seemed to suggest that rehabilitation was not their responsibility. Often when trying to unpack their thoughts care home staff would indicate how they dealt with the emotions of residents, families and friends, as well as sharing how they got around a lack of equipment for residents with stroke in order to prevent the resident or family having to buy equipment. They did not however, see this as rehabilitation, indicating that clarity and understanding of key terms is required. Engaging staff in tailoring not only highlights these barriers but offers the opportunity for clarity and adaption to overcome barriers. Throughout this research the staff engaged in tailoring in action would often, following a discussion about the evidence, comment upon how they were already carrying out aspects of best practice in their day to day roles, but were unaware of this. The process of tailoring in action enabled them to make some of these links.

7.1.1.4 Residents, relatives and significant relationships: keeping everyone happy

The business model and the notion of a resident being a customer seemed to have an impact upon the care assistant and their relationship with residents. Data analysed indicated that some care home staff perceived residents as wanting to get their monies worth, but this may have a counterproductive impact upon their stroke rehabilitation journey. The customer-provider model also impacted upon care home staff ability to balance the resident's needs and best interests with the expectations of relatives. As a result, there seemed to be a need to keep everyone happy, rather than focusing upon rehabilitation needs. Care staff need to be educated and supported in order to confidently discuss relevant stroke interventions and realistic outcome potentials with residents and their relatives.

The need to balance the fee-paying resident's expectations with their rehabilitation needs is complex. Bowers et al. (2001) found that care home residents who conceptualised care as purchased service rooted their expectations in terms of value and work performed. This perception of living in a care home has the potential to cause conflict with stroke rehabilitation principles which promote re-enablement and self-care. As a result, there is potential for the fidelity of the recommendation to be jeopardized by the need to appease

customers and the resident's rehabilitation would be put at risk. Tailoring as a consequence would be put at risk, as creating a fit here is more about a customer care model than adapting evidence-based recommendations. Effective tailoring in these circumstances would require unpicking of these factors and an emphasis upon educating residents and their families about stroke and stroke rehabilitation by care home staff in order to engage in the stroke rehabilitation journey where feasible. This is an area of care home context which is poorly understood but has the potential to influence many resident outcomes and quality of life factors, and to limit the fidelity of tailoring.

7.1.1.5 Values

A real concern for many stroke survivors is what is perceived as arbitrary rationing (The Chartered Society of Physiotherapy & The Stroke Association, 2010). This includes those who live in care homes. It is therefore essential that all decisions are based solely on the stroke survivor's need, not on where they live, their age or the resources available (The Chartered Society of Physiotherapy & The Stroke Association, 2010: p. 8). Findings from both the face to face interviews and the consensus workshops highlighted that care home staff expressed frustration at the inequity they felt in relation to elderly stroke care. Many care home staff suggested that because residents with stroke were in a care home they were less likely to receive interventions to minimise the effects of stroke. Here it is societies view of older people and care homes that has the potential to create barriers to tailoring the evidence for stroke to the care home context.

Care home staffs' view of age and the resident's perceived potential, also had the capacity to reduce the desire to tailor best practice interventions for older residents with stroke.

The Centre for Policy on Ageing (2009) define ageism as

“an attitude of mind that gives rise to age discrimination, may be *direct* when an older person is treated differently solely because on their age, or *indirect* when an older person is disproportionately disadvantaged by a policy or set of actions equally and universally applied” (P.11).

Findings indicate that some care home staff perceived frail, older residents as being in need of care and not willing, or able to participate in opportunities to limit the impact of stroke. Other care staff seemed to indicate that residents with profound disabilities

following their stroke were difficult to engage with. Research suggests that often rehabilitation interventions are not focused upon residents with greater levels of disability and higher levels of need (Fletcher-Smith, 2015; Smithard, 2017). The frailty of some residents does indeed require specific tailoring of the evidence to meet their needs. Indeed, this emphasises a limitation within the best practice guidelines, which fail to acknowledge frailty and assume that 'one shoe fits all'. Furthermore, Fletcher-Smith (2015) found that residents with dementia received less therapy input than those with mild cognitive impairment or normal cognition. Indeed, very few residents had one chronic condition, such as stroke, many had several and most had complex needs. As a result, tailoring best practice recommendations for stroke, for many residents was to miss the point and could limit the ability of the care staff to provide holistic interventions that were tailored for the individual. Implementing condition specific recommendations therefore has the potential to create barriers to tailoring care to meet resident's individual needs. Tailoring can however, enable staff to identify these issues and to adapt the evidence to better suit the needs and abilities of specific groups and individuals. This conflict between recommendation tailoring and tailoring for the individual is interesting; but as care home staff develop their skills in relation to tailoring this could potentially enhance the relevance of care interventions.

Baker et al. (2015) concluded that tailored interventions were more likely than non-tailored interventions, to improve evidence use within practice. The degree to which practitioners tailor at an individual level is however often unclear. Study findings indicated that some participants were using the information from the tailoring workshops to plan implementation of the evidence into day to day practice. These are what Wright et al. (2007) described as the 'added bonuses' of tailoring. In doing so however, they were at risk of further tailoring the evidence, which has the potential to endanger the fidelity of the original evidence. Nevertheless, Beck et al. (2010) found that tailoring interventions based critical characteristics enabled more person-centred interventions, whilst maintaining intervention fidelity. This suggests that ownership of the tailoring process and it's use at local level has the potential to enhance implementation. It also highlights that once the concept of tailoring has been adopted by practitioners it can used independently within a given context.

7.1.1.6 Knowledge and knowledge use

Engagement in tailoring was at times influenced by the perceived benefits and threats to the care staffs' current norms and values. Individual beliefs and a lack of knowledge or understanding about specific evidence such as best practice guidelines can result in resistance to implementing evidence-based practice (Borggreve & Timen, 2015; Fischer, Longe, Klose, Greiner & Kraemer, 2016). Tailoring best practice guidelines to create a fit to the local context, therefore offers the practitioner, facilitator or researcher the opportunity to explain the purpose and content of the guideline recommendations and enables the end users, in this case care home staff, to discuss and adapt the recommendations to create a better fit to their day to day practices. Flottorp and Oxman (2003) and Harrison et al., (2005) found that tailoring can transform existing evidence for use in a particular practice setting to enhance implementation outcomes.

This study found that day to day practices were built around a culture of custom and practice, which can create barriers to tailoring as this could be seen as a threat to the work place status quo (Nutley et al., 2003; Brady et al., 2011). For some participants, the need to be 'better' than other care homes seemed to incentivise tailoring despite the potential threats to current custom and practice. A review by The Health Foundation (2011) concluded that competition may improve clinical outcomes and costs, but may also impact negatively on professionalism, access and equity and cause fragmentation. The key driving factor within this study, however, was the participants desire to improve care for residents with stroke.

Some data suggested that staff were reluctant to carry out rehabilitation regimens prescribed by other professionals due to a fear of doing harm. Narratives within the findings report staff expressing concerns about hurting or distressing residents when carrying out rehabilitation exercises. This reflects a similar finding from Wright et al. (2007) who reported on general practitioners' reluctance to deliver best practice warfarin therapy due to a fear of doing harm. These perceptions have the potential to reduce knowledge use and as a consequence dilute the likelihood of staff implementing tailored evidence into practice. Implementation tailoring will therefore, have to consider

strategies to overcome these barriers, such as education and partnership working with specialist professionals, such as physiotherapists.

7.1.2 Collaboration

This research project highlights the need for engagement and collaboration of all involved in the resident's stroke journey. Successful implementation of best practice recommendations is not solely about getting specific research into practice, it is about creating a culture within service contexts where all stakeholders are involved in a collaborative effectual process, which focuses on the resident, to enable quality outcomes informed through implementation of best practice recommendations.

The team culture created within a care context can also impact upon evidence use in practice (Kent and McCormack, 2010). Multidisciplinary team work can convey many benefits for implementing stroke best practice recommendations along with establishing mutual support for the stroke survivor when transferring into the care home setting. Effective team work requires an understanding and respect for the competencies of other team members to ensure individual professionals feel valued for the unique expertise and commitment they bring to the team (Mental Health Commission, 2006).

Findings from this study identified several impacts of collaboration, or the lack of it. These impacts have two main foci, one is the impact upon the context of care and how this influenced tailoring in action, and the other is upon the impact of stroke interventions for residents.

7.1.2.1 Collaboration, context and the impact upon tailoring in action

Identifying who collaborators are and the influence of this upon tailoring in action produced interesting and relevant findings, which had an impact upon the process of tailoring. For example, findings highlighted the existence of hierarchies between professionals and organisations outside the care home. Furthermore, the care home staff reported they felt undervalued and not respected by their acute sector colleagues. Similar findings emerged from the Royal College of Nursing (2012) report on the views of frontline staff in care homes, which found that "some respondents also felt that a cultural divide between the different professional teams existed and that, compared with nursing

staff in the NHS, care home nursing staff were not as highly respected or valued” (p.21). These hierarchies had an impact upon collaboration and the ability of the care staff to engage in co-production to plan residents care with outside partners. An unequal relationship creates a power imbalance which can create fear and resentment. Care staff often expressed a fear to change regimens set out by acute sector professionals and felt that their views were not valued. This could potentially create a barrier to implementing stroke best practice guidelines. Indeed, Amador, Goodman, Mathie and Nicolson (2016), suggest that valuing the respective contributions of care home staff and building on existing ways of working can facilitate more meaningful, integrated ways of developing practice.

In order to tailor evidence the staff engaged in tailoring in action have to be able to make decisions in relation to day to day use of the tailored evidence. If day to day decision making is influenced by external parties who are not involved in direct care delivery, this can create a barrier to tailoring. This also, as a result can create barriers to implementing best practice and limits the potential for creative collaboration designed to maximise the resident’s potential.

The narratives recorded around permissions was interesting from a tailoring perspective. Similar barriers to adapting evidence-based practice were found by Specht (2013) who concluded that care home staff had limited decision-making authority to implement change. The process of tailoring could be interrupted by control over decision making around risk aspects of care for residents with stroke. There was some suggestion that care home staff were reluctant to undo prescriptions of care set out by professionals in the acute sector prior to admission into care homes. This can have a huge impact upon tailoring the stroke best practice evidence, as regardless how good a fit can be created to improve the use of evidence in practice, the fear of challenging the care instructions from other professionals has the potential to delay or stop the implementation.

Furthermore, during the consensus building workshops care home staff reported that they were often not engaged in the pre-discharge care planning process, which resulted in the care home staff feeling undervalued and not trusted to make decisions about care. As a result, there is the potential for the resident’s current care needs to be unmet, with care

home staff continuing to deliver care prescribed by practitioners who remain distant to the tailoring process. These factors result in barriers to tailoring, where tailoring is not possible in action as permissions to change and evolve care exist outside the care home setting. Care therefore is performed as prescribed 'in the moment' but is restrictive and dated to an historical account which relates to assessment performed prior to the resident's transfer into the care home.

Findings from interviews and workshops indicated that care home staff confidence in tailoring was further impinged by a perceived power imbalance between care home nurses and acute care based nurses. This can potentially impact upon care staff motivation to tailor recommendations and strategies to implement stroke best practice, this relationship and its impact upon the care outcomes for residents is under investigated. Acute nurses, nurses who worked in the acute hospitals, employed by health boards, often dictated care regimes. Rather than using more holistic collaborative approach, which recognised and utilised the expertise of all involved in the resident's transition into the care home environment. This led to Registered Nurses working in the care home sector feeling their expertise was undervalued and often ignored during transition planning. The National Institute for Health Care Excellence (NICE, 2015) have designed guidelines for the 'Transition between inpatient hospital setting and community or care home settings for adults with social care needs', the document calls for a higher degree of collaboration, with recommendation 1.1.4 calling for the person, their carers and all health and social care practitioners to be involved the transition from hospital to a care home. The document does not however seem to offer any guidance to overcome the power hierarchies between acute sector staff and care home staff that often exist. These factors highlight the need for all stakeholders to engage in an equal collaborative relationship in order to tailor strategies to ensure day to day practices appropriately use the evidence base for stroke.

Staff who are engaged in decision making feel valued, respected and supported (Kings Fund, 2012 Leadership Review). Furthermore, the Cavendish review (2013) highlights that care outcomes improve when all staff feel valued as part of a team. Henneman, Lee, and Cohen (1995) found it difficult to define empirical referents of collaboration citing reasons related to context. They do nonetheless, conclude that collaboration requires

competence, confidence and commitment from all parties involved; with respect and trust being key underpinning factors (Henneman et al., 1995). More of a resident-centred focus, which encourages feedback and shared values (Nancarrow, Booth, Ariss, Smith, Enderby, et al., 2013) might create a more inclusive environment for interdisciplinary working. A study by Wild, Nelson, & Szczepura (2010) for the Joseph Rowntree Foundation recommends a need for better understanding between hospital, community and residential staff about their roles and responsibilities, but also about the values and principles that underpin their work. Nursing staff working in care homes often report feeling isolated and undervalued, which decreases their confidence to fulfil their role (Owen et al., 2012).

7.1.2.2 Collaboration and the impact upon interventions for stroke

Findings from the data collected during the workshops, suggested that a power imbalance exists between acute sector staff and care home staff. This power imbalance affects the collaborative process and as a result impacted upon the care home staffs' motivation and confidence to implement evidence-based stroke interventions. This study highlighted that care home staff were wary of deviating from care regimens created prior to the residents' discharge from the acute sector. When the resident's needs changed their rehabilitative journey was often delayed by a fear of doing harm or acting without permission.

Care home staff often felt unsupported by interprofessional colleagues when trying to refer people for further rehabilitation. Several findings indicated difficulties for care home staff trying to get specialist help for residents with stroke. This seems to be a national problem, as a 'Moving On' Report by the Chartered Society of Physiotherapy and The Stroke association found that 83% of physiotherapy staff believe that the process of transfer of care for Stroke survivors could be improved (P. 2). In addition, 21% of Stroke survivors who felt they needed community-based physiotherapy did not receive any from the NHS (P. 2). A similar picture emerged in the findings for occupational therapist interventions in the care home setting. Whereas, the NICE 2013 Stroke Rehabilitation guidelines, recommendation 1.1.14 stipulate that people transferred from hospital to a care home should receive assessment and treatment from stroke rehabilitation services to the same standards as they would receive in their own home.

Study data highlighted the importance of value, as care staff narratives expressed views around feelings of being undervalued by acute sector staff. The lack of a multi-professional approach to people with the residual effects of stroke living in care homes has the potential to make tailoring the evidence for stroke to this context a futile exercise. After all, if care home staff are wary of changing prescriptions of care designed outside the care home context, they would not be engaged in informed decision making and tailoring would therefore not be a worthwhile process. Policy makers and service providers should promote partnerships in order to create equitable services, which encourage all professionals engaged in the persons stroke journey to engage in decisions to promote the use of stroke best practice interventions, and to tailor them to a given context, thus meeting the needs of the individual regardless of their place of residence. Furthermore, valuing and involving care home staff in the resident's transition into the care home setting is more likely to motivate care home staff and equip them with the confidence necessary to engage in the tailoring process to adapt and implement best practice recommendations regardless of the resident's post-stroke needs.

Collaboration is therefore vital to engage care home staff in the initial care planning and to enable them to operate tailoring in action to ensure that the resident's care evolves as their needs dictate, and to allow best practice recommendations to be tailored for implementation into day to day practices. As found by Gallagher-Thompson et al. (2003) and Wright et al. (2007) collaboration is an integral part of the tailoring process, and whilst there were many challenges for care home staff, the need to improve the outcomes for residents with stroke emphasises the need for collaboration throughout the tailoring process. Furthermore, Gallagher-Thompson et al. (2003), Poulsen et al. (2010) and Wright et al., (2007) believe that involving end users in adapting evidence-based interventions for their particular setting was effective. Whilst non-engagement with end users can have a negative impact upon implementation and quality outcomes (Hickson & Hill, 1997).

7.1.3 Tailoring in Action

Tailoring in action describes the active engagement of end users, in this study care home staff, during engagement with data collection and during day to day activities within the

care home where they actively adapt and integrate the evidence base for stroke into their day to day practice context. Tailoring in action therefore, describes the process of tailoring from adaption of evidence right through to the tailoring of implementation strategies for a given setting. This reflects the model cases highlighted in the concept analysis of tailoring, where tailoring was used throughout the implementation process (Gallagher-Thompson et al., 2003; Wright et al., 2007). Whilst the influence of context has been examined under the feasibility and collaboration headings within this chapter, there is a need to examine the challenge to the fidelity of tailoring in action.

7.1.3.1 Tailoring in Action: the influence of context and fidelity

One of the most challenging aspects of tailoring evidence for a particular context is the need to maintain the fidelity of the original evidence. Indeed, during the course of this study it was essential to negotiate between maintaining the fidelity of the evidence whilst balancing the real-world requirements of the care home setting. Harrison et al., (2010) found that local contexts may legitimately require important variations when tailoring evidence to a given setting. This study however, highlights that whilst it was necessary that tailored evidence focused upon creating a fit with the resident's individual needs, as well as the day to day running of the care home, mapping out these processes can help us to better understand what works in a given situation, and as a result identify any dilution of the original evidence. Asking participants to share and reflect upon these aspects during the tailoring workshops enabled a greater insight into this process and helped to clarify when tailoring was happening and what it looked like. Participants, in this study care home staff, reported sharing meanings around the evidence and communicating with the wider workforce to identify how the evidence could be implemented, and how any identified barriers could be overcome. This multifaceted nature of tailoring can enable a move towards more resident sensitive outcomes, but researchers should ensure that all elements of tailoring are examined to prevent the potential to further threaten the fidelity of the original evidence.

Several factors were identified that had the potential to dilute fidelity, such as: collaboration and the need to please all stakeholders; transition into the care home and decision making and the factors influencing the decisions, such as the level of disability and frailty experienced by the resident.

The success of tailoring in action requires collaboration from all parties engaged in the resident's stroke journey. Furthermore, it was essential that all healthcare professionals were aware of the evidence to promote stroke best practice and collaborate to implement the best practice recommendations in order to maximise the resident's stroke interventions to enable outcomes to be achieved. A lack of collaboration by stakeholders throughout the resident's stroke journey, has the potential to fragment care and limit the fidelity of the recommendations and disables coproduction. This was highlighted by care home staff during the interviews and workshops. Indeed, they recognised the need for more equal collaboration, which recognises their expertise and as a result ensures the resident has appropriate care at the right time.

A focus upon adapting the evidence to involve and consider the views of all collaborators however, can mean that the resulting recommendations are far removed from the original evidence, thus putting fidelity at risk. Collaboration and communication therefore, not only influence the success, or otherwise, of tailoring in action, but have the potential to focus upon appeasing team members at the expense of the evidence fidelity. In essence, the need to engage stakeholders in co-production can put the fidelity of the original evidence at risk. Tailoring using consensus scoring was a useful way to limit the potential threats to fidelity, by balancing the benefits of engaging end users whilst maintaining the fidelity of the evidence. The resulting discussions during consensus scoring focused upon how the evidence could be used in practice, and which professional groups would take responsibility for specific aspect, rather than changing the evidence. Language was adapted, but this was more to aid understanding and acceptance than to alter the evidence, thus putting minimal risk to fidelity, but enhancing the ownership, understanding and acceptance by care home staff.

The level of disability experienced by residents, along with debilitating consequences of stroke and multiple complex comorbidities impact upon scope of tailoring stroke specific recommendations. Findings suggest that staff struggled to focus upon disease specific recommendations when residents often had several diseases. Indeed, Hughes, McMurdo and Guthrie (2012) highlight that disease specific guidelines can be problematic for people with multimorbidity and often lead to overwhelming treatment burden and polypharmacy. Furthermore, medical interventions versus quality of life issues created

conflict and had an impact upon tailoring process, as findings indicated that staff often felt treatment administered to residents was futile and followed guidelines rather than focusing on quality of life. Some data recorded staff reflecting on their own mortality and suggesting that they would not want their family to promote these types of interventions. This fear of extending futile treatments can impact upon staff engagement in tailoring the evidence, as they were reluctant to do harm and wanted to promote quality and dignity for residents.

Tailoring in action focused upon the evidence for stroke, specifically the stroke best practice recommendations as set out by the Intercollegiate Stroke Working Party (2012), but this in itself created a barrier to tailoring, as it was not specific to the needs of some individuals. Care staff did however suggest that in practice they would tailor the care to the resident. This suggests another aspect to tailoring, one which is more resident centric and in the moment of care. It does nonetheless, add weight to the possibilities of tailoring in the sweet spot to balance evidence with the specific needs of a resident in the care home context. This individualised use of tailoring in action has the potential to adapt multiple sources of evidence, to a given context; and as a result, offers a structured approach to Implementing evidence-based practice.

7.2 Developing a process map of tailoring

This purpose of this chapter was to draw together study findings and analysis to discuss the complex, dynamic process, of tailoring and to identify emerging theories to create a process map for tailoring in action.

Tailoring was found to comprise a fluid multifaceted phenomenon, which can be used in action as a process designed to create the best fit between evidence and the care home real world context. Implementation theory suggests that tailoring can influence the implementation of best practice (Ploeg, Davies, Edwards, Gifford & Miller, 2007; Baker et al., 2010; Baker et al., 2015), however Wensing (2017) calls for more insight into tailoring methods within implementation research. The key to tailoring lies in coproduction, which in turn engages the end users, in this case care homes in research, raises awareness about specific evidence (in this case, the evidence base for stroke best practice), and enables end users to engage in implementation planning.

A key output from the findings of this thesis is an understanding of tailoring in action, and specifically the concept of a ‘sweet spot’ (Figure 7.1), where the efforts of coproduction are at a pinnacle. It is within this sweet spot that the evidence has been tailored through co-production with end users to produce context ready evidence where fidelity and real world practice is balanced. It is the balancing of scientific evidence with day to day practices, within a given context, that enables implementation of best practice. This research study has identified tailoring as a way to achieve this. Furthermore, generating this real world coproduced tailored evidence facilitates end users to make sense of, and have ownership of, the final product. In turn, this enabled end users (care home staff) to make sense of and plan for the changes required to implement the tailored evidence into their particular practice context. This coproduction happens in the practice context, where the evidence is tailored to create a fit with the salient language and day to day practices of end users.

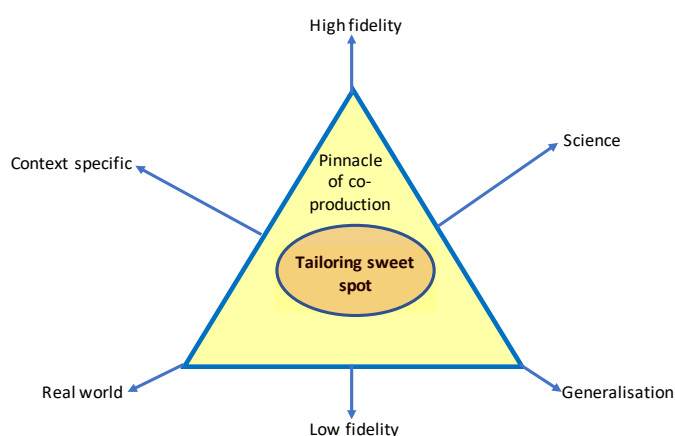


Figure 7.1: Identifying a tailoring ‘sweet spot’

Balancing fidelity in this tailoring ‘sweet spot’ facilitates a more creative real life use of evidence in day to day practices and one which can be revisited as a matter of regular reflection and evaluation to create a reflexive responsive implementation culture. The discussions during the consensus workshops highlighted how a fit can be achieved by discussing how elements of the best practice recommendations could be tailored to the

care home context. An example of this can be seen in the narratives around collaboration where workshop participants are discussing who they might collaborate with to implement stroke best practices (Chapter 5, p.125) as set out in the 'personal daily activities' recommendation (Intercollegiate Stroke Working Party, 2012). Similarly, the workshops identified barriers, such as valuing time spent with residents who required rehabilitation and the use of tailoring to reflect and adapt care home values around this by not being quick to judge and recording this time in the resident's care plan (Chapter 6, p.161). This iterative nature of tailoring makes it a worthy implementation mechanism, as it offers a way to engage the end users of the evidence, that is the practitioners who will be implementing it, in a tailoring process which examines the evidence and uses consensus driven co-production to create a realistic fit with day to day practice and the available organisational resources. Tailoring therefore, focuses upon applicability rather than evidence validity (Straus, Tetroe & Graham, 2009), and in turn increases the likelihood of adoption of the tailored evidence into a given context.

The resulting theory builds to a map of the tailoring process (Figure 7.2), whilst identifying the tailoring attributes required for tailoring to be executed in a given context. This process map of tailoring offers a unique way to balance complex day to day interaction within a context to create a fit with evidence based guidelines to enable end users to adapt the evidence to their specific care setting.

The elephant in the room throughout this study has been the question of whether tailoring is a deliberate act or something that is done at local level without practitioners even realising they are tailoring the evidence. This study cannot possibly answer the question as to when or if tailoring happens as a subconscious or a non-deliberate act and seems to suggest that in reality it is both. Findings from this study do demonstrate that tailoring if used as a deliberate process can adapt evidence to the local context and create a balance between the fidelity of the original evidence and the feasibility of creating a fit

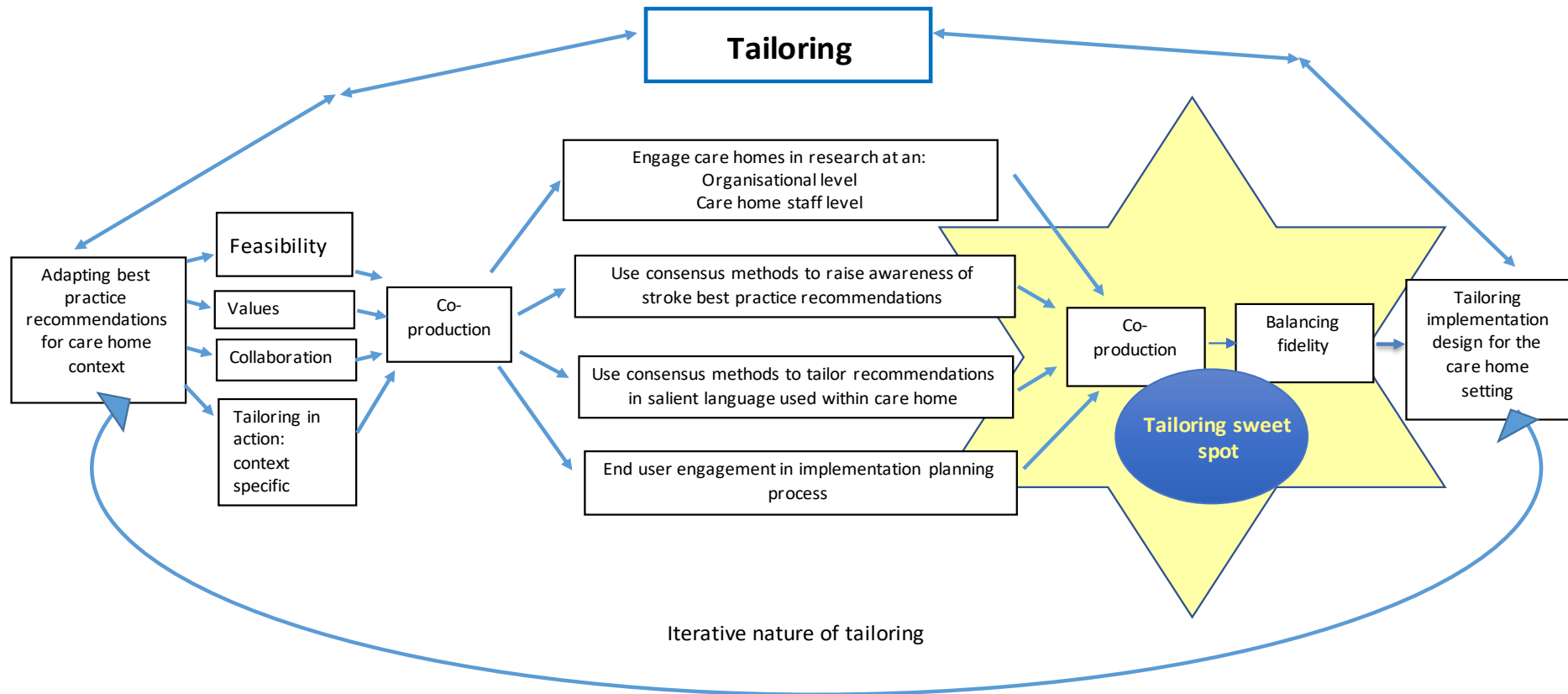


Figure 7.2: Tailoring in Action: A process map

with day to day practices. Following a process map when tailoring in action also benefits implementation research knowledge, as the more researchers describe the processes used the more informed we can become as to what works and what does not. The tailoring process map therefore offers implementation researchers a process to clearly plan out how evidence and the consequent implementation strategies are adapted to the local context.

7:6 Study reflection and reflexivity

The skills utilised within this study highlighted the complimentary nature of the researcher's nursing and educationalist skills within this qualitative research study. Indeed, nurses are ideally placed to carry out qualitative research enquiries, especially using an epistemological view grounded in constructivism. Applying constructivism enabled the researcher to develop meaning by unpicking the narratives from care home staff of their experiences and events as they engaged with their day to day world within the care home context (Charmaz, 2014). As a result, the researcher acquired a greater understanding of the culture and context, where stroke interventions were being delivered. At the same time the researcher was able to observe and develop theory in relation to the role of tailoring as an implementation approach.

Choosing a suitable approach for a research project can be challenging as often several methods offer elements of relevant approaches. In order to develop theory, it was essential that tailoring was studied in action in the context it was being used. The engagement emphasis within this study, along with the practice base setting, would suit an action research project. And if the sole focus were about implementing stroke best practice guideline recommendations, this would have been a reasonable method of choice. This study however, had another focus and that was to examine the tailoring process, whilst using tailoring to adapt national stroke best practice recommendations for the care home setting. With the need for consensus with regards to the tailoring of the recommendations in mind, this would point towards a Delphi study. A Delphi study engages groups of experts and guides them through a series of intensive questionnaires interspersed with controlled feedback (McKenna, 1994). This multi-staged approach had

the potential to be problematic for the care home sector, where retention and continuity of staff can be a challenge. In addition, the care home managers had previously indicated they did not like questionnaires; and the expertise involved in engaging with a Delphi study might have been daunting for care home staff. Case study design was therefore, an ideal choice here as it enabled the researcher to engage with the care home staff to tailor stroke best practice guidelines, whilst unpicking the process of tailoring itself. Case study therefore, enabled an empirical inquiry within the real-life context of the care homes, whilst data was sought to examine the boundaries between the phenomena of tailoring and the care home context (Yin, 1994). Cross case analysis enabled results from each care home to be compared and combined (Stake, 2006). This method highlighted the reflexive, problem solving approach to adapting stroke best practice recommendations for this context that tailoring offered. Furthermore, carrying out this process using nominal group technique and cognitive questioning with care homes staff, enabled the researcher to use the identified tailoring paradigms, to construct a map of the tailoring in action process, which can inform implementation research knowledge and be used to compliment future implementation strategies. As a result, it enabled knowledge that emerged from the care home setting to develop its own theoretical structures and modes of practice (Gibbons et al., 1994). In addition, a collaborative approach to tailoring offers a greater sensitivity for the impact of knowledge production in the care home setting and enabled care home staff and researchers to reflect upon the values of the individuals and groups involved in knowledge production for this setting.

Case study therefore, offers more than just involving the care home staff in a process of change through consensus, it offers an in-depth study of how care home staff engage in tailoring and consequently enables the development of theory building in relation to tailoring constructs to establish where tailoring fits within implementation research. Multiple case study enables the examination of tailoring in action in several care home contexts, which offers a better opportunity to examine concepts, and can then interpret patterns within each case and then analyse cross-case to develop more generalist principles in terms of tailoring constructs (Stake, 2006).

Successful implementation of evidence is not solely about getting specific research into practice, it is about creating a culture within service contexts where all stakeholders are

involved in a collaborative effectual process. Case study was an effective choice for this research inquiry, as it enabled engagement with care home staff, which encouraged them to share their insights. Case study therefore, enabled the researcher to engage care home staff in the process of tailoring the intercollegiate stroke best practice recommendations. This could arguably have been achieved using an action research approach, but case study also enabled the researcher to collect data about the process of tailoring. The ability to gather data in order to unpack the process of tailoring, enabled the consequent theory map of tailoring to emerge.

Open recruitment enabled most care home staff to volunteer in a non-threatening environment. Carrying out data collection in a familiar environment, also seemed to aid recruitment of participants, especially as many of the care home staff were unable to drive and explained that they would be very reluctant to travel to another venue. Recruitment at another venue would have been problematic. Care home staff readily discussed their views, and often seemed to start off quite nervous of the voice recorder and then forget it was there; with some staff commenting, once it was switched off, that they had forgotten all about it. Often discussions continued after the workshops had concluded and recorder was switched off, they seemed reluctant to leave and continued to discuss issues covered in the workshops. Accurately, capturing these conversations was difficult, but these relaxed conversations did seem to suggest that the care home staff were comfortable sharing their views. This was not really the case in the care home where the manager had instructed staff to attend, they all disappeared as soon as the workshop concluded. This again emphasised the benefit of self-selection by care home staff. This was very noticeable for the researcher, but difficult to intervene as it run a high risk of humiliating and alienating a very enthusiastic manager. The data gathered for the consensus was nonetheless very similar to the issues raised by the other care homes. This indicated that although at times reluctant to participate the information provided reflected their experiences. Kayser-Jones (2003) discusses the potential to be 'seen as a threat' to the care home industry (P:145), as a researcher I was very aware that I was a guest in this environment and made every effort to ensure minimal disruption to the day to day activity of the care home. And to create an environment for care home staff to discuss their views. These discussions, did nonetheless take place in the care home, and as

a result there was a potential for bias. Whilst I endeavoured to remain objective, it is always difficult not to sympathise with staff when they express their inner thoughts and frustrations. For this reason, case study, rather than ethnography enabled the care staff to express their views, rather than the researcher developing meaning from observed actions. In addition, this approach enabled a degree of detachment. Which for this particular study was relevant and help to enrich the data and give the care staff a voice.

The initial interviews opened up the care home routines and challenges for the researcher and highlighted the day to day care offered for residents with stroke. Moreover, this contact with care home staff helped to build a rapport. The flexibility of multiple case studies enabled each care home to share their unique insights, whilst enabling the researcher to analyse findings and to highlight similarities.

The consensus approach used within this study was initially designed to send out recommendations with a Delphi scoring system, which staff would complete prior to the workshop, but after discussions with care home managers this was adapted, and a nominal group technique was used. Black et al. (1999) suggested that consensus development is affected by the context and participants. It was essential therefore, to adapt the data collection methods to suit the care home context (Luff, Ferreira & Meyer, 2011). Care homes were sent the recommendations to be tailored in advance, but care staff did not read or engage with the recommendations prior to the workshops. On reflection, this would seem to have been an unrealistic expectation. They did however, seem to enjoy unpicking the meaning of the recommendations in the presence of co-workers and the researcher. This, although time consuming, led to insightful discussions, which in turn provided rich data. Whilst recognised research methods help the novice researcher to plan and guide their data collection, it is the researcher who has to form the in-action relationships with participants.

Very often questions were asked to clarify meaning of the intercollegiate recommendations. It is imperative as a researcher that you avoid influencing participant's responses, this was a challenging dilemma in these circumstances. The researchers teaching and education skills often came to the fore, providing strategies to engage the participants in addressing their own questions as a group. For example; asking other care

home staff participants what they understood by the recommendation was a good way to generate discussion, rather than the researcher answering the questions, but this was not always possible as some elements of the language left the whole group dumbfounded. As an early career researcher these experiences were invaluable and served to highlight that real-world research is about adopting a flexible, reflexive approach in order to achieve maximum engagement and collaboration with research participants to gather their views and experiences.

The cognitive questioning (Willis & Artino, 2013) approach was an ideal way to enable layering of the discussion and helped the researcher to really delve into the care home staff judgements and comprehension around the recommendations. And in particular their responses in relation to how they felt the recommendations could be tailored to create a fit for their day to day practices. Having a workshop questions spine helped, but discussions were not limited to this. Also, as researcher confidence grew, reliance upon prepared questions became less essential. This enabled a less stifled, freer flowing discussion, where care staff's opinions and comments drove the discussion.

This study also highlighted the developmental nature of consensus building, where a one-time consensus meeting would not enable the richness of data to flow. Indeed, consecutive meetings with the research participants during the consensus building workshops enabled a greater insight into the tailoring process, and the finer details of how participants were using skills and knowledge gained during the workshops to share knowledge with their work place setting and to begin tailoring the local context in order to implement the evidence for stroke care interventions.

This study highlights the care home context, not only as an important area for research and development, but as a context willing to engage in research to improve the resident's experience and quality of life. Policy makers should consider engaging care homes when developing health and social care guidelines, which have the potential to impact upon the lives of care home residents and their families. In addition, guidelines and the consequent recommendations made should be produced in a language which promotes universal usage, rather than be context or discipline specific. Furthermore, regulatory bodies, such

as CSSIW, should include best practice recommendations within their benchmarking, in order to incentivise the adoption of best practice guidelines within the care home sector.

This research study also highlighted areas for further investigation within the care home context, which included the care home hierarchies and how this has the potential to influence the implementation of best practice. Further research is required to investigate the impact of these stakeholder hierarchies in order to facilitate smooth transitions from acute sector to the care home setting, and to enable true collaboration between staff from both sectors to enable best practice outcomes for residents with stroke. It is also worth investigating whether, or not, the resident's voice gets lost or diminished in these hierarchical relationships. Another aspect which would benefit from further examination was the influence of the customer provider relationship between the care home and residents.

7:7 Limitations

Searching for answers, making the invisible obvious and recognising the significant from the insignificant (Morse 1994, p:25) within the large volume of data collected was a daunting but very rewarding process. The key aim was to examine themes identified during the scoping review and concept analysis, but it was also imperative to enable new themes to emerge in order to produce an inductive meaningful account of the narratives provided by care home staff. It was vital that the researcher remained open to these new possibilities, but also to be mindful of not looking for what the researcher wanted to find.

This case study provided narratives and descriptions of the case interactions and field notes to explain and highlight researcher interactions (Stake, 1995). Indeed, a key aspect of the researcher role was to co-produce, but also to facilitate a better understanding of the best practice recommendations and to help research participants to unpack the evidence in relation to their day to day practices and was central to this study. Whilst this facilitative role was aimed at producing greater engagement for co-production, there is also a risk of dilution of researcher objectiveness as the researcher immerses themselves in the views and experiences of the care home staff it is difficult not to feel a degree of sympathy and allegiance with their plight.

Recruitment of care homes was challenging, and three out of the four homes that began this journey engaged throughout. How representative of the whole care home population these participants were is unclear, but the enthusiasm of the staff who did engage enabled data collection and findings to create a process map of tailoring, which is applicable to this and other healthcare contexts.

Recommendations sent for consensus prior to workshops were not read or commented upon. One manager explained that they get many questionnaires sent to them by researchers and they rarely fill them in, and that they are more comfortable engaging face to face with the researcher. Additionally, care home staff appeared most comfortable discussing recommendations in small groups. In order to build collaborative relationships with the care homes and to create an environment where participants readily shared their thoughts and ideas, data collection using consensus methods, were adapted for use in this context. A limitation of using consensus methods however, is that although it may be a useful way to capture collective knowledge, it is inevitably vulnerable to the possibility of capturing collective ignorance (Murphy et al., 1998). The use of cognitive questioning to unpick answers help to limit any adverse effects of collective consensus and resulted in rich data.

A further limitation of the consensus workshops and indeed this study, was that the residents themselves were not involved. The complexities involved in recruiting and preparing residents was unfortunately not possible within the time constraints of this study. The complex processes involved in the recruitment of frail older people to research studies is a factor which Shepherd, Nuttall, Hood and Butler (2015) believe often results in residents being unable to participate and one which led them to call for approval processes that better ensure residents can participate in research in a timely manner. The fact that this study was performed by a single researcher also had an impact upon the ability to recruit and develop the residents' engagement, as to enable the residents to share their views a diverse, responsive approach to data collection that is sympathetic to the resident's needs is required by a team of researchers (McMurdo et al., 2011).

As mentioned earlier, due to time scale and scope of study the specific Implementation of the tailored recommendations into practice was not examined within this study. The

primary focus was upon the process of tailoring to a given context and preparing for implementation. It has not therefore, been possible to explore the entire process of implementation through the course of this research. This study has however, created valuable new knowledge about tailoring as an implementation mechanism by focusing on co-production to tailor the evidence base for stroke to a specific context, the care home, and anticipatory implementation of the tailored evidence. The researcher and care home staff have therefore worked in partnership to tailor the guidance and to use the tailoring process to prepare for and in some cases to begin the process of implementing into practice.

7:8 Chapter Summary

Tailoring offered an effective way to balance theory and practice. It enabled a connection between the real world of care homes and the scientific evidence in relation to post stroke rehabilitation. This was achieved by enabling care home staff to collaborate in worthwhile discussions of what will work for them, in this particular context. Balancing the many complex care home interactions both internally and externally is a real challenge and one that is likely to be constantly in a state of flux. The tailoring in action process offers a unique way to balance these factors to achieve situations where stroke best practice recommendations can be adapted and used within the day to day care home practices. The Tailoring in Action process in figure 7.2 sets out a map of how co-production was achieved by engaging end users within their practice context. Adapting data collection methods to ensure they were sympathetic to end users' values and sought engagement rather than alienation. The aim of co-production in the first phase of the tailoring in action map is to create a fit with the local context to ensure the feasibility of the evidence for implementation. The coproduced recommendations created through collaboration between researcher and end users facilitated a tailoring sweet spot, which balanced the real world of the care home context with the scientific world of evidence, to create a workable alternative.

As introduced earlier in this chapter, this study identified a tailoring sweet spot (figure 7.1) where the efforts of coproduction are at a pinnacle. This coproduction happens in the practice context, where the evidence is tailored to create a fit with the salient language

and day to day practices of end users. Tailoring in the sweet spot inevitably has the potential to diminish the fidelity of the evidence, but this softening of the scientific evidence is balanced by the creation of real world, tailored, evidence. Generating this real world coproduced tailored evidence, enables end users to make sense of, and have ownership of, the final product. This in turn enables end users (care home staff) to make sense of and plan for the changes required to implement the tailored evidence into their particular practice context. This process also engages tailoring to identify the challenges to implement the tailored evidence and to coproduce implementation strategies that can maximise impact, whilst creating a fit with context, cultures and routines.

Balancing fidelity in this tailoring sweet spot facilitates a more creative real life use of evidence in day to day practices. One which can be revisited as a matter of regular reflection and evaluation to create a reflexive responsive implementation culture, which better meets the needs of service users. This iterative nature of tailoring makes it a worthy implementation mechanism.

These findings identify questions about the evidence itself, such as can nationally designed evidence-based recommendations ever be suitable for a specific context? Such generic evidence can appear unattractive or irrelevant to particular care settings, and this in turn can limit implementation. Tailoring offers a process to create a fit, which through coproduction can create a balance between the fidelity of the evidence and the context specific characteristics.

7:9 Thesis overview

This case study presented an in-depth study of tailoring, in the care home setting. The initial literature review in chapter 2, sought to examine how the evidence base for stroke was being implemented. This highlighted the potential benefits of tailoring when preparing for and implementing best practice. Studies reviewed reported the benefits of tailoring (Bo et al. 2007; Brady et al. 2011; De Koning et al. 2005; Ferry et al. 2004; Ford-Lattimore et al. 2008; Gage et al. 2000; Hoe Heo et al. 2010; Heuschmann et al. 2006; Kormer-Bitenskey et al. 2008; La Bresh 2006; Luker & Grimmer-Somers 2009; Micieli 2006; Middleton et al. 2009; Wright et al. 2007). Several studies sought to adapt national

or global guidelines to the local context (Bo et al. 2007; De Koning et al. 2005; Ferry et al. 2004; Gage et al. 2000; Heuschmann et al. 2006; Micieli 2006; Middleton et al. 2009; Wright et al. 2007). Whilst others recommended the use of tailoring interventions when discussing their results and implementation compliance (Sullivan et al. 2008; Van Peppen et al. 2008).

Key implementation themes highlighted were: the engagement with staff in the local context, and strategies that sought to tailor evidence to the local setting and the traits of the staff involved. Healthcare professionals are significantly more likely to comply with clinical guidelines following a tailored and multifaceted intervention (Wright et al., 2007). Baker et al. (2010, P: 5) defined tailored implementation strategies as 'strategies to improve professional practice that are planned taking account of prospectively identified barriers to change' (P: 5). The literature, however, suggested that the scope of tailoring was much wider reaching and a complex phenomenon. Tailoring did nonetheless, emerge as a relevant implementation strategy worthy of further investigation, with the potential to engage with care homes to examine the suitability of the stroke best practice recommendations for this context. In order to gain a definitive understanding of tailoring a concept analysis of tailoring was performed.

Chapter 3 presented a concept analysis of tailoring, which sought to unpick the mechanisms used within the various tailoring processes adopted within the literature, and to extract the necessary evidence to establish a worthwhile framework for tailoring within implementation science. The concept analysis highlighted key tailoring concepts such as: engagement, stakeholder involvement, the notion of tailoring in action, feasibility (the need to create a fit) and fidelity (the degree to which the original meaning is protected). This in turn led to the creation of an initial map of tailoring concepts, which were then used to inform data collection and analysis.

The research methods, discussed in chapter 4, were designed to examine whether tailoring was a suitable implementation vehicle to adapt national stroke best practice recommendations for the care home context. A constructivist approach was used, which used a multiple case study design to gather qualitative data. In the first instance data was gathered to highlight the current stroke care practices within the care homes. Analysis of

this data informed the consensus workshops, which also adopted a cognitive interview approach to unpick the care home staff's understanding and views of the intercollegiate stroke best practice recommendations and enabled an in-depth analysis of tailoring in action.

Data collection and findings were presented in chapters 5 and 6. Key qualitative narratives were unpacked and presented to develop an understanding of tailoring in action in the care home context. Key themes and concepts were illustrated using visual network maps, which were utilised to determine the variables for further analysis (Miles, Huberman and Saldana, 2014)

Chapter 7 sought to make sense of the findings and to analyse the emerging theories in relation to tailoring in this context. Results highlighted that when all the factors which make up tailoring are working in harmony, this can create a tailoring sweet spot (Figure 7.3). It is within this sweet spot that the evidence can be tailored through co-production with end users to produce context ready evidence where fidelity and real world practice is balanced. It is the balancing of scientific evidence with day to day practices, within a given context, that enables implementation of best practice. This research study has identified tailoring as a way to achieve this. In addition, end users began the process of discussing and planning how recommendations can be mapped onto day to day practices, thus offering the prospect of successful implementation into a given context. High fidelity of tailoring attributes is essential for success. Low fidelity, especially in terms of collaboration and evidence puts the process at risk.

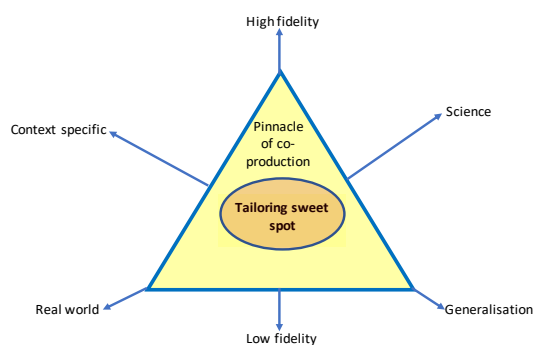


Figure 7.3: Identifying a tailoring 'sweet spot'

A key benefit of the tailoring process is the iterative nature of tailoring. This enables a flexible and non-linear process, which incorporates engagement and a desire to create feasibility with day to day care home life. Tailoring is a process that offers a useful way to engage end users in discussions around best practice recommendations. This process helps to unpack meaning in order to tailor recommendations for a particular setting. The collaborative nature of tailoring makes identifying barriers and enablers to implementing evidence-based recommendations a more natural process. Indeed, study participants were unconsciously doing this in practice when sharing what they had learnt in the recommendation tailoring workshops.

Tailoring is an implementation process aimed at adapting evidence for use in a specific context, whilst promoting engagement and building awareness and knowledge around the evidence. The developing knowledge enables end users to begin the process of tailoring implementation strategies sensitive to the local setting. This in action practice development enables a better fit to context and the customs and practice that influence acceptance and implementation. Tailoring in action (Figure 7.4) therefore presents a coproduction framework for adapting evidence and tailoring at local level to design strategies to implement the tailored evidence into practice. Thus, creating a 'sweet spot' where the evidence can be used in the real world of practice. This balancing of feasibility and fidelity has real potential to improve implementation of evidence-based practices in all healthcare environments.

Tailoring is a time limited process, which begins with end users collaborating to tailor best practice recommendations and moves on to tailor implementation strategies to enable the recommendations to be implemented into day to day practice, whilst reducing or removing potential barriers to implementation success. Implementation researchers should consider using this approach when introducing evidence for implementation.

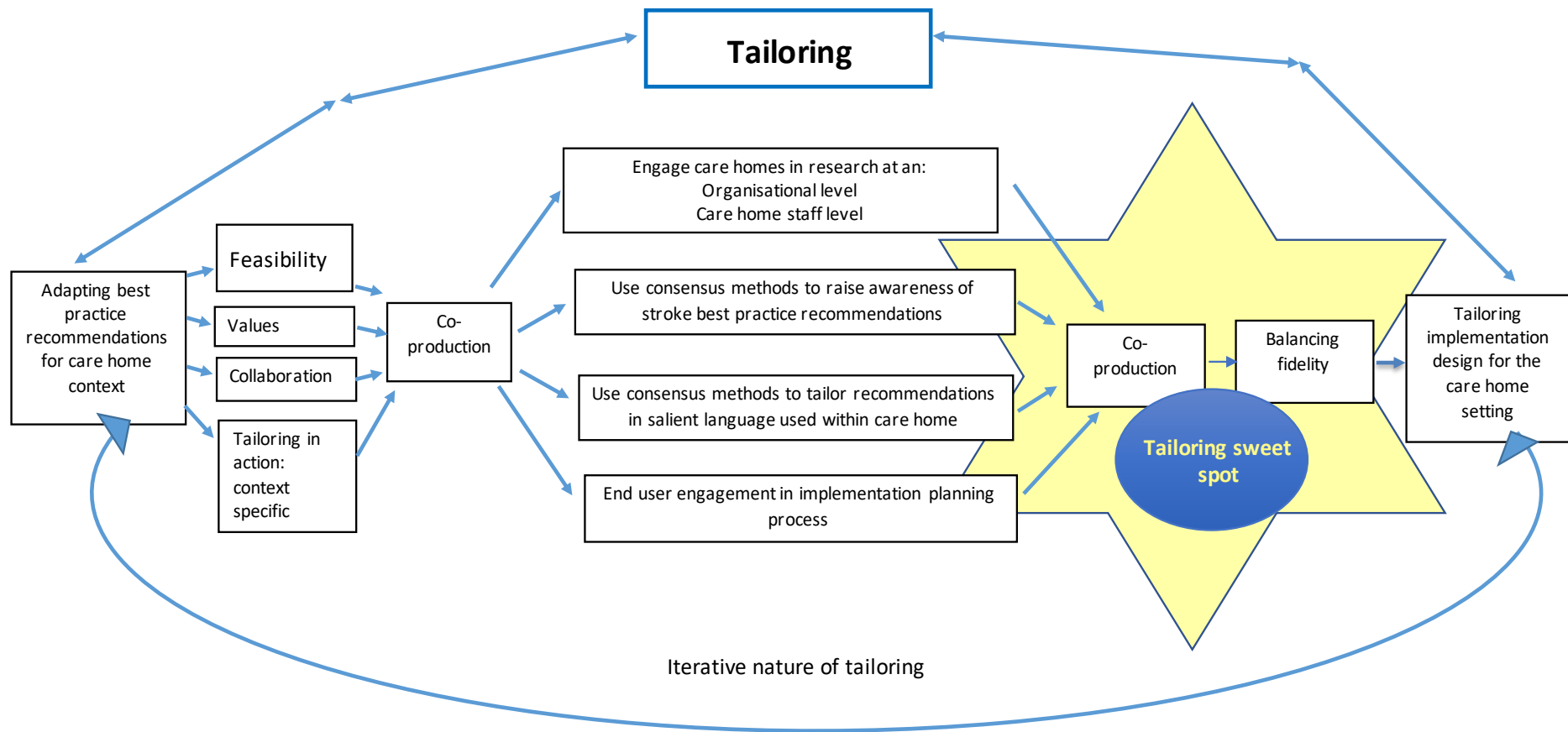


Figure 7.4: Tailoring in Action: A process map

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Appendices

Appendix 2:1: Scoping literature

Type of Intervention	Studies	Intervention Category	Barriers Identified	Enablers Identified
Financial Interventions (N=2)				
	Cadilhac (2007)	Provider incentives, Provider salaried service		
	Chappel (2001)	Provider incentives,		
Regulatory Interventions (N=2)				
	Acker (2007)	Peer review		Collaboration and networking
	Schwamm (2009)	Peer review		
Organisational Interventions (N=18)				
Provider oriented interventions (N=11)	Audebert (2006) Audebert (2009)	Communication and case discussion between distant health professionals – telemedical stroke network		Continuous medical education Increased awareness Resources – fast access to brain imaging
	Bisaillon (2004)	Clinical multidisciplinary teams- creation of a new stroke team		
	Donnelly (2004)	Skill mix changes		

		Continuity of care - arrangements for follow-up		
	Fjaertoft (2003)	Continuity of care - arrangements for follow-up		
	Gibbon (2002)	Clinical multidisciplinary teams		
	Hoody (2008)	Communication and case discussion between distant health professionals – telemedical stroke network	Lack of awareness Knowledge and skills	Accurate diagnosis Timely referral
	Joubert (2008)	Clinical multidisciplinary teams Formal integration of services	Lack of awareness	Point-of care reminder Academic detailing
	Joubert (2006)	Continuity of care – arrangements for follow-up		
	Mayo (2008)	Clinical multidisciplinary teams – new team of disciplines		
	Power (2006)	Service reorganisation, changing traditional roles	Failing systems	
	Woo (2008)	Formal integration of services Continuity of care – case management		
Patient orientated interventions (N=1)	Newell (2009)	Presence and functioning of adequate mechanisms for dealing with patient suggestions – collection and publication of local narratives		
Structural interventions (N=9)	Bates (2000)	Presence and organisation of quality monitoring mechanisms		
	Bisaillon (2004)	Changes to the setting/site of service delivery- development of a stroke unit		Team communication strategy

		Changes in physical structure, facilities and equipment Changes in scope and nature of benefits and services		
Organisational interventions (continued)	Brady (2011)	Changes in scope and nature of benefits and services	Communication Conflicting practices Staff perceptions of roles and involvement	Training Developed guideline Guideline relevant
	Ciccarese (2004)	Presence and organisation of quality monitoring mechanisms		
	DeLemos (2003)	Changes to the setting/site of service delivery		
	Ellis (2005)	Changes in scope and nature of benefits and services Presence and organisation of quality monitoring mechanisms Staff organisation		
	Heuschmann (2006)	Presence and organisation of quality monitoring mechanisms		
	Murray (2003)	Changes to the setting/site of service delivery Changes in scope and nature of benefits and services	Reimbursement policies that discourage the provision of rehabilitation	
	Newell (2009)	Changes to the setting/site of service delivery	Finances Rural location and isolation	

		Changes in scope and nature of benefits and services		
Professional interventions (N=55)				
	Albakri (2003)	Audit and feedback		Collaboration Performance feedback
	Amato (2006)	Educational meetings Local consensus process Educational outreach visits Audit and feedback		
	Bedregal (2001)	Marketing - survey of targeted providers to identify barriers to change	Lack of local agreement Non-involvement in decision making Lack of human resource capacity to adapt to change Financial resources System organisation and organisational culture	Joint decision making Continuing education
	Bendz (2003)	Marketing - survey of targeted providers to identify barriers to change	Incongruence between stroke survivor and health professionals focus and conceptions	Holistic assessment
	Bo (2007)	Marketing - survey of targeted providers to identify barriers to change		
	Brady (2011)	Distribution of educational materials		
		Educational outreach visits		

	Brown (2007)	Marketing - survey of targeted providers to identify barriers to change		
	Brown (2000)	Audit and feedback		
	Cadilhac (2008)	Local opinion leaders Audit and feedback		
	Chappel (2001)	Local consensus process		
	Copenhaver (2007)	Educational meetings		Web-based training tutorial
	Crotty (2004)	Educational outreach visits Audit and feedback		Outreach visits
	DeKoning (2005)	Marketing - survey of targeted providers to identify barriers to change		Record keeping Formal delegation Guideline compliance
	Duffy (2003)	Audit and feedback		
	Ferry (2004)	Educational meetings	Engagement with clinicians Other projects running at the same time Local resources and time available Arranging meetings	
Professional interventions (continued)	Gillen (2007)	Marketing - survey of targeted providers to identify barriers to change		
	Gommans (2005)	Audit and feedback		
	Gropen (2006)	Audit and feedback		
	Hanger (2002)	Audit and feedback	Resources	Nurse educator

	Hart (2006)	Marketing - survey of targeted providers to identify barriers to change		
	Hart (2007)	Marketing - survey of targeted providers to identify barriers to change	Lack of knowledge about intervention and or condition Fear of doing harm Lack of resources, especially time	Knowledge facilitation Belief in tool
	Heo Heo (2010)	Audit and feedback		
	Ickenstein (2005)	Audit and feedback		
	Joubert (2008)	Audit and feedback		
	Joubert (2005)	Local opinion leaders Audit and feedback		
	Kavanagh (2006)	Distribution of educational materials Audit and feedback	Environmental change	Model for change in practice
	Kormer-Bitensky (2008)	Distribution of educational materials Marketing - survey of targeted providers to identify barriers to change	Sustainability of resources Clinicians may not be comfortable using internet	
	Kormer-Bitensky (2007)	Marketing - survey of targeted providers to identify barriers to change		
	Kucukyazici (2009)	Audit and feedback	Lack of continuity of care	
	Kwan (2004)	Audit and feedback		Team work Collaborating in pathway design
	Landgraff (2009)	Audit and feedback		

	Luker (2009)	Audit and feedback	Beliefs and prioritisation principles of staff	
	Mayo (2008)	Educational outreach visits		
	McClatchey (2001)	Audit and feedback		
	Middleton (2009 and 2011)	Educational meetings Local consensus process Educational outreach visits Audit and feedback		
	Pandey (2006)	Marketing - survey of targeted providers to identify barriers to change	Lack of audit and data feedback	
	Panella (2003)	Audit and feedback	Documentation methods Data collection methods	
	Perry (2006)	Marketing - survey of targeted providers to identify barriers to change		
	Perry (2003)	Educational meetings Local opinion leaders Audit and feedback		Education Opinion leaders Audit and feedback
	Power (2006)	Audit and feedback		
	Read (2006)	Audit and feedback		
	Rudd (2001)	Audit and feedback		
	Salbach (2009)	Marketing - survey of targeted providers to identify barriers to change		
	Sandercock et al., 2002		Onset/arrival time in hospital	Education for patients and members of the general public

	(Systematic review of the effectiveness, cost-effectiveness and barriers to implementation of thrombolytic and neuroprotective therapy for acute ischaemic stroke in the NHS)		Patients knowledge Lack of scanning facilities In hospital delays Physician opinion Difficulties obtaining informed consent Poor education and training	Training and education for healthcare staff Re-organisation of in-hospital systems
	Steiner (2009)	Marketing - survey of targeted providers to identify barriers to change		
Professional interventions (continued)	Stevens (2007)	Local opinion leaders	Nursing staff lacked basic therapy skills Other demands on staff Lack of collaboration between disciplines Lack of continuity Passive involvement of physicians Lack of role clarity Poor documentation	
	Stoeckle-Roberts (2006)	Local consensus processes Local opinion leaders Marketing - survey of targeted providers to identify barriers to change		
	Stuart (2010)	Marketing - survey of targeted providers to identify barriers to change		

	Sullivan (2008)	Marketing - survey of targeted providers to identify barriers to change		
	Tadros (2009)	Audit and feedback		
	Tan (2007)	Audit and feedback		
	Taylor (2006)	Audit and feedback		
	Van Peppen (2008)	Marketing - survey of targeted providers to identify barriers to change		
	Woo (2008)	Audit and feedback		
	Wright (2007)	Educational meetings Educational outreach visits Audit and feedback	Underdevelopment of training Lack of engagement with audit and clinical governance systems	Education meetings Audit and feedback Outreach visits Guideline information pack Electronic referral template Guideline reminders, such as posters and coasters
	York (2003)	Local opinion leaders Mass media – targeted population		

Appendix 2:2: Characteristics of scoping review interventions mapped onto the Knowledge to Action Framework (Graham et al. 2006).

KTA Phases and Constructs	Studies: Intervention/mechanisms
Phase 1: Identify problem/identify, review, select knowledge.	
Identify a problem that needs addressing	<p><i>A need to improve compliance with stroke guidelines and care pathways</i>(Albakri et al 2003; Audebert et al. 2009; Bo et al. 2007; Brady et al. 2011; Brown et al. 2007; Brown et al. 2007; Chappel et al. 2001; Ciccarese et al. 2004; Crotty et al. 2004; Donnan 2003; Furie et al. 2011; Gage et al. 2000; Gormmans et al. 2005; Hart and Morris 2008; Heuschmann et al. 2006; Hoody et al. 2008; Hurdowar et al. 2007; Ickenstein et al. 2005; Kavanagh et al. 2006; Kucukyazici et al. 2009; Kwan et al. 2004; Landgraft et al. 2009; Lindsey 2000; Luker and Grimmer-Somers 2009; Micieli and Cavallini 2006; Ovbiagele and Saver 2006; Panella et al. 2003; Panzarasa et al. 2007; Perry and McLaren 2003; Power et al. 2007; Quaglini et al. 2004; Read and Levy 2006; Salbach et al. 2009; Stevens et al. 2007; Stoeckle-Roberts et al. 2006; Tan et al. 2007; Taylor et al. 2006; Van Peppen et al. 2008; Wright et al. 2007).</p> <p><i>Improving stroke rehabilitation outcomes</i> (Alexander et al. 2001; Amato et al. 2006; Bates and Stineman 2000; Bendz 2003; Blackmer and Jefromova 2002; Bravi and Stoykov 2007; Brown and Schultz 2010, Donnelly et al. 2004; Gillen et al. 2007; Haigh et al. 2001; Hanger 2002; Hankey et al. 2002; Hopman and Verner 2003; Hubbard et al. 2009; Jette et al. 2005; Korner-Bitensky et al. 2007; Korner-Bitensky et al. 2008; Leeds et al. 2004; Murray et al. 2003).</p> <p><i>Improving care processes</i> (Bravata et al. 2010; Chen and Worrall 2006; DeKoning et al. 2005; Ellis et al. 2005; Gropen et al. 2009; Heo et al. 2010; LaBresh 2006; McClatchey 2001; Newell et al. 2009; Panzarasa and Stefanelli 2006; Quaglini et al. 2001; Schwamm et al. 2006; Stradling 2009; Stuart et al. 2010; Sullivan et al. 2008; Woo et al. 2008).</p> <p><i>A need to implement stroke unit care</i> (Allen et al. 2003; Bisailon et al. 2004; Cadilhac et al. 2008; Duffy et al. 2003; Fjaertoft et al. 2004).</p> <p><i>Improving education and educational tools</i> (Copenhaver et al. 2009; Ferry et al. 2004; Ford et al. 2008; Gropen et al. 2006; Pandey and Cursio 2006; Steiner et al. 2009; Tadros et al. 2009; York 2003).</p> <p><i>Improving integrated care and team working</i> (Gibbon et al. 2002; Joubert et al. 2009; Joubert et al. 2006; Mayo et al. 2008).</p>
Identify the need for change	The need for change in all studies originated from national and international evidence for stroke not being used in practice; or a need to adapt practice in order to implement the evidence base for stroke.
Identify change agents	Only 7 studies (Cadilhac et al. 2008; Ferry et al. 2004; Joubert et al. 2005; Middleton et al. 2009; Perry et al. 2003; Steven et al. 2007; Stoeckle-Roberts et al. 2006; York, 2003) identified change agents to promote intervention implementation.
Identify target audience	Most studies targeted acute hospitals (n=35), or acute stroke units (n=10), with one study targeting an outpatient department. Other studies targeted GP's and or primary care (n=16). Studies also targeted community hospitals (n=10)and stroke rehabilitation (n=11). Very few studies targeted care homes (n=2).

Review evidence/literature	All studies reviewed and presented evidence to support the need to implement evidence within stroke, but very few studies discussed evidence to support the choice of interventions being used to implement the evidence. In addition, evidence around the context of care and the organisational cultures which prevailed were often inadequate.
Phase 2: Adapt knowledge to local context	
Develop/adapt innovation	<p>Several studies tailored or adapted the evidence to the local context (n=19).</p> <p>More specifically several studies (Bo et al. 2007; De Koning et al. 2005; Ferry et al. 2004; Gage et al. 2000; Heuschmann et al. 2006; Micieli 2006; Middleton et al. 2009; Wright et al. 2007) adapted national or global guidelines to the local context.</p> <p>Following an audit to examine compliance with recommended antithrombotic therapy, Bo et al. (2007) adapted a guideline for the prevention of cardioembolic events to better suit the local context. They found that this led to better guideline compliance and as a consequence better patient outcomes.</p>
Phase 3: Assess barriers to knowledge use	
Assess barriers to using the knowledge	19 studies assessed barriers, which influenced the implementation of the intervention for stroke. Only one study (Brady et al. 2011) set out to expose barriers and enablers in order to inform and design a randomised control trial, that is examined the potential barriers prior to implementing the interventions.
Phase 4: Select, tailor, implement interventions	
Select and tailor interventions to promote the use of the knowledge	<p>Some authors (Sullivan et al. 2008; Van Peppen et al. 2008) recommend the use of tailoring interventions when discussing their results and implementation compliance.</p> <p>7 studies (Kormer-Bitenskey et al. 2008; Brady et al. 2011; Ferry et al. 2004; Hoe Heo et al. 2010; La Bresh 2006; Ford-Lattimore et al. 2008; Luker and Grimmer-Somers 2009; Wright et al. 2007) tailored implementation interventions to the local context.</p> <p>Luker and Grimmer-Somers (2009) suggest that implementation strategies must be tailored to the local setting and the traits of the staff involved. Beliefs and priorities of the staff involved in the translation of evidence into practice should be explored before implementation strategies can be tailored.</p>
Link to appropriate individuals or groups who have vested interests in the project	28 studies used links to appropriate individuals or groups who had a vested interest in the project. Engagement with stakeholders varied from recommendations for stakeholder engagement (Ford-Lattimore et al. 2008; La Bresh 2006; Schwamm et al. 2006; Schwamm et al. 2009; Veazie et al. 2005), to analysis of stakeholder views (Bedregal and Ferlie 2001), to engaging with stakeholders to adapt and develop interventions for the local context (Allen et al. 2003; Bo et al., 2007; Brown et al. 2007; Chappel et al. 2001; Gropen et al. 2009; Heuschmann et al. 2006; Hurdowar et al. 2006; Middleton et al. 2009; Perry and McLaren 2003; Power et al. 2005; Rudd et al. 2001; Sandercock et al. 2002; Sullivan et al. 2008; Taylor et al. 2006; Wright et al. 2007).

	Other studies involved multidisciplinary team members in implementation of interventions, using opinion leaders, champions and key individuals and or provided information for key individuals and stakeholders (Amato et al. 2006; Bisaillon et al. 2004; Ferry et al. 2004; Joubert et al. 2008; Luker and Grimmer-Somers 2009; Panella et al. 2003; Stoeckle-Roberts et al. 2006).
Pilot test	Only one study was designed to test the implementation interventions used (Brady et al. 2011). Although several studies reflected upon barriers to implementation in their evaluation or discussion section.
Implement	Of the 113 papers studied within this review only 77 implemented interventions within stroke care. Others were literature reviews or discussion papers around implementation interventions.
Phase 5: Monitor knowledge use	
Evaluate the process	<p>Only 3 studies (Brady et al. 2011; Chappel et al. 2001; Stevens et al. 2007) examined elements of the implementation process.</p> <p>Brady et al. (2011) examined their implementation interventions used to implement mouth care post stroke. information gained was used to tailor design of a RCT which took into account identified barriers and enablers and issues specific to the local context.</p> <p>Chappel et al. (2001) examined and developed processes for local priority setting.</p> <p>Stevens et al. (2007) examined the process involved in preparing treatment implementation methods in stroke rehabilitation.</p>
Evaluate the outcomes	60% (n=67) of the total studies (n=113) examined, evaluated implementation outcomes.
Phase 6: Sustain knowledge use	
Maintain change – sustain on-going knowledge use	Sustainability was not evident in the literature.
Disseminate results of the implementation process	All studies examined were widely published.

Appendix 3:1: Borderline cases

Borderline cases				
Author and date	Study focus	Tailoring existing evidence/ guidelines (<i>Evidence tailoring</i>)	Tailoring implementation strategies to the local context (<i>Context tailoring</i>)	Outcome
Abulkhair et al. 2010	Adapting National Comprehensive Cancer Network (NCCN) guidelines for use in the Middle East and North Africa (MENA) regions	Yes NCCN guidelines were adapted by a group of expert professionals, who made recommendations with regards to adaption of the NCCN guidelines for the MENA region.	No	An adapted guideline for MENA region. No measurable outcome evident.
Alanen et al. 2008	To establish nurses' experiences of guideline implementation and find factors which influence implementation.	No	Yes Performed focus group interviews with nurses to ascertain their views on guideline implementation. Identified local barriers to implementing best practice guidelines for hypertension	Several factors affecting implementation were identified, they included: Adapting guidelines to the local circumstances, this was seen as crucial for successful implementation. Support from management and other professional groups were also perceived as vital. Nurses awareness and attitude towards the guideline Personal resources, such as time management, required to implement the guideline
Bollini et al. 2008	Tailored Schizophrenia treatment guidelines for local mental health services	Yes A team of senior clinicians and methodologists reviewed clinical guidelines and defined criteria for their operation into clinical indicators. Tailoring methodology is not clarified.	No	Authors believe they have developed a useful tool.

Croudance et al. 2003	Randomised control trial to examine the impact of adapted national guidelines compared to implementation of non-adapted national guidelines.	Yes GP facilitated workshops based on a modified nominal group technique to adapt national guideline for local use	No	No impact on practitioner performance. No impact on patient quality outcomes
Flottorp and Oxman 2003	Used a checklist to identify barriers and possible interventions to tailor interventions to improve the management of urinary tract infections and sore throat.	No	Yes In order to generate ideas to tailor interventions to address identified barriers the following were used: <ul style="list-style-type: none"> • Review of the literature • Brainstorming • Focus groups • A pilot study • Small group discussions • Interviews 	A systematic approach using qualitative methods helped identify barriers and to generate ideas for tailoring interventions
Graham et al. 2005	Adapted national and international leg ulcer best practice guidelines for local use.	Yes Guideline tailoring used the following process: <ul style="list-style-type: none"> • Systematic searching for practice guidelines • Appraising the quality of identified guidelines using a validated guideline appraisal instrument • Content analysis of guideline recommendations • Selecting recommendations to include in the local protocol Obtain practitioner and external expert feedback on the proposed protocol	Whilst Graham et al did not attempt to tailor context in this study, the knowledge and expertise brought to the discussion by the stakeholders could in theory begin a process of context tailoring as they have the potential to identify local factors and inform implementation strategies	Creation of an adapted guideline tailored to the local context

Graham et al. 2004	Examined the factors which influenced the implementation of an evidence-based foetal health surveillance guideline	No	Yes Data regarding views about implementation were gathered using focus group interviews (with nurses) and individual interviews (with educators and administrators).	Found that there is a need to investigate the barriers and enablers that may influence the use of evidence-based guideline in practice. In addition, this research also highlights the importance of careful tailoring of implementation interventions to address the identified barriers.
Hamilton et al. 2007	Examines barriers and enablers to change prior to the implementation of a multidisciplinary assessment for acute stroke care	No	Yes Researchers used interviews and questionnaires to obtain the views of key stakeholders	The data enabled the tailoring of the implementation strategy to the specific needs of the Trust.
Harrison et al. (2005)	Leg-ulcer care in the community, before and after implementation of an evidence-based service	Yes Guideline adaption: <ul style="list-style-type: none"> • interdisciplinary task force • feedback from external experts • Adapt to local context <ul style="list-style-type: none"> ○ Audit of existing models of delivery ○ Identify influencing factors Implementation strategies: <ul style="list-style-type: none"> • Education and training • Introduction of “buddy system” • Service reorganisation 	No	Reorganisation of care for people with leg ulcers was associated with improved healing and more efficient use of resources
Hutt et al 2006	A multifaceted intervention to implement guidelines in a nursing home setting	No	Yes Engagement with key professionals to assess implementation barriers Staff development and education Guideline tool kit	Results indicate that interprofessional collaboration to identify barriers and enablers and to design implementation strategy helped to enhance guideline use

Jans et al 2001	Sought to identify barriers and problems that GP's expected to encounter when adhering to Dutch guidelines for the management of asthma and COPD.	No	Yes Researchers used questionnaires to identify barriers to implementing the guideline They used strategies such as, education, discussion groups and audit and feedback as strategies to overcome perceived barriers and to facilitate the implementation of best practice guidelines.	Although the researchers attempted to tailor implementation strategies to better fit the context the validity of the guideline validity was questioned by several GP's and this perhaps raises the need for consideration of local adaption of guidelines, to fit the needs of the local context.
Janssen et al. 2011	A qualitative study of the implementation of a triage in emergency departments guideline.	No	Yes Used questionnaires and focus group interviews to examine the factors influencing the implementation	Factors influencing implementation were identified as: <ul style="list-style-type: none"> • Social context • Organisational level • Knowledge • Insight • Skills • Work preferences • Motivation • Commitment/ support • Roles and responsibilities • Workload • Resources Identification of barriers and tailoring implementation strategies to these barriers improves the implementation.

Kirsh et al. 2008	In-depth case analysis of implementation and sustainability	No	Yes Case records and observations were used to examine the pre-implementation context, the process of tailoring and implementation of the intervention	Concludes that interventions must be tailored to meet the needs of the sites in which they are implemented. Guidance on specifics of tailoring to the practice environment is not explored.
Leslie et al. 2006	Study reviewed implementing ADHD national guidelines into primary care setting	No	Yes The study used open-ended interviews with clinicians to establish if the national guideline was suitable for this primary care setting	Results indicated that there was a need to tailor implementation strategies to more closely fit the needs of children and families in this primary care setting.
Lobach 1995	Describes a model for adapting a diabetes clinical guideline for electronic implementation in primary care	Yes Uses consensus building, which consists of Delphi survey method to review guideline by rating the relevance of recommendations and to elicit comments on how the recommendations might be modified to make them more acceptable. Opinion leaders were engaged to influence practitioners to engage in guideline adaption and to be a resource for practitioner and influence clinical practice.	No	The process used enabled the published guidelines to be adapted to the primary care setting and facilitated guideline acceptance. Consensus methods via survey enabled rapid feedback, allowed clinicians to have input individually and to express views, which they may not have voiced in a public forum. Group consensus at the final meeting allowed dissenter to discuss concerns with colleagues and ultimately join the consensus opinion.

Poulsen et al. 2010	Cultural adaption of a national evidence-based parenting intervention	<p>Yes</p> <p>Examine potential interventions</p> <p>Making necessary modifications, by assessing the target population in relation to cultural norms. Modifications were made to address the local cultural issues relating to sexual education.</p> <p>The core guideline elements were not altered to safeguard fidelity</p>	No	An evidence-based intervention can be successfully adapted for a new context if it is relevant to local needs
Schull et al. 2011	Describes the development of a guideline and training program designed to integrate HIV/AIDS care with other primary care in Malawi	<p>Yes</p> <p>Multidisciplinary team tailored guideline and designed training intervention.</p> <p>Guideline tailoring:</p> <ul style="list-style-type: none"> Group discussions with key personnel Review of current treatment policies Creating a match between current practice and national guideline recommendations 	No	Tailored guideline is currently being piloted.

Appendix 3:2: Related cases

Related cases				
Author and date	Study focus	Tailoring existing evidence/ guidelines (<i>Evidence tailoring</i>)	Tailoring implementation strategies to the local context (<i>Context tailoring</i>)	Outcome
Ackermann et al. 2007	Adapting the Diabetes Prevention Program (DPP) for YMCA delivery	No Discusses adapting diabetes guidelines to fit in with reviewed literature, but no evidence of tailoring attributes. Overall it is unclear how existing intervention was tailored, article describes intervention, rather than the process used.	No	Development of a model for broad community based diabetes prevention lifestyle intervention.
Chlan et al. 2011	Tailoring a treatment fidelity framework for an intensive care unit	No Tailoring methods unclear; appear to use local facilitators and education.	Identified inconsistencies in presentation and implementation of an innovation. Introduced a treatment fidelity framework to monitor adherence of participants. Offered training to participants in an attempt to overcome inconsistencies in treatment delivery	Adherence to treatment framework showed a steady improvement
Hart and Morris 2008	Reviews guideline compliance rates	No	Potential Uses interviews and questionnaires to seek clinicians views about guideline compliance rates	Study found poor compliance rates. The need for training; knowledge and skills and relevance of the guideline were identified as key factors affecting implementation.

<p>Helfrich et al. 2007</p>	<p>Adapt an organisational framework of innovation implementation developed and validated in a manufacturing setting</p>	<p>No</p>	<p>Unclear Performs an investigation into suitability of adapted framework prior to implementation. Data collection included: Interviews Questionnaires Archival documents The following determinants of implementation effectiveness emerged: <ul style="list-style-type: none"> • Management support • Resource availability • Implementation policies and practices • Innovation champion • The fit between the innovation and users' values The climate for implementation.</p>	<p>The adapted conceptual framework was a good fit with the empirical data, and offered a model for implementing complex innovations.</p>
<p>Hickson and Hill 1997</p>	<p>Implementation and audit of a nutritional assessment tool designed for use by community nurses.</p>	<p>Yes Tool was adapted for use in the community using: <ul style="list-style-type: none"> • Training and educational workshops Use of the tool was evaluated using a questionnaire and case note audit.</p>	<p>No</p>	<p>Although the nutritional assessment tool was adapted for use in the community, how this was achieved is somewhat unclear and resulting uptake was poor.</p>
<p>Hysong et al. 1998</p>	<p>Examined implementation strategy patterns in Veterans Affairs primary care clinics</p>	<p>No Audit of clinic performance No tailoring processes discussed.</p>	<p>No</p>	<p>Local adaption may result in more successful implementation and higher guideline adherence.</p>

Jansen et al. 2007	An ethnographic process evaluation of tailoring intervention procedures to routine primary health care practice.	Proposes a guideline for tailoring	Maybe Observations and interviews were used to investigate the factors which influenced programme tailoring in the primary health care environment	Tailoring intervention procedures without standard protocols hindered implementation. Found that a guideline for tailoring was required
Jones et al. 2007	Examined barriers and enablers affecting the implementation of a Canadian clinical practice guideline	No	Although tailoring was not specifically used this paper sought to identify barriers and enablers in the ITU setting to the use of a national nutritional guidelines. Different sites were used to establish the factors which influenced guideline adoption	Interview data analysis highlighted barriers such as: Resistance to change, lack of awareness, lack of critical care experience, resource constraints, workload, paucity of evidence, and outdated guidelines
Lundgren et al. 2011	Examines how community-based addiction treatment organisations modify evidence-based practice.	Yes Interviews practitioners.	No	Concludes that evidence-based practice is often modified and calls for standards that define appropriate modifications. Believes that guidelines for modifications to evidence-based practice should be set by researchers and not treatment providers.
Maviglia et al. 2003	Implementing complex, multistep computerized practice guidelines for the long-term management of chronic diseases.	No	Yes Effort to achieve agreement among experts with regards to guideline recommendations was extremely time consuming and often overcomplicated the guideline.	Implementing complex guideline is extremely difficult. Biggest obstacle to implementation of guideline was with presentation and integration into clinical workflow. Clinicians rarely interacted with the online version of the guideline.
Montoya et al. 2011	Development of a primary care cardiovascular disease	Yes Summarised and tailored evidence-based strategies for cardiovascular	No	Authors concluded that this methodology enabled target users to translate general, evidence-based

	prevention and management guideline	disease to formulate a local guideline. Eight review committees reviewed current guidelines and made recommendations that were relevant to the specific practice population.		interventions into care strategies specifically for the practice population.
Peleg et al. 2008	Describes lessons learnt from adapting a generic narrative diabetic foot guideline onto a clinical information system.	Yes Guidelines were created by researchers in the field of computerised guidelines Often clarifying decision making concepts was problematic. As was creating a suitable fit with the local setting and integration with workflow.	No	The use of the finalised guideline in practice was not evaluated.
Ploeg et al. 2010	A mixed method study to examine the role of best practice champions	No	Yes Interviews and surveys were used to examine the role of champions in diffusing best practice guidelines.	Champions were found to tailor evidence to their local context. They collaboratively made decisions about which guideline recommendations to implement, which educational strategies to use and which assessment tools to put in place. The two strategies most frequently used to tailor implementation to the organisational context were: exploring, auditing, and monitoring best practices and policy and documentation changes to incorporate best practice guideline recommendations.
Van Peppen et al. 2008	Surveyed the used and barriers and facilitators for use of a Dutch	No	Yes Surveyed physiotherapists to establish perceived barriers and	The researchers concluded that robust setting-specific tailored implementation strategies based on

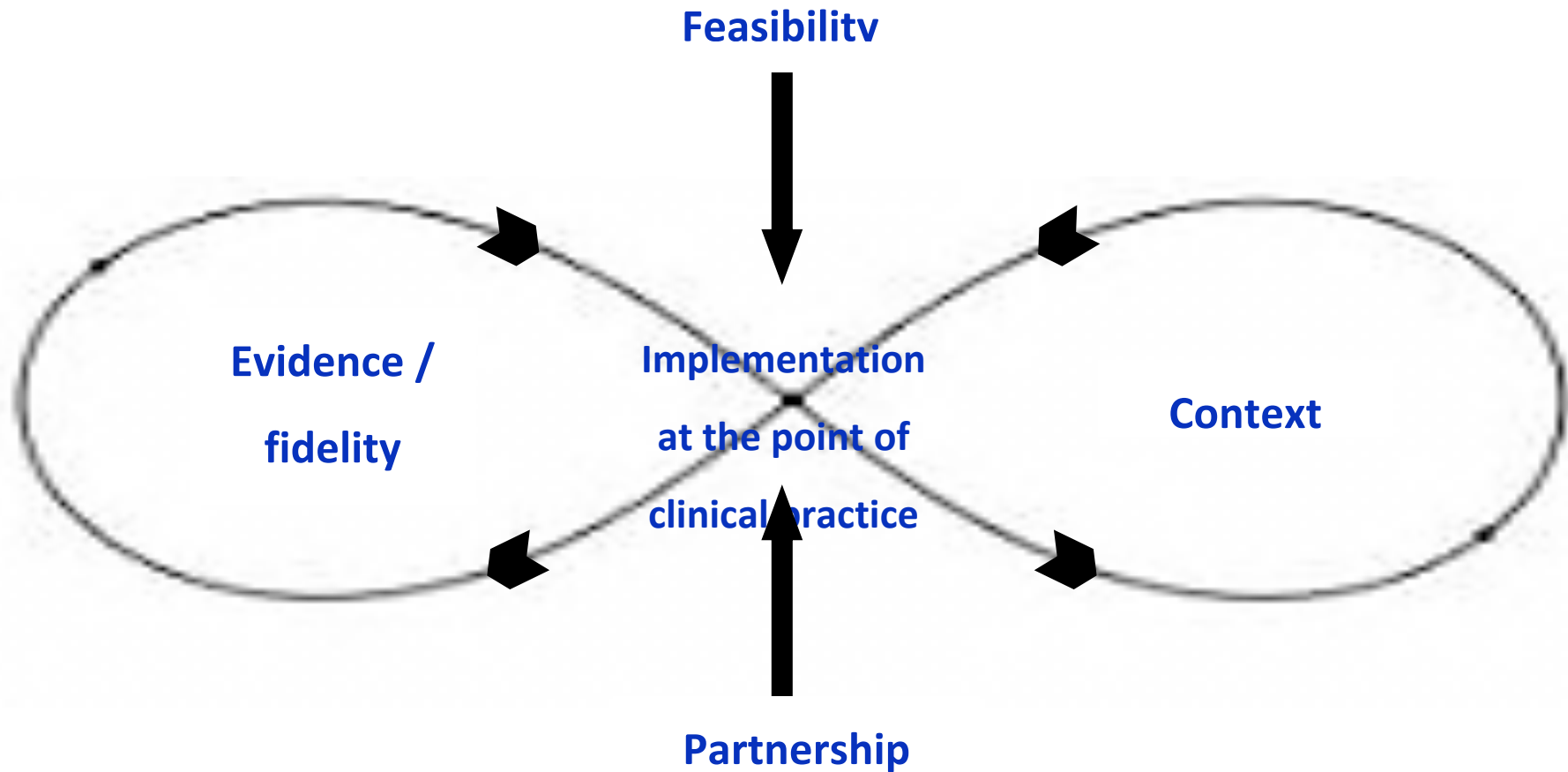
	physiotherapy clinical practice guideline		enablers to using a national guideline. Although they found a positive attitude towards using the guideline, they also found the following barriers: Changing routines Time investment Financial compensation	the reported barriers and enablers was required.
Vidal-Trecan et al. 1999	Assessed the practical feasibility and adaption of thyroid nodule guidelines	Yes Clinicians were questioned about the completeness and usefulness of guideline recommendations via a self-administered, semi-structured questionnaire.	No	Survey results led to minor changes to the final version of the guidelines.

Appendix 3:3: Contrary cases

Contrary cases				
Author and date	Study focus	Tailoring existing evidence/ guidelines (<i>Evidence tailoring</i>)	Tailoring implementation strategies to the local context (<i>Context tailoring</i>)	Outcome
Crotty et al. 2004	A randomised control trial intervention to implement evidence-based practice in residential care	No	No Clinicians at intervention site received training and education Link nurses were appointed at intervention sites A pharmacist visited each site	Outcomes were measured using pre-and post-intervention audits. No significant difference was found between the groups.
Tan et al. 2007	An audit of the impact of implementation of a stroke care pathway.	No Unclear how evidence base was used to design the care pathway. Does not appear to collaborate with key stakeholders. The pathway was introduced to clinicians at a local conference and the principle investigator contacted frontline staff throughout the duration of the study	No There appears to have been no examination of the local context.	The authors found a poor adherence to the stroke care pathway, which resulted in continued treatment delays.

Appendix 3:4: An emerging framework for Tailoring Guideline Implementation

Tailoring in Action



Appendix 4:1: The original and revised interview schedules.

Original questionnaire:

Interview programme for care home staff

Q1 – Please tell me what your role is and what that involves in (*Name*) Care home

Q2 – Do you care for any residents with stroke?

Q3 - How do you think the effects of stroke influence:

Q3a - The physical functioning of residents

Q3b - Residents mental health and well-being

Q3c - Residents ability to self-care

Q3d - Residents self-esteem and autonomy

Q3e - Residents social integration and isolation following stroke

Q4 - How do you and the care team within your home:

Q4a - Facilitating development of coping and adaption skills for residents with stroke

Q4b - Promote physical well-being, including skin care, nutrition & hygiene for residents with stroke.

Q4c - Create a sustainable environment for rehabilitation for residents with stroke

Q4d - Collaborate with and reinforce the treatment regimens of other professional groups involved in the care of residents with stroke

Q4e - Create a 24 hour presence for residents with stroke

Q4f - Engage in or engage with specialist roles, such as continence and skin care for residents with stroke

Q4g - Provide emotional support for residents with stroke

Q4h - Get information about stroke

Q4i - Keep a record of your care interventions for residents with stroke

Q4j - Review the quality of your care interventions for residents with stroke

Q1 – Please tell me what your role is and what that involves in (*Name*) Care home

Q2 – Do you care for any residents with stroke?

Q3 - How do you think the effects of stroke influence:

Q3a - The physical functioning of residents

Q3b - Residents mental health and well-being

Q3c - Residents ability to self-care

Q3d - Residents self-esteem and autonomy

Q3e - Residents ability to socially interact following stroke

Q3f – Do you think stroke can socially isolate residents?

Q4 - How do you and the care team within your home:

Q4a – Help to develop the residents coping and adaption skills following stroke?

Q4b – Promote or encourage physical well-being, including skin care, nutrition & hygiene for residents with stroke.

Q4c - Create an environment for rehabilitation for residents with stroke

Q4d - Collaborate with other professional groups involved in the care of residents with stroke

Q4e – Reinforce the treatment regimens of other professionals involved in the care of residents with stroke.

Q4f – Create a 24 hour presence for residents with stroke

Q4g – Engage in or engage with specialist roles, such as continence and skin care for residents with stroke

Q4h – Provide emotional support for residents with stroke

Q4i – Get information about stroke

Q4j – Keep a record of your care interventions for residents with stroke

Q4k – How do you review the quality of care for residents with stroke?

Appendix 4:2: Initial coding framework

Tailoring characteristic	The Beeches	The Oaks care home	The Sycamores care home
Consequences: impact upon care home culture and day to day running of home			
Language			
Feasibility: fit with care home context			
Fidelity: do the tailored recommendations still reflect fundamental characteristics of the original recommendations			
Time: process or one off event? tailoring in action and the impact upon context			
People: what they bring, insiders/outside rs the perspectives of the care home staff			
Stakeholders: who they are and who they represent; who's views matter more?			

Different types of evidence: what get privilege and why			
Barriers: factors which will influence implementation of the tailored recommendations			
Enablers: : factors which will influence implementation of the tailored recommendations			

Extra characteristics:

Raising awareness

Risk taking

Responsibility

Appendix 4:3: Developed coding framework

Tailoring characteristic	The Beeches	The Oaks care home	The Sycamores care home
<p>1. Consequences: impact of care home culture and day to day running of home</p>	<p>“The kind of residents we have are taken up with washing, dressing, moving from room to room and that is what are time is taken up with unless we have anybody who has had a stroke and then we understand they can’t use the left side or they can’t move their right hand, or their speech has gone from some people who have had strokes. So we have to do hand movements because what they are saying there is not coming out. If you understand, so they are the kind of things we do” (first workshop transcription, page 4, goal setting, carer).</p> <p>We haven’t had a lot of stroke people only people with dementia, (I would be willing to learn) but if we had someone coming in it would be nice if somebody that told you properly what we are supposed to do (first workshop transcript, page 7, goal setting, carer).</p> <p>Well at the moment the carers are not supposed to talk with family more written in notes with the nurses. Especially if it is medical we are not supposed, nurses tell us because we ask – family should go to nurse</p>	<p>Whether it was effective and he was less frustrated and less ‘kick offs’ (first workshop transcript, page 2, goal setting: carer).</p> <p>But if we had not pushed with those goals, he would have still had his nasal gastric tube.</p> <p><i>So how did you know to push?</i></p> <p>Because we sat there and talked to him what was important to him, what he did not like about the tube, conscious of it, feel it at the back of his throat, people could see it, all those things. So we started to explore other options and get other people involved. We got MDT sent him off to... and swallow, all those sort of things (first workshop transcript, page 3, goal setting: carer).</p> <p>When they come to us they just get on with it really. All the caring so when you are asking what our achievements are, for us our biggest goal for anyone would be we have the right information for</p>	<p>Don’t really do unless they have physio we don’t really do rehab. It just gets draw into one big problem (first workshop transcript, page 12, goal setting: nurse).</p> <p>We see physio as being the rehab (first workshop transcript, page 12, goal setting: nurse).</p> <p>Usually we don’t get training we have to ask for it (first workshop transcript, page 9, goal setting: nurse).</p> <p>We could write it in the care plan but it does not mean that it is always read although the basic outline is the person’s needs (first workshop transcript, page 14, goal setting: nurse).</p> <p>The only way you could do it to make sure every person’s needs were met and updated regularly through their carers (first workshop transcript, page 14, goal setting: nurse).</p> <p>If enough people do it they would go with the flow (nurse).</p>

	<p>in charge (first workshop transcription, page 8, goal setting carer).</p> <p>We do rely on carers a lot (first workshop transcription, page 9, goal setting, nurse).</p> <p>Yeah but does that include cleaners and kitchen staff because we don't want them interfering in what we do. Maybe carers and nurses – that will separate us from them (first workshop transcript, page 16, consensus methods, carer).</p> <p>Is there a call for them being involved – no they shouldn't be involved (first workshop transcript, page 16, consensus methods, nurse).</p> <p>I think once we know it is a bit different, if we know what something means, it is just that we don't come across it every day. When you have been told it, you learn from it. You go along with it but until we have been shown it I probably wouldn't have known it (first workshop transcript, page 18, goal setting: carer).</p> <p>But now I understand your goals so now I understand it but half an hour ago you were saying goals and I thought what the hell is she talking about! (first workshop transcript, page 19, goal setting: carer).</p> <p>I understand your goals but I think here we have got no goals to achieve for the</p>	<p>when they come in here, things are not set out, the best quality of life for them (first workshop transcript, page 3, goal setting: carer).</p> <p>Their initial goals is to keep them comfortable, settle them in, but as you get to know them there are some patients that you recognise potential (first workshop transcript, page 6, goal setting: carer).</p> <p>Old care plan (nurse) - Yeah I was just thinking that (first workshop transcript, page 9, goal setting: manager).</p> <p>It would be goals (nurse)</p> <p>Careful nowadays - Realistic achievement of goals (manager).</p> <p>We can't bring things like that in it...(nurse)</p> <p>Got to sort that out (manager)</p> <p>Careful what you write (first workshop transcript, page 9, goal setting: nurse and care home manager discussing documentation).</p> <p>But when somebody has had a very bad stroke and they end up with gastric feed or a 'peg' we are not really able to participate in that decision most of the time, the relatives are so scared of losing</p>	<p>Yeah go with the flow –know what is best (carer) (first workshop transcript, page 22, goal setting).</p> <p>Would not get written on dependent on certain staff, writing these things on. Not reviewed as often as it should be. Not used as it should be (first workshop transcript, page 14, goal setting: nurse).</p> <p>What the physio are trying to do with the people here who have had strokes is to maintain the level that they are at now, not improve them maintain it (first workshop transcript, page 19, goal setting: nurse).</p>
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	<p>residents we have got (first workshop transcript, page 19, goal setting: carer).</p> <p>What is saying we have got a timescale we have got from 8 O'clock till 11 ish because we have to get them ready for dinner, we have got how many people on that list, say 7 people to get up, wash them, dress and make them andlikes to do their hair, likes to take them to the hairdresser and sometimes very rare you do not have time to do that and get to know them, we haven't got time. Really speaking we are actually only making sure they are clean, being fed and not in pain and looked after (first workshops transcript, page 23, goal setting: carer).</p> <p>Really speaking we are actually only making sure they are clean, being fed and not in pain and looked after (first workshop transcript, page 23, goal setting: nurse).</p> <p>They need interaction with us but they are not they are getting stereo typed – it is like on a conveyor belt and it should not be like that (first workshop transcript, page 25, goal setting: carer).</p> <p>We are having to move on to our next job. And that is why I was so defensive to say about paperwork because nobody, with no disrespect I do not want to do any more paperwork. I want to be looking after them</p>	<p>mum/dad/whatever they do not realise the implication that they may never again but able to have a drink again, never eat again, they may possible be bed bound, there are actual affects that a stroke has on somebody and we have had people here for years who can't communicate – no quality of life whatever. You know, and the decision has to be made to keep that person alive by the relatives (first workshop transcript, page 11-12, goal setting: nurse).</p> <p>There has to be a prognosis this is not appropriate, then again all that was made without the families consent. This little old lady can't consent. Even the peg lady said why are we stuffing the tube down... (first workshop transcript, page 12, goal setting: nurse).</p> <p>I think it is important to get the message across I am not just saying young staff –it is to everyone. Wrong word, wrong tone of voice, impatience it makes that patient feel, when they are so dependent on you, that they have lost their independence and dignity, we need to give it back to them as much as possible (first workshop transcript, page 14, goal setting: care home manager).</p> <p>You may not have a choice.</p>	
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	<p>– you know what I mean (first workshop transcript, page 26, goal setting: carer).</p>	<p>Once the tube is in, it is so difficult to stop we have actually said now when the GP was here and everybody we have actually said if (name omitted) is not a candidate to have a tube in her tummy that is fine, we have got to have another meeting, we have got to decide what is in the best interest</p> <p>What are we trying to achieve for this lady?</p> <p>If the family decide that they don't want it to happen...</p> <p>It is not as straight forward as that, the tubes are in,</p> <p>Legally best interests? (first workshop transcript, page 14, goal setting: nurse).</p> <p>We do it on care plan but not as goals.</p> <p>The care plan used to be this is your aims and this is your goals. One sheet – so simple. The powers that be did not think that was good enough so they changed it, and changed it, we have now got a sheet for every single problem that this person has (first workshop transcript, page 23, goal setting: care home manager).</p>	
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		<p><i>Do they relate to what you currently do?</i></p> <p>Maybe way it is set out. We all do these things everyday but we don't actually put it down (first workshop transcript, page, 28, goal setting: nurse).</p> <p><i>Do you think that implementing these will enhance the care?</i></p> <p>No. Not necessarily – because we do it anyway (first workshop transcript, page 28, goal setting: nurse).</p> <p>Some of it is basic care – seems to have gone both in the hospital and cascades down into the care home as well (first workshop transcript, page 30, goal setting: care home manager).</p> <p><i>How do you think the rest of your colleagues would react to this – goal setting?</i></p> <p>End of the day it's people's life – everyone would go with it (first workshop transcript, page 34, goal setting: carer).</p>	
2. Tailoring guideline - Language	This thing talking about goals, we just go in and give them the best care that they can get. (Beeches first workshop, page 3, 5/2/14: carer)	<p>So this one is about the patients</p> <p>I think were you have got be given help should say</p>	How do you think your colleagues here etc. would accept the wordage? Would you be able to fit this amount of words in your

	<p>Are you happy with expressions such as cognitive or linguistic impairment? (page 13)</p> <p>Yes!</p> <p>What you mean, you mean?</p> <p>Are you happy with that terminology?</p> <p>No, don't know what it means.</p> <p>Right o.k. thank you for that.</p> <p>Anyone else know what it means?</p> <p>Don't know what cognitive means.</p> <p>I know what linguistic means (page 14).</p> <p>Well I would say toif I got given that, being my nurse, I would say what does that mean in a way you sort of know but</p> <p>To put it into layman terms and layman terms is exactly what you need if you are going to be using it on a day to day basis otherwise you will just ignore it, and not use it.</p> <p>So, what do you think cognitive or linguistic impairment means?</p> <p>Problems - Thinking – can't use limbs</p> <p>So, if you wanted to say they was participating in a goal setting unless they choose not to or are un able to because of</p>	<p>For residents to be given help. Know what you are talking about from the start.</p> <p>O.k.</p> <p>Define and express the views</p> <p>You helping them to express what they want</p> <p>So are you happy with that wordage now.</p> <p>So now we have got:</p> <p>For residents to be given help to understand the nature and process of goal setting and be given help to define and express their personal goals. Like that better?</p> <p>Yeah (Oaks first workshop page17/18)</p> <p>Look at the last one.</p> <p>Have goals that are meaningful and relevant.</p> <p>Happy with that one – do we need where appropriate there do you think?</p> <p>Yeah</p> <p>A challenging but achievable.</p> <p>Yeah</p> <p>Include both short term and long-term targets.</p>	<p>recommendation into your current what you do, would they need to be worded altered?</p> <p>Not sure.</p> <p>Does everyone know what that was about?</p> <p>They might not know what cognitive or</p> <p>Some of the words like that may need to be altered.</p> <p>o.k.</p> <p>So cognitive, linguistic impairment</p> <p>what number are we on next – 5</p> <p>Clinicians some people may not know what we are referring to.</p> <p>So how do you think we could alter that so that everyone would be able to recognise immediately what has been asked for?</p> <p>Put it into the language they use.</p> <p>What would you understand if we were talking about cognitive/linguistic impairment what would you use?</p> <p>Ability to communicate</p> <p>Mental capacity.</p> <p>In relation to cognitive – level of understanding.</p> <p>Carers – the same</p>
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	<p>what would you want to replace that with if anything</p> <p>Thought processes or – speaking ability.</p> <p>Yes</p> <p>What speaking ability or the ability to communicate (page 14).</p> <p>Perhaps on No. 5 (c) where it talks about the resident being given help to understand the nature and process of goal setting and be given help to define and articulate their goals – are you happy with that no (page 15).</p> <p>Yes – o.k.</p> <p>Do you think were we have clinicians in (d) you would prefer nurses/carers or (page 15)</p> <p>Yes, That what I would do but I would read this and I would sort of know myself but I would ask the nurse what does that mean and they would say relay it back me (page 15).</p> <p>But we need you to understand it this has been designed by you for you as it were(page 15).</p> <p>Who would be the clinicians – well it would be you guys.</p> <p>Are we clinicians – you are indeed.</p>	<p>What do we mean by short term and long term?</p> <p>Do we need to define that?</p> <p>No –they would know.</p> <p>Yeah</p> <p>O.k.</p> <p>Include both single clinicians and also the whole team.</p> <p>What would you like in there</p> <p>Care home staff?</p> <p>Care practitioners. Does that include nursing as well?</p> <p>Yeah</p> <p>Alter to single care practitioners and also the whole team.</p> <p>Happy with that – Yeah -o.k. (Oaks, first workshop, page 18/19)</p> <p>Documented with specified time bound measureable outcomes.</p> <p>Don't think you can have time bound personally</p> <p>Long and short-term goals aren't you.</p> <p>Look at Alan if you say within so may weeks, you're are waiting for and that - lot of work back and to.</p>	<p>What about define and articulate their personal goals?</p> <p>If you articulate something you are explaining to somebody what it is. So define and explain (Sycamores, first workshop, page 15).</p>
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	<p>Well I have never been called that. What would you like to be called within reason?</p> <p>Carers and nurses. I thought it was the whole team.</p> <p>I thought what that was saying is do we want it explained singular or the whole thing.</p> <p>All part of team - yeah</p> <p>all these fancy words aren't for me that is why they put it in it is us that do it. That is why Is saying if we don't understand a word, we are more like cares than clinicians (page 16).</p> <p>Would you like that to say to include carers/nurses or would you prefer it to say care home staff.</p> <p>Yeah – care home staff. To include all care home staff.</p> <p>Yeah but does that include cleaners and kitchen staff because we don't want them interfering in what we do, because they give drinks</p> <p>Maybe carers and nurses – that will separate us from them</p> <p>Good point.</p> <p>Is there a call for them being involved – no they shouldn't be involved (page 16)</p>	<p>Because you have got your time limit.</p> <p>So what we are try to say the help is needed as soon as possible.</p> <p>A specified time. Timeframe not meet.</p> <p>So that alerts you, to what has not been done. Not been sorted.</p> <p>If you don't set a timeframe you can't measure it.</p> <p>No.</p> <p>I just don't think where you have got time bound it does not sit right</p> <p>What would you like?</p> <p>Time line</p> <p>Got to do it in that time.</p> <p>Time frame.</p> <p>Be realistic.</p> <p>Realistic in there then? Everyone knows what that means.</p> <p>Not everyone knows what that means – I don't - exactly – so if that was written on a piece of paper you would ask what that means.</p> <p>When I started NVQ the trainers used the word holistic – what do you mean holistic, what are you on about but it has stuck in my mind.</p>	
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	<p>Is that going to cause confusion?</p> <p>I think once we know it is a bit different, if we know what something means, it is just that we don't come across it everyday. When you have been told it, you learn from it. You go along with it but until we have been shown it I probably wouldn't have known it.</p> <p>Yes.</p> <p>What about other folks who are not here today and this gets put into the documentation will they know what it means?</p> <p>Well no, because they haven't been taught.</p> <p>For them is there another way we could express it so that they may have more of an idea of what we are looking for or not. (page 18)</p> <p>So, I know what you mean, if I had picked this up before seeing you I would not understand it, but I would go to a nurse likesaid and asked them to explain. You mean to read it just now.</p> <p>So, if you were writing it out in terms if you had just picked it up</p> <p>But now I understand your goals so now I understand it but half an hour ago you were saying goals and I thought what the hell is she talking about!</p>	<p>When you put your goal setting recommendations in your record would it be a good idea to put that at the start to know what you're are looking to achieve.</p> <p>With an explanation of what it is.</p> <p>For that one :</p> <p>Are documented with realistic time frame and measurable outcomes.</p> <p>Yeah.</p> <p>o.k.</p> <p>Achievement evaluated using goal target attainment</p> <p>Basically saying only achieved it if they have met the goals</p> <p>Recheck on your goals basically isn't it.</p> <p>Re-evaluate the goals through your time frame to have achieved it, is the goal reached isn't it.</p> <p>The goal reached within the time frame. Because it has got to be something hasn't it.</p> <p>Achievement evaluated using goal attainment.</p> <p>Could change that to:</p> <p>Have they achieved their goal?</p>	
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	<p>I understand your goals but I think here we have got no goals to achieve for the residents we have got.</p> <p>O.k.</p> <p>But that is why we are doing the stroke.</p> <p>You have just explained several episodes of care where you have got goals you are not calling it that (first workshop, page 19: carer)</p> <p>I would say about 95% of the residents don't think there are goals for them, so where are they going, what is their aim, they're just, as long as they are comfortable, happy and clean (first workshop, page 19: carer)</p> <p>Say what I am going to say next – got to say it, please don't, why should I, it is bad and you are all going to say ooo but I am not being funny the nurses, no disrespectthe nurses are on £15 an hour, I do not know what you are on, up my wages and I might.</p> <p>Well what do you think it is asking you to do?</p> <p>Learn more and for learning , because a nurse has been to college and Uni –very good they should get</p>	<p>(Oaks, first workshop, page 19/20)</p> <p>Include carers where appropriate.</p> <p>Yes</p> <p>O.k.</p> <p>Do you like the word 'carers' or would you prefer to use family and carers</p> <p>We have done this as a whole team</p> <p>I think they mean informal carers, that is where I am wondering wording for you guys</p> <p>Would be better relative and family</p> <p>So what do you think?</p> <p>Family and significant others.</p> <p>O.k.</p> <p>But not the word carers.(Oaks first workshop, page 21)</p> <p>Guide and inform therapy and treatment.</p> <p>The goals are used to guide and inform therapy and treatment.</p> <p>What's that.</p> <p>You will have set a goal for everything they are doing so when you pass on that information whether in the care plan or when you hand over, everyone will know</p>	
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	<p>Can I just say something?</p> <p>I am on 'crap' money.</p> <p>If you don't want to learn – get out of the care system.</p> <p>No</p> <p>Because that is what it is</p> <p>I know that</p> <p>I want it in my pay packet as well.</p> <p>I know where you are coming from with the money</p> <p>So is it about the carer or the resident?</p> <p>It's about the residents</p> <p>Yes it is about the residents, cos it is but I am not bloody going to do training to be</p> <p>No, you have got it a bit wrong chick</p> <p>It is psychological how it affects them in the head.</p> <p>O.k. (first workshop, page 28, goal setting)</p> <p>Next one is – participate in the process of setting goals unless they choose not to or unable to because of their thought processes and their ability to communicate etc.</p> <p>Did anyone have under7 for that?</p> <p>No</p>	<p>what you are seeking to achieve through those goals.</p> <p>Like that wording differently? What would you like it to look like?</p> <p>So if what you are saying this is the information that is passed on to everybody this will be done on the hand over. That is communication.</p> <p>Goal is passed on.</p> <p>Goals are communicated within the team to provide care.</p> <p>Yeah.</p> <p>O.k. (Oaks, first workshop, page 21/22)</p>	
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	<p>See I did not understand it but I put 8.</p> <p>But now I want to change it to 9.</p> <p>O.k. fair enough</p> <p>Quite voice here at 1.06</p> <p>Yes, definitely it is a personal</p> <p>Homed in on the individual and what happens here</p> <p>Say I am not to do this or do that</p> <p>The person themselves are not expressing to do anything in any shape or form.</p> <p>Yes</p> <p>Because that is what I like about the</p> <p>So it almost gives you a tool for managing that concept.</p> <p>O.k.</p> <p>You are all happy that you involve the residents in the aims and task but goal setting hopefully in the future?</p> <p>O.k.</p> <p>So to be given help to understand the nature and process of goal setting I guess at present that includes the staff right now as well as the residents, so maybe the people that are in this room, if you do choose to move this forward that would be your role not just with residents but also with other</p>		
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	<p>members of care staff to explain what we are looking for.</p> <p>Do you think that at the moment your care plans and whatever written documentation that you use do they articulate to residents goal or they similar goals for all the residents?</p> <p>All the same (page 32/33).</p> <p>We know someone who walked, who walked like to the toilet and to get in the chair</p> <p>You have not got that in your documentation?</p> <p>No we don't sort of say it every day.</p> <p>To us it just comes as an everyday thing.</p> <p>If somebody wants something we would not go all the time and put it in our care plan, so and so has walked</p> <p>This would not require you to do that but what this is saying is, if you are happy to meet goals</p> <p>Definitely</p> <p>Would the goals not then help you, to say we need the resources.</p> <p>Yeah</p> <p>We need the courage to say as well... (page 35/36)</p>		
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	<p>Let's just look at this last one</p> <p>If we have got under the goals for (d)</p> <p>Goals that are meaningful and relevant to the residents, do you want patients in there by the way?</p> <p>Residents</p> <p>O.k.</p> <p>Are challenging as we mentioned earlier but achievable.</p> <p>I think that is the key they have got to be achievable</p> <p>It is pointless setting them otherwise.</p> <p>Include the short term – 8 weeks</p> <p>Long term weeks/months target.</p> <p>Um</p> <p>Include the carers and the nurses</p> <p>Yeah</p> <p>O.k</p> <p>Are documented with specific time bound</p> <p>Do you want them to be time bound or staged?</p> <p>Which is easier for you?</p> <p>Time bound sounds awful, as if you are rushing them.</p>		
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	<p>As if you are bound for time that what that means.</p> <p>So documented with staged measurable outcomes.</p> <p>Have achieved, achievement is evaluated using goal attainment, so in other words when they have achieved the goal.</p> <p>Yeah</p> <p>Are you happy with that statement?</p> <p>It is a bit of a 'gob full' isn't it.</p> <p>It is yeah.</p> <p>Yes it is</p> <p>I think it is very big</p> <p>So what could you put instead.</p> <p>Have achieved as indicated in the staged goal outcome</p> <p>I think it is the whole sentence isn't it</p> <p>The achievement yeah,</p> <p>Evaluate it</p> <p>Take that word out, because we know we are evaluating because we are doing it.</p> <p>So you have achieved the goal</p> <p>Just think of another word or take that one out</p> <p>Have achieved or have achieved</p>		
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	<p>Have achieved the end result</p> <p>Yeah</p> <p>Say it again</p> <p>If you have already got the goal and you know what to do you have got to the end well you have achieved the goal.</p> <p>I think as well there is an element in this when you, if you have got your staged goals,</p> <p>Let's go back towho didn't get to the dinner table</p> <p>If after two monthsgets pneumonia and he is not agreeing you need to re-evaluate it</p> <p>So are we saying they have either achieved the goal or we need to re-evaluate it.</p> <p>They have achieved the goal at this present time.</p> <p>He might not have, he might have got to his 2 months</p> <p>Are we going to say that he could of achieved it but because of other things he has not achieved it but you wouldn't just leave it you would re-evaluate</p> <p>Yeah</p> <p>I would of thought he had achieved the goal at that present time, which he has but then you would have to say</p>		
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	<p>You would have to reassess it again</p> <p>Yeah</p> <p>To see</p> <p>Re-evaluate it</p> <p>The problem with ongoing goals it is not measured, so if we have measured goals, to be set at staged times, if they are not going to reach the measure do we re-assess and set different targets.</p> <p>Yes that is what we have to do in our assessment in our care plans anyway on the risk assessment and that because you can see it goes up and down for different people all the time.</p> <p>They have good and bad days.</p> <p>Right o.k. in my head and you are going to shout at me now, but the only word I can think of is and give me a different one if you think of one</p> <p>Achieve the goal and re-evaluate it and the word is reconfigure the goal</p> <p>Can you think of another word that says the same thing.?</p> <p>Reconfigure means keeping an eye on it.</p> <p>Reconfigure means</p> <p>Reset it is yeah</p> <p>Reset that is good – then we reset the goal.</p>		
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	<p>Yeah</p> <p>O.k.</p> <p>I will change that</p> <p>Include carers where appropriate – I am not quite sure what they mean about carers</p> <p>I am thinking relatives rather than carers</p> <p>Yes because they don't need to know everything do they?</p> <p>Include relatives where appropriate</p> <p>That is where the dignity and confidentiality comes in.</p> <p>Yeah</p> <p>So you are you happy to include because obviously the carers will be included in everything.</p> <p>Yeah(page 40/41)</p>		
<p>3. Feasibility:</p> <p>Fit or focus within the care home:</p> <ul style="list-style-type: none"> • at organisational level • individual level 	<p>Do you set any care goals for them?</p> <p>I think we set standards (first workshop transcript, page 1, goal setting: nurse).</p> <p>So if the nurses sets the standards, then obviously the carers are going to carry out the care, so how do they know what to do is that broken down?</p>	<p>It takes time to do these things with these patients, if you have got three or four having physio for half an hour each time 4 times a day it is just not realistic and (name omitted) is like with this gentleman you are difficult he is OCD... as well, it is not straight forward but that is their input, here you go, here's your list</p>	<p>The general care is quite good, but, it is not necessarily indicate that the person has had a stroke (first workshop transcript, page 11, goal setting: nurse).</p> <p>The small goals like lifting up a cup, like moving a leg things like that we do not record as goals and perhaps we should (first</p>

	<p>Yes it is broken down(first workshop transcript, page 1, goal setting: nurse).</p> <p>How?</p> <p>It is broken down into basically; It is broken down into how they wash, how they move, how they feed their ability, pressure areas we look after that.. Carers would reposition them and chart them and report to us. If any changes. Got the aims that they have and the carers have got tasks that they have to perform (first workshop transcript, page 2, goal setting: nurse).</p> <p>How do the carers know for example anything has been achieved. what to look for</p> <p>They would know because they should have reports from the nurses every day. Any changes occurred (first workshop transcript, page 2, goal setting: nurse).</p> <p>We get told daily and we get to know and if we see something we can go and we get to know them bit better and we can go and say well she did this and you think oh, then if the next lot of carers go in done same thing and we report back to the nurses – that is how it is done (first workshop transcript, page 2, goal setting: carer).</p> <p>Like their mobility some days they might be able to do a couple of steps with a frame whereas another day you might have to get</p>	<p>off you go (first workshop transcript, page 4, goal setting: carer).</p> <p><i>If you were to do that would that make more work or would it fit in with what you currently do?</i></p> <p>We do it now.</p> <p>Even though we do not look at it as a goal it is on the plan of care (first workshop transcript, page 9, goal setting: nurse).</p> <p>We do it on care plan but not as goals. The care plan used to be this is your aims and this is your goals. One sheet – so simple. The powers that be did not think that was good enough so they changed it, and changed it, we have now got a sheet for every single problem that this person has (first workshop transcript, page 23, goal setting: care home manager).</p> <p>This would actually condense it all into a single sheet</p> <p>Could we actually devise a sheet for goals, for targets, for time set,</p> <p>Evaluation (first workshop transcript, page 23, goal setting: nurse).</p>	<p>workshop transcript, page 12, goal setting: nurse).</p> <p>Yeah we are repositioning and moving limbs all the time but it is not physio but also not what we see as rehabilitation (first workshop transcript, page 12, goal setting: nurse).</p> <p>We are moving limbs which is exercise which is physio really (first workshop transcript, page 12, goal setting: nurse).</p> <p>We are looking at splitting the unit into smaller pods so that you have got staff so the communication and the care will be better getting that across maybe doing that will work because being such a huge team of one, communication is not always fantastic it gets missed (first workshop transcript, page14, goal setting: nurse).</p> <p>The only way you could do it to make sure every person's needs were met and updated regularly is through the carers. She says... (nurse)</p> <p>And what would that look like? (researcher).</p> <p>Said about our Manager's chart so that everyone can see but then every carer has not got masses of people to look at there is what two – that's manageable. Communicated on the sheet which everyone</p>
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	<p>a wheelchair because they are not walking as good you know that is the type of things that we do, so when it comes to goals unless it was like said to us you need to do this and this with a certain person today then we would not know (first workshop transcript, page 3-4, goal setting: carer).</p> <p>I think personally that rehabilitation is trying to help somebody do things the best they can and to use their arms after they have had the stroke. Do things a bit better (first workshop transcript, page 7, goal setting: carer).</p> <p>But there are times as carers we see somebody who is on a different diet that needs a bit more and we go to the nurse – that could be a goal (first workshop transcript, page 9, goal setting: carer).</p> <p>Sometimes they start off with just a soft diet and then it goes a bit more different – pureed it changes every day – changes so quick (first workshop transcript, page 9, goal setting: carer).</p> <p>If something has changed it will go in their care plan... everything is documented (first workshop transcript, page 10, goal setting: nurse).</p> <p>If we don't know what we are doing we have not got a goal to aim for (first workshop transcript, page 31, goal setting: carer).</p>	<p>Maybe way it is set out. We all do these things everyday but we don't actually put it down (first workshop transcript, page 28: nurse).</p> <p><i>Do you think that implementing these will enhance the care?</i></p> <p>No. Not necessarily – because we do do it anyway (Nurse).</p> <p>We can't change the services we are battling against and I know all the girls do what they can with the resources we have got. So no not necessarily. No (first workshop transcript, page 28, goal setting: care home manager).</p> <p>One thing that I would like to see happening is, I know you said you had got exercises off the physio, half an hour- 4 times a day that is not always necessary if all the staff were trained to do these exercises as part and parcel when they are getting them up or when they are mobilising them, when they are changing them and it became a way of life and that is what you do on a regular basis (first workshop transcript, page 30, goal setting: manager).</p> <p>We used to do that. Time and things (first workshop transcript, page 30, goal setting: carer).</p>	<p>sees (nurse)(first workshop transcript, page 14, goal setting).</p> <p>What about the emotional side of rehabilitation? (researcher)</p> <p>We have got the activities here, try and get them involved in doing that and even playing the board games that is emotion for getting involved- cognitive element - it is physical as well, they are do whatever they are doing so they are moving and they go on the quizzes. And it is getting their brain ticking over (nurse) (first workshop transcript, page 16, goal setting).</p> <p>We have constant communication that is how, - that is how you achieve your goal. If there is issues we try to record conversation where needed not all the time would not do any nursing things, I would just be writing. Where there is an issue they don't understand I try to explain this – you know (first workshop transcript, page 18, goal setting: nurse)</p> <p>Anything you would need to change to do that any big things to implement that (researcher).</p> <p>No initially a change of mind set how the nurses write things down but if we all went through it and gave an example of this is</p>
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	<p>They are doing it. Need to achieve that goal. Changing the care plan. Getting the aim and putting the goal underneath it (first workshop, page 36, goal setting: nurse).</p> <p>Not got the steps to demonstrate that. Got care plan written on my arm so that I don't forget (first workshop transcript, page 36, goal setting: nurse).</p> <p>So you think these goals are relevant to what you currently do and you are happy to try and get them into your current practice</p> <p>We have discussed ways in which we might do that (first workshop transcript, page 41, goal setting: nurse).</p> <p>We all know what we are doing working as a team. And to some extent you know what is already going on. ...sometimes there is no consistency sometimes if I have been off for a week I will say... they don't tell me how to do my job because I am a carer but I will say I am not sure and she will say what they have been doing this day. So I will ask because they've been here and they know. And it is nice to see the care and discuss it. So we will pass it on (first workshop transcript, page 45, goal setting: carer).</p>	<p>They find time for other tasks of care, I am not saying we have not got the capacity to go to an hour and half each morning one person doing physio (first workshop transcript, page 30, goal setting: manager).</p> <p>One small task a day.</p> <p>If the staff were trained better to deal with that stroke as they are washing them - exercise, not a chore, it is all part of care (first workshop transcript, page 30, goal setting: manager).</p>	<p>how write certain things down. Then no (nurse) (first workshop transcript, page 21, goal setting).</p>
4. Fit with resident's individual needs/complex comorbidities	<p>This thing talking about goals, we just go in and give them the best care that they can get (first workshop transcript, page 3, goal setting: carer).</p>	<p>Some people's stroke are different to each other, because some people have a mild stroke requiring just physio and day to day and some might need further (first</p>	<p>Look at specific residents, we have got here I can't see specific short-term goals change much for that person (first workshop transcript, page 14, goal setting: nurse).</p>

	<p>More dementia here. They are coming in with a stroke so nine times out of ten like said they can't compute, because of their dementia we keep them clean and tidy and fed we do like said they do have good days, we do promote and we give them dignity but there is rehabilitation thing we can't rehabilitate somebody who's... We have not been taught to rehabilitate (first workshop transcript, page 4, goal setting: carer).</p> <p>You are thinking of the people we have got and you do think how can we make the day more interesting for them. Now today they are having a bit more because we are having a singer on and there is more for them in the lounge, instead of them just sleeping there will be someone in the lounge to keep them awake. Yesterday we tried to play bingo, they can't play it, but a least we will sit with them and try and do things with them, but it is not... (first workshop transcript, page 21, goal setting: carer).</p> <p>Yeah but some people of 80 years of age still go out for their newspaper and doing things, but some of our resident don't want to do anything. Some do not even want to get up in the morning (first workshop transcript, page 22, goal setting: carer).</p>	<p>workshop transcript, page 1, goal setting: carer).</p> <p>The gentleman that we have got he cannot communicate, we started out with a book got severe... he could not do it, we had big problem communication and frustration. Important to break this down to make a goal that he can effectively communicate (first workshop transcript, page 1, goal setting: carer).</p> <p>We can't outcome of that, tried all sorts we had the speech and language in and they wrote him off. Stroke team involved, they are involved now, he is not a straight forward gentleman, not just a stroke patient he is... with other issues as well (first workshop transcript, page 1, goal setting: carer).</p> <p>Yes, we had a gentleman that came in with 'nil by mouth' needed nasal gastric tube fitted on his face, he would not come out of his room he was really conscious we went through the process of the 'peg' inserted with him, they had wrote him off in hospital as not a candidate to have the 'peg' inserted and eventually he eats, he has a shandy, only small amounts. Goal achieved (first workshop transcript, page 2, goal setting: nurse).</p>	<p>For the people who have had a stroke they find, it is harder for the family to except what has happened to them and they tend to treat them like a child although they have had a stroke a lot of them have still got it, they know what is happening to themselves (first workshop transcript, page 17, goal setting: nurse).</p>
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	<p>We are getting the worse people that can't do that. But they are still a person and may need to have that. They need interaction with us but they are not they are getting stereo typed – it is like on a conveyor belt and it should not be like that (first workshop transcript, page 25, goal setting: carer).</p> <p>I think we should, if they are going to come in here like (<i>name omitted</i>) has just said we should look after them if it is a year, a month or seven years we need to know everything dementia, Alzheimer's, strokes, swallowing difficulties everything. We need to now we need to look because otherwise we haven't got the tools we can't look after that person (first workshop transcript, page 31, goal setting: carer).</p>	<p>He had had a stroke a good 5 to 6 years before he came to us and he has not got OCD complications on top of the issues of the stroke, so it gives us more problems in trying to get closeness with him. Can't go in there, If you put your hand on something or touch something he will just explode so staff get wary, because he can get quite violent, it is just because he gets so frustrated bless him, it is a shame because you are limited, now and again he will draw something but it is completely different to what he actually saying and what he actually wants. You can be in there an hour trying to figure out what he wants (first workshop transcript, page 4, goal setting: carer).</p> <p>You know with the gentleman here who wanted a drink he was unable swallow... he understood all the risks so we got people in and documented it all, ...his risk to take.</p> <p>That is him engaged in his role care.</p> <p>He said to me today I am not going to the pub today because I can't have a beer (first workshop transcript, page 33, goal setting: nurse).</p>	
5. Fidelity: do the tailored recommendations still reflect			

fundamental characteristics of the original recommendations			
6. Time: process or one-off event? tailoring in action and the impact upon context		But I think sometimes the people we have got in the home who have had strokes they have had them for years before they came here, so they have already been failed. By who ever looked after them before (first workshop transcript, page 29, goal setting: carer).	
7. Value Views of carers in relation to: <ul style="list-style-type: none"> • respect • collaboration • feeling undervalued • loss of control 	<p>I would hate to make somebody worse, we need people to train us so we know what we are doing in that kind of situation, with the elderly we know what we are doing but with the stroke patient if they are in a certain, I know everyone is different and what works for one person may not work for another, I know there has got to be some kind of guideline that we are trained with (first workshop transcript, page 7, goal setting: carer).</p> <p>Carers do get told – things we know we report to the nurse, and nine times out of ten when they do come in they ask to speak to the nurse and the nurse has this information anyway. That we have passed on. Like an update to the care plan. If family asked they get filled in that way (first workshop transcript, page 9, goal setting: carer).</p> <p>We have had things go on in the last few weeks it may be in their best intention but</p>	<p>I have visited her daily because she is a particular friend of mine you ask questions the diagnosis now is what did it say?... not formally diagnosed, it is here she is challenging confused. High risks of falls, that is the information we have got on this lady (first workshop transcript, page 5, goal setting: manager).</p> <p>They don't care do they? (first workshop transcript, page 5, goal setting: carer).</p> <p>No potential, zimmer frame? – No potential. Although I have walked her in the hospital with a frame</p> <p>Used a stick before, because her balance wasn't very good – but oh no, no. So that is it. We are supposed to have a one to one and sit there and stop her getting up in case she falls and deal with her dementia now! (first workshop</p>	

	<p>they think (kitchen and domestic staff) they should go up and give someone a drink but when they have been told a couple of times when a certain person should not have straw in their drink and they go willy-nilly and make the drinks and put a straw in them all, well no I am sorry leave the care to nursing to the carers and the nurses (first workshop transcript, page 16, goal setting consensus: nurse).</p>	<p>transcript, page 5, goal setting: manager).</p> <p><i>So the barriers as you see them, it's the other services not collaborating with you?</i></p> <p>They pass 'the buck' (first workshop transcript, page 5, goal setting: carer).</p> <p>We should all be working as a team (first workshop transcript, page 5, goal setting: manager)..</p> <p>If you have a massive stroke and end up like some of our patients here, would you want us to intervene, you would say no, no, but if you have a massive stroke it is going to happen because you can't tell us. I know (first workshop transcript, page 14, goal setting: nurse).</p> <p>I have warned my kids – I will come back and haunt them, I don't want them to do it (first workshop transcript, page 14, goal setting: manager).</p> <p>It's horrendous. We hate doing it. It is not just distressful to her, it is distressing for the staff as well (first workshop transcript, page 14, goal setting: nurse).</p> <p>Comes down to money at the end of day. Lot of money going to other areas very</p>	
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		frustrating (first workshop transcript, page 34, goal setting: carer).	
8. Value Valuing residents and the residents' perspective	<p>I would say about 95% of the residents don't think there are goals for them, so where are they going, what is their aim, they're just, as long as they are comfortable, happy and clean. But that is the elderly, but I know we are doing about strokes and all the younger people. What we are doing today, we are not doing out them (first workshop transcript, page 19, goal setting: carer).</p> <p>They just want to be fed, kept warm and see their relatives it is not like, they are not leaving here (first workshop transcript, page 20, goal setting: carer).</p> <p>So the people that maybe they have a left side or a right side weakness and they are training themselves to use their non-affected side that does not happen with the 80+ - well it does but some it does but we have more that are demented so they don't really know they just sit with their food in front of them (first workshop transcript, page 20, goal setting: carer).</p> <p>If we choose to ignore it – then we shouldn't be doing it. We should not be in that job (first workshop transcript, page 30, goal setting: carer).</p>	<p>'This lady is not living she is existing, when she is choking she can't ask for help/assistance, she can't move her own limbs, if a head goes back she bring it forward, what a terrible, terrible thing to put this lady through. (first workshop transcript, page 15, goal setting: nurse).</p>	<p>A lot of them have similar issues/problems, but each problem is based on that person's individual needs (first workshop transcript, page 12, goal setting: nurse).</p> <p>Because having the physio affects their physical and mental wellbeing doing something and they have more control (first workshop transcript, page 13, goal setting: nurse).</p> <p>Awful lot that you do with them is actually not being recorded (researcher).</p> <p>A lot of that is about communication and therapeutic touches (nurse).</p> <p>Because you know them you know if they are restless etc. The way they are (nurse) (first workshop transcript, page 17, goal setting).</p> <p>Sometimes it is really hard, because the gentleman upstairs, his wife was convinced that she was taking him home at one point. But is hard not to break their dreams. I kept saying wait and see if there is any improvement because I did not want to give her that straight. Time to move on, I think</p>

			<p>she has (first workshop transcript, page 18, goal setting: nurse).</p> <p>The relative is expecting one thing and you know they are going to achieving something else (first workshop transcript, page 18, goal setting: nurse).</p>
<p>9. Stakeholders: who they are and who they represent; who's views matter more?</p>	<p>Basically nine times out of ten they have come in with CVA they have had many years ago so an initial impact of stroke received physio/rehabilitation in hospital that is not followed up in community. When they come into a nursing home they are looked after by nurses and we do not have any input from physios/OT's. We do have input for speech therapy and SALT team. So they really are the only service we dip into (first workshop transcript, page 5, goal setting: nurse).</p> <p>Carried on for a year or so but the OT/physios said that there is no point in doing it if she does not want to do it. Reached her potential. She is one of our younger ladies (first workshop transcript, page 6, goal setting: carer).</p> <p>Yes, they should have some form of, like OT's coming in, physio show us how to do things, we don't seem to have anything like that here and I think we need it. Need physios to come in I think it would be rehabilitation – wouldn't it. Rather than them just coming into a care home and at</p>	<p>physio came and gave him a big list double sided and said do this with him 4 times a day and as she is showing me what to do, he is doing all this he doesn't want it as she is hurting him, because it is so stiff she is doing this with the shoulder, she is hurting him and he doesn't understand, he can't express his fear, she comes back in and says have you done (first workshop transcript, page 4, goal setting: carer).</p> <p>They come out</p> <p>There is the list you do!</p> <p>That's what the community physio does</p> <p>Then you don't see then for six weeks!</p> <p>Then someone new comes in and they do something different and you think, well... (first workshop transcript, page 7, goal setting: carer).</p> <p>We did that, we do that we do massage.</p>	<p>I know we had a lady ... community physio coming out and then they discharge and we are left to do exercises with them (first workshop transcript, page 6, goal setting: nurse).</p>

	<p>the minute we are just a care home with elderly people but more and more young people are having them and need help so I think we do need more of that kind of people to work with us the OT's etc. (first workshop transcript, page 4, goal setting: carer).</p> <p>Why would you say that you currently don't have OT's and physios coming in?</p> <p>They are elderly (first workshop transcript, page 4-5, goal setting,: carer).</p> <p>Do you see anybody from the Stroke Rehabilitation service coming in?</p> <p>No, we see no-one do we?</p> <p>Do you refer to any outside services?</p> <p>Contact the G.P.</p> <p>Because 9 times out of 10 we know the GP is going to say no (first workshop transcript, page 26, goal setting: carer).</p>	<p>But when the physio came that is what she told us anyway.</p> <p>The damage is done, you are not going to undo it are you?</p> <p>It is like breaking a leg and not getting it plastered you know what I mean (first workshop transcript, page 8, goal setting: carer).</p> <p>Well backup from outside agencies that is what we battle with (first workshop transcript, page 28, goal setting: carer).</p> <p>Yeah training would help especially with learning about somebody's stroke would be training - need back up (first workshop transcript, page 29, goal setting: carer).</p> <p>Very daunting.</p> <p>Two pages, for one, they speak to you as if you're are absolute idiots!!! Show it to you, as if you are an idiot, it is hell, like you say if they did it on an everyday basis, we would not have to bring physio in in the first place (first workshop transcript, page 31, goal setting: carer).</p> <p>It does have great benefits for the stroke patient, it really, really does.</p> <p>Yes</p>	
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		Because I worked as a physio aid with a physio and it does make a difference. Difference – amazing (first workshop transcript, page 31, goal setting: manager).	
10. History: how are previous experiences used in the tailoring process	<p>Goal thing is confusing me – this achieving goals, at the end of the day I have achieved a goal by seeing that those people are comfortable (first workshop transcript, page 10, goal setting: carer).</p> <p>I can say Jane if you worked here, how we work here – the carers do everything and which I can understand. I worked in another care home, we had rehabilitation, we had physios coming in, I loved it because they showed us everything to do with certain people. Like having someone walk just a couple of steps, like a goal, I call it my aim, but it is like a goal and it is lovely because I was shown, I knew what I was doing, but in here at the minute we haven't been shown it, so that is where (name omitted) is coming from, we haven't been shown that it is just bum, bum, bum but if we are shown and this is what we have got to follow and they are always telling us to do our care plans, follow what it says, so then we would get more time to do because we have been shown what to do (first</p>	<p>Going back 15 years ago I worked in a care home that actually employed a private physio who trained a vast majority of the staff in helping stroke patients it is amazing what you can do if you know exactly how to do it (first workshop transcript, page .</p> <p>So in a way I think the homes have gone backwards in what we do for stroke patients very much so, instead of forwards and it is down to finance (first workshop transcript, page 8, goal setting: manager).</p> <p>I think the system has as well, because years ago if you wanted a specialist wheelchair you would get one. Might wait. Get one. They are now like 'gold' (first workshop transcript, page 8, goal setting: nurse).</p> <p>Old care plan (nurse) - Yeah I was just thinking that (manager).</p> <p>It would be goals (nurse)</p>	<p>Quality perspective care reviewed every month (first workshop transcript, page 11, goal setting: nurse).</p> <p>So how does that, goal sit within their activities is that set in their care? (researcher)</p> <p>We did have it at one point, didn't we? (nurse)</p> <p>Not there.</p> <p>Not seen as part of rehabilitation.</p> <p>Not from the nursing goals – no.</p> <p>Not essential</p> <p>We did have a social care plan in it, the activities do their own they have their own slot, they do all that side. Not in nursing care plans.</p> <p>We used to have this recorded specifically as a goal (first workshop transcript, page 17, goal setting: nurse).</p> <p>The carers used to write things that they had done and then we would write a paragraph</p>

	workshop transcript, page 30, goal setting: carer).	<p>Careful nowadays - Realistic achievement of goals (manager).</p> <p>We can't bring things like that in it... (nurse)</p> <p>Got to sort that out (manager) (first workshop transcript, page 9, goal setting).</p> <p>The care plan used to be this is your aims and this is your goals. One sheet – so simple. The powers that be did not think that was good enough so they changed it, and changed it, we have now got a sheet for every single problem that this person has (first workshop transcript, page 23, goal setting: manager).</p>	(sentence or two) what we had done (carers had given medicine) and then that was stopped and now we have the rounder chart and the care plan being reviewed daily, in the past. But because of time restraints we were finding that people were copying things. Now we have got rounder charts it is quicker and each thing that would have on the care plan has been labelled on the chart, and we have problems with personal hygiene then the carers would just write, as that is the norm, told had a wash, personal hygiene give, still there ticked rather than ... writing a sentence everyday seems pointless, being done anyhow no time to spend with residents if need because don't have to write anything, where on the rounding chart it seems that they are being reviewed (first workshop transcript, page 18, goal setting: nurse).
11. Barriers: negative factors which will influence implementation of the tailored recommendations	<p>We have not been taught to rehabilitate (first workshop transcript, page 5, goal setting: carer).</p> <p>Well at the moment the carers are not supposed to talk with family more written in notes with the nurses. Especially if it is medical we are not supposed, nurses tell us because we ask – family should go to nurse in charge (first workshop transcript, page 8, goal setting: carer).</p>	<p>When they come to us they just get on with it really. All the caring so when you are asking what our achievements are, for us our biggest goal for anyone would be we have the right information for when they come in here, things are not set out, the best quality of life for them (first workshop transcript, page 3, goal setting: carer).</p> <p>No we have to push for them, there has been a few we have had to get physio in.</p>	<p>People who can't communicate, we can't measure that (first workshop transcript, page 17, goal setting: nurse).</p> <p>Is there anything you think that would stop this happening? (researcher)</p> <p>Maybe for some carers who are set in their ways maybe (first workshop transcript, page 17, goal setting: nurse).</p>

	<p>Yes it is about the residents, cos it is but I am not bloody going to do training to be... (first workshop transcript, page 28, goal setting: carer).</p> <p>It is like EMI for instance, for EMI I am not EMI trained and I think all my residents are EMI but they are not apparently. I would love to go on an EMI course, it the same for stroke and things like that we don't know until we learn (first workshop transcript, page 31, goal setting: carer).</p> <p>Do you think there is anything that would stop you doing this?</p> <p>Resources and management (first workshop transcript, page 43, goal setting: carer).</p> <p>That's it we can talk with the manager and can say this gets done it's not just a carer saying like you know some people in here do think it is the carer just saying oh don't put her on that put her on that and it's not you say it for their safety, but some carers in here do think you are saying it just for saying it sake.</p> <p>This is where we fall down and this is where when people aren't united (first workshop transcript, page 45, goal setting: carer).</p>	<p>Nothing would be done, we have to then wait for a doctor before it can be done. We can't just ring physio and ask them to come out (first workshop transcript, page 5-6, goal setting: carer).</p> <p>I also think it depends on what age you have your stroke. The girl who was interested in the group, the young carer had had a stroke herself and actually has moved on and work in the hospital, she had all the help she needed to regain her life after she had had her stroke. It is not the case with older people (first workshop transcript, page 8, goal setting: manager).</p> <p>Staff have very little specific training on strokes. We have had a bit through the Stroke Association but we cannot send everybody at once on courses. Three or four staff on it – that is it (first workshop transcript, page 11, goal setting: manager).</p> <p>First of all we would like to know the reason for the strokes. Because some people do not know what a stroke is, causes of strokes, signs, how to avoid it (first workshop transcript, page 11, goal setting: carer).</p> <p>I think from my part of it, all people in care should really, really understand the psychological, social effects (first</p>	
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	<p>Now yesterday we were talking and certain people in here are not supposed to be on stand aids, but they are putting people on stand aids. So I had to get the DN to tell the nurse in charge that it was not coming from me but people think oh no you can't do that, they think you are just having a go.</p> <p>Well no I am not, I have not been told and then it is like well (name omitted) knew why didn't she tell you.</p> <p>You are passing this information on.</p> <p>Well now I have got a nurse because some people won't do what they are supposed to do (first workshop transcript, page 45-46, goal setting: carer).</p>	<p>workshop transcript, page 11, goal setting: carer).</p> <p>Well we here do not have access to computer systems, so it would only apply to people who are willing to do it in their own home and in fairness some of the 'on line ' training is not appropriate. I used to do a lot of training in homes and I really feel it has got to be interactive and not just sitting and answering questions on a computer (first workshop transcript, page 12, goal setting: manager).</p> <p>Not being disrespectful but we would not have the time (first workshop transcript, page 23, goal setting: nurse).</p>	
<p>12. Enablers: positive factors which will influence implementation of the tailored recommendations</p>	<p>If it is to do with the residents we are looking after, you can do that to make their lives more easier all for that (first workshop transcript, page 30, goal setting: carer).</p>	<p>We have had a bit through the Stroke Association but we cannot send everybody at once on courses. Three or four staff on it – that is it (first workshop transcript, page 11, goal setting: manager).</p> <p>(Name omitted) has just done the train the Trainer Course. She is having training sessions for staff on her unit. Hasn't done it yet but she is working up to it and I am will obviously as Sister, because I know what I want out of the training it is very daunting (first workshop transcript, page 13, goal setting: manager).</p>	

<p>13. Resources: the impact of resources upon tailoring</p> <ul style="list-style-type: none"> - carer resources - organisational resources 	<p>Believe me we would love to be able to go into the lounge on an afternoon and get the skittles out and play ball with them and stuff but sorry in here it is like when are they in here playing with them, they should be doing something else, we don't have the time, we would love to have the time but we don't get it (first workshop transcript, page 23, goalsetting: carer).</p> <p>What (name omitted) is saying we have got a timescale we have got from 8 O'clock till 11 ish because we have to get them ready for dinner, we have got how many people on that list, say 7 people to get up, wash them, dress and make them and (name omitted) likes to do their hair, likes to take them to the hairdresser and sometimes very rare you do not have time to do that and get to know them, we haven't got time (first workshop transcript, page 23, goal setting: carer).</p> <p>But in here, in the ideal world and in some places maybe you can, but when you are in here and it is right there is only 5 of you this afternoon, we have people in their bed who never get out of bed.</p> <p>You have got to go and look at them, those people who you have washed and dressed get them out of bed are put somewhere and sometimes 9 out of 10 they are forgotten</p>	<p>Specialist wheelchair for stroke patients. Absolute - no even any wheelchair. Tried to get a specialist wheelchair for a stroke patient (first workshop transcript, page 6, goal setting: nurse).</p> <p>Yes but they are not even assessed to which is the most suitable wheelchair, because you can't get a specialist wheelchair, you can't buy a cheap wheelchair because they are not always suitable for these people. Posture, balance, financial aspects. We have a lady with a broken hip waiting to be operated on, in severe pain on morphine.....can't walk they will not give her a wheelchair (first workshop transcript, page 6, goal setting: nurse).</p> <p>Now they have decided after all this time that she needs a specialist wheelchair – the woman will be dead before she gets it (first workshop transcript, page 7, goal setting: nurse).</p> <p>Would it be better if each home had their own physio (carer).</p> <p>I was going to say we really need a physio here, someone who specialises in physio and assessing the needs of the patient (manager)</p>	<p>Down to the equipment (first workshop transcript, page 9, goal setting: nurse).</p> <p>Physio.</p> <p>Very hard, cost, there is a waiting list (first workshop transcript, page 9, goal setting: nurse).</p> <p>Think it is lack of funding and if they can't get it they can't have physio can they (first workshop transcript, page 13, goal setting: nurse).</p>

	<p>about because you have not got the time to go back to them (first workshop transcript, page 24, goal setting: carer).</p> <p>It would be nice to say why didn't that person achieve that goal you have had months and months to achieve it because we did not have the staff to do it and it is not their fault for not achieving that goal! (first workshop transcript, page 24, goal setting: carer).</p>	<p>How much would that cost? (nurse)</p> <p>I am not on about how much it would cost – I am just saying... (manager).</p> <p>It would be brilliant (carer) (first workshop transcript, page 7, goal setting).</p> <p>We could do 'in house' training I used to do a lot , but don't have time now (first workshop transcript, page 13, goal setting: manager).</p> <p>We can't change the services we are battling against and I know all the girls do what they can with the resources we have got (first workshop transcript, page 28, goal setting: manager).</p> <p>Is there any way we could tailor these to improve the care? (Researcher)</p> <p>Improving it would be training (carer).</p> <p>Training? Staff training (researcher).</p> <p>Yes (carer) (first workshop transcript, page 28, goal setting).</p>	
<p>14. Risk: the impact of risk upon tailoring, which includes:</p> <p>Fear of litigation</p>	<p>We do rely on carers a lot (first workshop transcript, page 9, goal setting: nurse).</p>	<p>I think there should be plans if they assess that they use a hoist at all times we are no longer allowed to try and stand them, not allowed, get into trouble</p>	

<p>Risk averse practices</p> <p>Risk taking</p>	<p>Carers do get told – things we know we report to the nurse (first workshop transcript, page 9, goal setting: carer).</p> <p>You wouldn't tolerate it, like (name omitted) just said she has been told that that lady does not do that, so (name omitted) has done it all week, I come in and I make her do what she is not supposed to do. (name omitted) says I am not being funny but it is old now, it says in the care plan we don't do it well I am sorry until I am told I will not do it and she can then go, she would say look I am not being funny now but I would tell the nurse in charge (first workshop transcript, page 43, goal setting: carer).</p> <p>You need the team work and it has got to be it has got to go across the board, but if people don't know then they are not going to do it but if we have got this and the manager puts it to everybody to see and every nurse that comes on duty has blah blah has got to have this done today, then the nurse can tell the carer – it must be done and if it is not done give me the reason why it is not done – do you know what I mean? (first workshop transcript, page 44, goal setting: carer).</p>	<p>it is very difficult to set any specific goals like that anymore (first workshop transcript, page 2, goal setting: nurse).</p> <p>Our hands are tied really. People that come in they have already had strokes a long time go so the damage has been done a long time ago and I believe all this should be done before they come in to us.</p> <p>They never follow it through, never (first workshop transcript, page 3, goal setting: carer).</p> <p>As (name omitted) says you are limited to what you can actually do. Frightened to stand them, frightened to do this, the damage has been done long before they come to us (first workshop transcript, page 4, goal setting: carer).</p> <p>If the hospital decided 'nil by mouth' you have got to be so careful.</p> <p>Can't do anything, but in the past we would try a little bit on a piece and if we could see them swallowing we would work on it and call them back in when we got a bit of details – results. You are frightened of doing anything now (first workshop transcript, page 9-10, goal setting: carer).</p>	
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		<p>Don't really need to know what you are doing and with them coming out once to show you and go away, it is not perfect (first workshop transcript, page 31, goal setting: carer).</p> <p>Even yesterday I said to the physio reading it on a piece of paper how do we know if we are doing right.</p> <p>Frightened of hurting people you may been doing more damage, you don't know.</p> <p>More training on basic massage and basic exercises.</p> <p>We don't have to have a physio we could call it gentle exercise (first workshop, page 31, goal setting: carer).</p> <p>Anybody can do this, people are frightened of doing exercises if they think they are going to hurt them (first workshop transcript, page 32, goal setting: carer).</p> <p>We had a classic gentleman came to us...</p> <p>Use of the toilet - Fallen off twice – had a stroke came from (name omitted) Ward, Stroke rehabilitation Ward – came to us, we are not using the stand aid cannot</p>	
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		<p>hold on, got no standing power ... Within a week his social worker came in and she saw is using the electric stand up and she said he has deteriorated in the five days since he came here and I said no actually we feel it wasn't safe to put him on, correctly use of a stand aid you have got to understand the path, but she said it was assessed by the physio unit. I don't give a 'monkeys' who he was assessed by I don't feel it is safe.</p> <p>I said he had fallen off the stand aid twice in the hospital, so there you go on your way.</p> <p>You are battling – watch your back.</p> <p>Big issue – stops people doing things. Going that extra mile</p> <p>Sad really.</p> <p>Impact on patients (first workshop transcript, page 32-33, goal setting: nurse).</p> <p>Years ago you were not frightened of getting sued (manager).</p> <p>Claiming society (carer) (first workshop transcript, page 33, goal setting).</p>	
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15. Responsibility: Contractual responsibilities Policy responsibility Organisational responsibilities Decision making permissions	<p>We have had things go on in the last few weeks it may be in their best intention but they think they should go up and give someone a drink but when they have been told a couple of times when a certain person should not have straw in their drink and they go willy-nilly and make the drinks and put a straw in them all, well no I am sorry leave the care to nursing to the carers and the nurses (first workshop transcript, page 16, consensus methods – personal daily activities: nurse).</p>	<p>Up to the home to buy them, do they have them in their own home, even if the carer is going in 4 times a day, I think that has changed now, (name omitted) think this has changed they are saying it is up to the home or the family (first workshop transcript, page 6, goal setting: carer).</p> <p>It comes through with a full nursing assessment – Health Board come out to check we are following these care plans (first workshop transcript, page 32, goal setting: nurse).</p>	
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Appendix 4:4: Ethical approval letter

COLEG IECHYD A GWYDDORAU YMDDYGIADOL
COLLEGE OF HEALTH AND BEHAVIOURAL SCIENCES

YSGOL GWYDDORAU GOFAL IECHYD
SCHOOL OF HEALTHCARE SCIENCES

26th September 2012

Jane Montgomery
School of Healthcare Sciences
Bangor University
Archimedes Centre
Wrexham Technology Park
Wrexham
LL13 7YP



Dear Jane

Re: Healthcare and Medical Sciences Academic Ethics Committee (HCMS AEC) review of Proposal number 2012-08-01: 'Implementing a stroke best practice guideline in the care home setting' (please quote this number on all correspondence)

Thank you for submitting the requested amendments to the above proposal.

I am therefore able to give approval for your study on behalf of the AEC and this letter constitutes evidence of that approval should it be necessary for any applications to other RECs.

Should you need to make any substantial amendments to your study protocol during the lifetime of the research, you are required to submit notice of these to the AEC for further approval, prior to making any changes to the conduct of the study.

Please note that approval from this AEC does not convey automatic authority to proceed with your study. You are formally advised that it is essential to confirm with the relevant administrators whether you are required to submit your proposal to any other Ethics Committee(s) such as Local NHS Research Ethics Committee and NHS Research Governance Departments – prior to commencing your study.

You are required to notify this AEC of any amendments to your proposal that you are stipulated by any external body.

Once you have received approval from an external REC, you must provide a copy of your letter of approval for this AEC.

Please do not hesitate to contact me should you require further clarification.

Yours sincerely


Dr Siôn Williams
Chair, HCMS AEC.

Cc: Dr Chris Burton

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Appendix 4:5: Memorandum



MEMORANDUM OF UNDERSTANDING

A PROGRAMME OF WORK TO IMPLEMENT STROKE BEST PRACTICE IN THE CARE HOME SETTING

SCHOOL OF HEALTHCARE SCIENCES, BANGOR UNIVERSITY & CARE HOME

1. Both parties agree to co-operate in a programme of work entitled
“Implementing evidence for stroke within the care home setting: Tailoring
stroke best practice guidelines”.
2. Each partner will share information with the other to help promote mutual
understanding, and each will respect the confidentiality and intellectual
ownership of this information.
3. Each partner will seek to promote co-operation to mutual benefit, and will be
responsible for its own actions and its own costs.
4. Each partner will respect the name and high reputation of the other, and will
consult with the other regarding any publicity or external reference to this
programme of work.
5. If any partner has concerns about any aspect of the programme of work, then
they will raise it officially in writing with the head of school, Dr Malcolm
Godwin and, or within local programme of work events with Ms Jane Wright
for Bangor University and, care home manager, for the care
home environment.
6. Within the programme of work, a range of study information or research
data may be collected or held by either party. Both parties will ensure that all
data collected will be securely stored in line with Data Protection policy.
Confidentiality and anonymity for all participants is assured in all written
reports and publications, and individual written consent will be sought prior
to each data collection episode

7. Both parties will endeavour to exploit any commercial or scientific opportunities that emerge from this programme of work. The intellectual property of identified programme of work products is as follows:
- a. Any clinical, organisational or educational tools developed will become the academic property of Bangor University but will remain in use in the care home setting and subject to updating amendment as required.
 - b. The interpretation and any new products which emerge from the analysed data will become the property of the Bangor University research team.
 - c. Where the programme of work has the potential for academic or professional publication during and after the lifetime of the programme of work, then publications will be pursued jointly by all parties. All parties have a right to veto publication where there is a **direct risk** that publication of descriptions of company products may be commercially disadvantageous.

This memorandum of understanding will be valid for the lifetime of the programme of work.

Signed

Signed

Name

Name

Date

Date

On behalf of Care Home

On behalf of School of
Healthcare Sciences Bangor
University

Appendix 4:6: Participant, letter of invitation



PRIFYSGOL
BANGOR
UNIVERSITY

Ms Jane Wright
School of Healthcare Sciences
College of Health & Behavioural Sciences
Bangor University
Archimedes Centre
Wrexham Technology Park
Wrexham

LL13 7YP
Tel 01978 316353
E-mail jane.wright@bangor.ac.uk

Date

Name

Address

Dear ,

Letter of invitation: Tailoring a stroke best practice guideline for implementation in the care home setting.

I am writing to ask you to participate in a research project that we are undertaking to explore the use of evidence of 'what works' for residents with stroke in the care home setting. We are keen to engage with all staff working in this sector and to establish what you feel will help you to deliver stroke best practices for residents. The effects of stroke on people are considerable and long-term. The National Stroke Strategy (DoH, 2007) supports the need for further research to evaluate the effectiveness of rehabilitation interventions after the acute phase of stroke. In the care home environment it has been found that as many as one in six nursing home residents are residents with a stroke, and have a wide range of disabilities. There is currently little evidence of structured care for stroke survivors who reside in care homes. People affected in any way by stroke need to be able to access appropriate interventions that best meet their needs. We want you to help us find what can work in your care setting in terms of implementing this stroke best practice guideline.

The research is funded by the National Institute for Social Care and Health Research in Wales, and we have obtained Local Research Ethics Committee approval. The research will also form part of a PhD study.

If you decide to take part, you will be invited to participate in an interview. You will be given a choice of face to face interview or a telephone interview.

The interviews will be arranged for a time and venue to ensure minimum disruption to the running of the care home and delivery of care. The will take approximately 40 minutes. The interview questions will be designed to capture your views about caring for residents with stroke in your care home environment.

You do not have to take part in this research. However, you can find out more about the study if you read the enclosed 'Participant Information Sheet'. If you then feel you may be interested in taking part, please complete the enclosed reply slip along with your interview preference and return it in the Freepost envelope provided. You don't need a stamp. We will then contact you by telephone to arrange an interview date and time to suit you.

Please do not hesitate to contact myself (Jane Wright) or Dr. Christopher Burton from the research team (Tel: 01248 382556) if you have any questions about this research project.

Thank you for your time.

Yours sincerely,

Jane Wright
PhD student.

**PLEASE RETURN THIS REPLY SLIP IN THE PREPAID ENVELOPE IF YOU
ARE INTERESTED IN TAKING PART IN THIS STUDY**

*NAME &
ADDRESS
of participant*

INTERVIEW PARTICIPATION

I am happy to be contacted to arrange my involvement

in an interview

YES

☐

NO

☐

(Please tick your choice)

I would prefer to be interviewed

FACE TO FACE

☐

TELEPHONE

☐

(Please tick your preferred choice)

LANGUAGE CHOICE

I would like to receive the study information in

ENGLISH

☐

WELSH

☐

(Please tick your language choice)

Many thanks for agreeing to help us. Please return this sheet in the prepaid envelope. You do not need a stamp.

Appendix 4:7: Participant interview information sheet



Ms Jane Wright
School of Healthcare Sciences
College of Health & Behavioural Sciences
Bangor University
Archimedes Centre
Wrexham Technology Park
Wrexham LL13 7YP
Tel 01978 316353
E-mail jane.wright@bangor.ac.uk

Project title: Tailoring a stroke best practice guideline for the care home setting.

Interview Participant Information Sheet – Part 1

Version 1, 11th June 2012

Invitation to participate

I am writing to ask you to participate in a research project that we are undertaking to explore the use of evidence of 'what works' for residents with stroke in the care home setting. You are being invited to take part in this study to help tailor a stroke best practice guideline for your care home environment. This study is part of the researchers PhD. Before you decide it is important that you understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please contact either myself (Jane Wright) or Dr Christopher Burton at Bangor University (his details are at the end of this document) if there is anything that is not clear to you or if you would like more information.

- Part 1 tells you the purpose of the study and what will happen to you if you take part.
- Part 2 gives you more detailed information about the conduct of the study.

What is the purpose of the study?

We are keen to engage with all staff working in this sector and to establish what you feel will help you to deliver stroke best practices for residents. The effects of stroke on people are considerable and long-term. The National Stroke Strategy (DoH, 2007) supports the need for further research to evaluate the effectiveness of rehabilitation interventions after the acute phase of stroke. In the care home environment it has been found that as many as one in six nursing home residents are residents with a stroke, and have a wide range of disabilities. There is currently little evidence of structured care for stroke survivors who reside in care homes. People affected in any way by stroke need to be able to access appropriate interventions that best meet their needs. With your help we want to establish what can work in your care home in terms of implementing a stroke best practice guideline. It is essential that we work in partnership with care home staff in order to achieve this.

Why have I been chosen?

We want you to help us find what can work in your care setting in terms of implementing this stroke best practice guideline.

What will happen if I take part?

If you agree to take part in the study, we would like you to take part in an interview. The interview will be conducted after your contribution to work to develop recommendations for the care of residents with stroke in UK care homes. Your contribution may have been through completing a questionnaire or participating in a workshop. In both cases, the interview will involve discussing your views about the recommendations and the processes we are using to gather different opinions about the recommendations.

There will be a choice of interview dates. Interviews will be sound recorded to capture data.

Light refreshments will be provided during the interview. You will be able to claim for any travel expenses incurred between your usual place of residence and the interview venue. Please keep receipts of any expenditure.

Do I have to take part?

No. It is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and be asked to sign a consent form, a copy of which you can also keep. If you decide to take part, you can withdraw at any time and without giving a reason.

If you do decide to withdraw before the interview, you can do so by contacting Ms Jane Wright (01978 316353) or Dr. Christopher Burton (01248 382556) from the research team.

A decision to withdraw at any time, or a decision not to take part, will not affect your role within your work place.

What are the possible disadvantages and risks of taking part?

We do not anticipate any disadvantages or risks from taking part in the interview.

What are the possible benefits of taking part?

We cannot promise the study will help you, but the information you receive might help improve your awareness of stroke best practices and consequently the care of residence with stroke in your care home setting. You will also have the opportunity for your views and opinions to be heard.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

If you have a problem, please telephone the research team on 01248 382556.

Will my taking part in this study be confidential?

Yes. All the information about your participation in the study will be kept confidential. The details are included in Part 2.

Contact details

Dr. Christopher Burton
Centre for Health Related Research
Bangor University
Bangor LL57 2EF
Tel: 01248 382556
Email: c.burton@bangor.ac.uk

Ms Jane Wright
School of Healthcare Sciences
Bangor University
Archimedes Centre
Wrexham Technology Park
Wrexham LL13 7YP
Tel 01978 316353
E-mail: jane.wright@bangor.ac.uk

This completes Part 1 of the Information Sheet.

If the information in Part 1 has interested you and you are considering participation, please continue to read the additional information in Part 2 before you make your decision.

Project title: Tailoring a stroke best practice guideline for implementation into the care home setting.

Care home staff Information Sheet – Part 2**What will happen if I don't want to carry on with the study?**

You can withdraw from the interview at any time and without giving a reason.

If you decide for any reason to withdraw from the study during the interview, then please let the facilitators know. This will not be a problem, but we will not be able to destroy any information you have provided during the interview. As with all information we collect during the interview, this will remain fully anonymised. No-one will know you have been involved.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers, who will do their best to answer your questions. The contact telephone number is 01248 382556.

If you remain unhappy, or if you have any complaints about the way the researchers carry out the study, you may contact the Head of School, School of Healthcare Sciences as follows:

Dr, Malcolm Godwin

Head of School, School of Healthcare Sciences
College of Health & Behavioural Sciences
Bangor University
Gwynedd LL57 2EF
Tel: 01248 383117

Will my taking part in this study be kept confidential?

Yes. If you consent to be part of this study, all information that is collected about you during the course of the research will be kept strictly confidential.

The information we collect during the interview will be accessed and examined by responsible individuals from the research team. Information you supply will be used anonymously in reports, publications or for teaching purposes. All documents about your involvement in this study will be kept in locked filing cabinets or on password protected computers and will not be disclosed in any reports.

The data from this study will be kept for ten years and then disposed of securely. After ensuring that any identifiable data has been removed, we may also use the data we collect for teaching purposes.

What will happen to the results of the study?

We will be making a report of the study to the National Institute for Social Care and Health Research in Wales. We will also publish some of the findings in academic journals and present findings at conferences. No one will be named in any report or publication. On the Consent Form you will be asked to sign, you can ask for a summary of the results to be sent to you.

Who is funding the study?

This research study is being funded by the National Institute for Social Care and Health Research (NISCHR).

Who is undertaking the study?

A research team led by Dr Christopher Burton (Bangor University) is working together on the study. Your facilitator for the duration of this study will be Ms Jane Wright (Bangor University), you can contact Jane (using the details at the top of this letter) at any time to discuss the study and to ask for help and or advice. This study forms part of Jane's PhD NISCHR scholarship.

Who has reviewed the study?

This study was passed by the healthcare and Medical Sciences Academic Ethics Committee.

Thank you for taking time to read this information sheet.

If you then feel you may be interested in taking part, please complete the enclosed reply slip and return it in the Freepost envelope provided. You don't need a stamp. We will then contact you by telephone to discuss which workshop you would like to attend.

Please do not hesitate to contact myself or Dr. Christopher Burton from the research team (Tel: 01248 382556) if you have any questions about this research project.

Thank you for your time.

Yours sincerely,

Jane Wright

PhD student.

**PLEASE RETURN THIS REPLY SLIP IN THE PREPAID ENVELOPE IF YOU
ARE INTERESTED IN TAKING PART IN THIS STUDY**

*NAME &
ADDRESS
of participant*

INTERVIEW PARTICIPATION

I am happy to be contacted to arrange my involvement
in an interview

YES

☐

NO

☐

(Please tick your choice)

I would prefer to be interviewed

FACE TO FACE

☐

TELEPHONE

☐

(Please tick your preferred choice)

LANGUAGE CHOICE

I would like to receive the study information in

ENGLISH

☐

WELSH

☐

(Please tick your language choice)

Many thanks for agreeing to help us. Please return this sheet in the prepaid envelope. You do not need a stamp.

Appendix 4:8: Participant consent form



Ms Jane Wright
School of Healthcare Sciences
College of Health & Behavioural Sciences
Bangor University
Archimedes Centre
Wrexham Technology Park
Wrexham
LL13 7YP
Tel 01978 316353
E-mail jane.wright@bangor.ac.uk

WRITTEN CONSENT FORM FOR FACE TO FACE INTERVIEW PARTICIPANTS

Version 1, 2012

Title of study: **Tailoring a stroke best practice guideline for implementation into the care home setting.**

Name of Principal Investigator: Dr Christopher Burton

Name of researcher: Jane Wright

Participant Information Number:

**Please initial the
appropriate box**

YES

NO

1 I confirm that I have read and understood the information sheet for the above study, I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐☐

2 I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.

☐☐

3 I agree to:

Take part in the interview on (insert date).

☐☐

Allow my responses to questions asked during the interview to be saved and the data collected to be examined by the named (Jane Wright & Dr Christopher Burton) individuals from the research team.

Please initial the

appropriate box

YES

NO

☐☐

Allow the information I supply to be used anonymously in reports, publications or for teaching purposes.

☐☐

4 I consent to the use of an audio recorder during the interview and for the data to be used in the process of research for this study.

☐

5 I would like a summary of the results of the study when it is completed.

Name of participant

Date

Signature

Name of researcher

Date

Signature

Appendix 6:1: Consensus scoring

	Stroke best practice recommendation 6.35 Depression and anxiety and 6.36 Emotionalism	Rating 1 to 9 with 1 being least relevant to residents living with stroke in your care home and 9 being most relevant. Please indicate your choice by circling the relevant number										The Beeches: Individual care home consensus result scores n=									Total relevance scores
i.	A - Any patient considered to have depression or anxiety should be assessed for other mood disorders.	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8	9 n=3	27 =100%
ii.	B - Patients with mild or moderate symptoms of depression should be given information, support and advice (see recommendation 6.34.1G) and considered for one or more of the following interventions: <ul style="list-style-type: none"> Increased social interaction Increased exercise Goal setting Other psychosocial interventions. 	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8	9 n=3	27 = 100%
iii.	C - Patients prescribed antidepressant drug treatment for depression or anxiety should be monitored for known adverse effects, and treatment continued for at least 4 months beyond initial recovery. If the patient's mood has not improved 2–4 weeks after initiating treatment, check that the patient is taking the medicine as prescribed. If they are, then consider increasing the dose or changing to another antidepressant.	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8	9 n=3	27 = 100%

iv.	D - Patients receiving drug treatment for depression or anxiety should have it reviewed regularly to assess continued need.	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8	9 n=3	27 = 100%
v.	E - Brief, structured psychological therapy should be considered for patients with depression. Therapy will need to be adapted for use in those with neurological conditions.	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8	9 n=3	27 = 100%
vi.	F - Antidepressant treatment should not be used routinely to prevent the onset of depression	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8	9 n=3	27 = 100%
vii.	6.36 Emotionalism																				
viii.	A - Any patient who persistently cries or laughs in unexpected situations or who is upset by their fluctuating emotional state should be assessed by a specialist or member of the stroke team trained in the assessment of emotionalism.	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8	9 n=3	27 = 100%
ix.	B - Any patient diagnosed with emotionalism should, when they show increased emotional behaviour, be appropriately distracted from the provoking stimuli.	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8	9 n=3	27 = 100%
x.	C - Patients with severe, persistent or troublesome emotionalism should be given antidepressant drug treatment, monitoring the frequency of crying to check effectiveness. Patients should be monitored for known adverse effects. If the emotionalism has not improved 2–4 weeks after initiating treatment, check that the patient is taking the medicine as prescribed. If they are, then consider increasing the dose or changing to another antidepressant.	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8	9 n=3	27 = 100%

	Stroke best practice recommendation 6.24 Bowel and bladder impairment	Rating 1 to 9 with 1 being least relevant to residents living with stroke in your care home and 9 being most relevant. Please indicate your choice by circling the relevant number										The Beeches: Individual care home consensus result scores n=3 ■ score before cognitive interview ■ score following cognitive interview									Total relevance score
xi.	A - All wards and stroke units should have established assessment and management protocols for both urinary and faecal incontinence and for constipation in stroke patients.	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8	9 n=3	27 = 100%
xii.	B - Patients with stroke who have continued loss of bladder control 2 weeks after diagnosis should be reassessed to identify the cause of incontinence, and have an ongoing treatment plan involving both patients and carers. The patient should: <ul style="list-style-type: none"> Have any identified causes of incontinence treated Have an active plan of management documented Be offered simple treatments such as bladder retraining, pelvic floor exercises and external equipment first Only be discharged with continuing incontinence after the carer (family member) or patient has been fully trained in its management and adequate arrangements for a continuing supply of continence aids and services are confirmed and in place. 	1	2	3	4	5	6	7	8	9		1	2	3	4	5 ■ n=1	6	7	8	9 ■ n=2 ■ n=3	■ 23 = 85% ■ 27 = 100%
xiii.	C - All stroke patients with a persistent loss of control over their bowels should: <ul style="list-style-type: none"> Be assessed for other causes of incontinence, which should be treated if identified Have a documented, active plan of management 	1	2	3	4	5	6	7	8	9		1 n=1	2	3	4	5	6	7	8	9 n=2	23 = 85%

	<ul style="list-style-type: none">Be referred for specialist treatments if the patient is able to participate in treatmentsOnly be discharged with continuing incontinence after the carer (family member) or patient has been fully trained in its management and adequate arrangements for a continuing supply of continence aids and services are confirmed and in place.																				
xiv.	D - Stroke patients with troublesome constipation should: <ul style="list-style-type: none">Have a prescribed drug review to minimise use of constipating drugsBe given advice on diet, fluid intake and exerciseBe offered oral laxativesBe offered rectal laxatives only if severe problems remain.	1	2	3	4	5	6	7	8	9		1 ■ n=1	2	3	4	5	6	7	8	9 ■ n=2 ■ n=3	■ 23 = 85% ■ 27 = 100%

	Stroke best practice recommendation 7.1 Further rehabilitation	Rating 1 to 9 with 1 being least relevant to residents living with stroke in your care home and 9 being most relevant. Please indicate your choice by circling the relevant number										The Beeches: Individual care home consensus result scores n=										Total relevance scores
xv.	A - Any patient whose situation changes (e.g. new problems or changed environment) should be offered further assessment by the specialist stroke rehabilitation service.	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8	9 n=3	27 = 100%	

xvi.	B - A named person and/or contact point should be identified and communicated to the patient to provide further information and advice if needed	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8	9 n=3	27 = 100%
xvii.	C - Any patient with residual impairment after the end of initial rehabilitation should be offered a formal review at least every 6 months, to consider whether further interventions are warranted, and should be referred for specialist assessment if: <ul style="list-style-type: none"> New problems, not present when last seen by the specialist service, are present The patient's physical state or social environment has changed 	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8	9 n=3	27 = 100%
xviii.	D - Further therapy following 6-month review should only be offered if clear goals are agreed.	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8	9 n=3	27 = 100%
xix.	E - Patients should have their stroke risk factors and prevention plan reviewed at least every year	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8	9 n=3	27 = 100%






	Stroke best practice recommendation 6.25 Personal activities of daily living	Rating 1 to 9 with 1 being least relevant to residents living with stroke in your care home and 9 being most relevant. Please indicate your choice by circling the relevant number										The Beeches: Individual care home consensus result scores n=3										Total relevance scores
xx.	A - Every patient who has had a stroke should be assessed formally for their safety and	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8	9 n=3	27 = 100%	

	independence in all personal activities of daily living by a clinician with the appropriate expertise, and results should be recorded using a standardised assessment tool.																					
xxi.	B - Any patient who has limitations on any aspect of personal activities after stroke should: <ul style="list-style-type: none">• Be referred to an occupational therapist with experience in neurological disability, <i>and</i>• Be seen for further assessment within 4 working days of referral, <i>and</i>• Have treatment of identified problems from the occupational therapist who should also guide and involve other members of the specialist multidisciplinary team.	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8	9 n=3	27 = 100%	
xxii.	C - Specific treatments that should be offered to stroke patients (according to need) include: <ul style="list-style-type: none">• Dressing practice as a specific intervention for patients with residual dressing problems• As many opportunities as appropriate for repeated practice of self-care• Assessment for provision of and training in the use of equipment and adaptations that increase safe independence• Training of family and carers in how to help the patient	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8	9 n=3	27 = 100%	

	Stroke best practice recommendation	Rating 1 to 9 with 1 being least relevant to residents living with stroke in your care home and 9 being most relevant. Please indicate your choice by circling the relevant number										The Beeches: Individual care home consensus result scores n=6									Total relevance scores
xxiii.	All people with stroke in care homes should receive assessment and treatment from stroke rehabilitation services in the same way as patients living in their own homes	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8	9 n=6	54 = 100%
xxiv.																					
xxv.	All staff in care homes should have training on the physical, psychological and social effects of stroke and the optimal management of common impairments and activity limitations.	1	2	3	4	5	6	7	8	9		1	2	3	4	5 n=1	6	7	8	9 n=5	50 = 93%
xxvi.																					
xxvii.	Every patient involved in the rehabilitation process should: A - Have their feelings, wishes and expectations established and acknowledged	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8	9 n=6	54 = 100%
xxviii.	B - Participate in the process of setting goals unless they choose not to or are unable to participate because of the severity of their cognitive or linguistic impairments	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8	9 n=6	54 = 100%
xxix.	C - Be given help to understand the nature and process of goal setting, and be given help (e.g. using established tools) to define and articulate their personal goals	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7 n=1	8	9 n=5	52 = 96%
xxx.	D - Have goals that <ul style="list-style-type: none">are meaningful and relevant to the patientare challenging but achievableinclude both short-term (days/weeks) and long-term (weeks/months) targetsinclude both single clinicians and also the whole team	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8	9 n=6	54 = 100%

<ul style="list-style-type: none"> are documented, with specified, time-bound measurable outcomes have achievement evaluated using goal attainment include carers where appropriate 																			
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Workshop recommendation consensus scoring for each care home																					
	Stroke best practice recommendation 6.35 Depression and anxiety and 6.36 Emotionalism	Rating 1 to 9 with 1 being least relevant to residents living with stroke in your care home and 9 being most relevant. Please indicate your choice by circling the relevant number											The Oaks: Individual care home consensus result scores n=5 ■ score before cognitive interview ■ score following cognitive interview								Total relevance scores
xxxi.	A - Any patient considered to have depression or anxiety should be assessed for other mood disorders.	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8 n=1	9 n=4	44 = 98%
xxxii.	B - Patients with mild or moderate symptoms of depression should be given information, support and advice (see recommendation 6.34.1G) and considered for one or more of the following interventions: <ul style="list-style-type: none">Increased social interactionIncreased exerciseGoal settingOther psychosocial interventions.	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8 n=1	9 n=4	44 = 98%
xxxiii.	C - Patients prescribed antidepressant drug treatment for depression or anxiety should be monitored for known adverse effects, and treatment continued for at least 4 months beyond initial recovery. If the patient’s mood has not improved 2–4 weeks after initiating treatment, check that the	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8	9 n=5	45 = 100%

	patient is taking the medicine as prescribed. If they are, then consider increasing the dose or changing to another antidepressant.																				
xxxiv.	D - Patients receiving drug treatment for depression or anxiety should have it reviewed regularly to assess continued need.	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8	9 n=5	45 = 100%
xxxv.	E - Brief, structured psychological therapy should be considered for patients with depression. Therapy will need to be adapted for use in those with neurological conditions.	1	2	3	4	5	6	7	8	9		1	2 n=1	3	4	5 n=1	6 n=1	7  n=1	8	9  n=2  n=1	 31 = 69%  29 = 64%
xxxvi.	F - Antidepressant treatment should not be used routinely to prevent the onset of depression	1	2	3	4	5	6	7	8	9		1	2 n=1	3	4	5	6	7	8	9 n=4	38 = 84%
xxxvii.	6.36 Emotionalism																				
xxviii.	A - Any patient who persistently cries or laughs in unexpected situations or who is upset by their fluctuating emotional state should be assessed by a specialist or member of the stroke team trained in the assessment of emotionalism.	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8	9 n=5	45 = 100%
xxxix.	B - Any patient diagnosed with emotionalism should, when they show increased emotional behaviour, be appropriately distracted from the provoking stimuli.	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6 n=1	7	8	9 n=4	42 = 93%
xl.	C - Patients with severe, persistent or troublesome emotionalism should be given antidepressant drug treatment, monitoring the frequency of crying to check effectiveness. Patients should be monitored for known adverse effects. If the emotionalism has not improved 2–4 weeks after initiating treatment, check that the patient is taking the medicine as prescribed. If they are, then consider increasing the dose or changing to another antidepressant.	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6 n=1	7	8	9 n=4	42 = 93%

	Stroke best practice recommendation 6.25 Bowel and bladder impairment	Rating 1 to 9 with 1 being least relevant to residents living with stroke in your care home and 9 being most relevant. Please indicate your choice by circling the relevant number										The Oaks: Individual care home consensus result scores n=5									Total relevance score
xli.	A - All wards and stroke units should have established assessment and management protocols for both urinary and faecal incontinence and for constipation in stroke patients.	1	2	3	4	5	6	7	8	9		1	2 n=3	3 n=1	4	5	6	7	8	9 n=1	18 = 40%
xlii.	B - Patients with stroke who have continued loss of bladder control 2 weeks after diagnosis should be reassessed to identify the cause of incontinence, and have an ongoing treatment plan involving both patients and carers. The patient should: <ul style="list-style-type: none"> Have any identified causes of incontinence treated Have an active plan of management documented Be offered simple treatments such as bladder retraining, pelvic floor exercises and external equipment first Only be discharged with continuing incontinence after the carer (family member) or patient has been fully trained in its management and adequate arrangements for continuing supply of continence aids and services are confirmed and in place. 	1	2	3	4	5	6	7	8	9		1 n=2	2 n=1	3	4	5 n=1	6	7	8	9 n=1	18 = 40%
xliii.	C - All stroke patients with a persistent loss of control over their bowels should: <ul style="list-style-type: none"> Be assessed for other causes of incontinence, which should be treated if identified Have a documented, active plan of management 	1	2	3	4	5	6	7	8	9		1 n=4	2	3	4	5	6	7	8 n=1	9	12 = 27%

	<ul style="list-style-type: none">Be referred for specialist treatments if the patient is able to participate in treatmentsOnly be discharged with continuing incontinence after the carer (family member) or patient has been fully trained in its management and adequate arrangements for a continuing supply of continence aids and services are confirmed and in place.																				
xliv.	D - Stroke patients with troublesome constipation should: <ul style="list-style-type: none">Have a prescribed drug review to minimise use of constipating drugsBe given advice on diet, fluid intake and exerciseBe offered oral laxativesBe offered rectal laxatives only if severe problems remain.	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8	9 n=5	45 = 100%

	Stroke best practice recommendation 7.1 Further rehabilitation	Rating 1 to 9 with 1 being least relevant to residents living with stroke in your care home and 9 being most relevant. Please indicate your choice by circling the relevant number										The oaks: Individual care home consensus result scores n=									Total relevance scores
xlv.	A - Any patient whose situation changes (e.g. new problems or changed environment) should be offered further assessment by the specialist stroke rehabilitation service.	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8 n=1	9 n=4	44 = 98%

xlvi.	B - A named person and/or contact point should be identified and communicated to the patient to provide further information and advice if needed	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6 n=1	7 n=1	8	9 n=3	40 = 89%
xlvii.	C - Any patient with residual impairment after the end of initial rehabilitation should be offered a formal review at least every 6 months, to consider whether further interventions are warranted, and should be referred for specialist assessment if: <ul style="list-style-type: none"> New problems, not present when last seen by the specialist service, are present The patient's physical state or social environment has changed 	1	2	3	4	5	6	7	8	9		1	2	3	4	5 n=1	6 n=2	7 n=1	8 n=1	9	32 = 71%
xlvi.	D - Further therapy following 6-month review should only be offered if clear goals are agreed.	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6 n=1	7 n=2	8	9 n=2	38 = 84%
xlix.	E - Patients should have their stroke risk factors and prevention plan reviewed at least every year <ul style="list-style-type: none"> 	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6 n=1	7	8	9 n=4	42 = 93%

	Stroke best practice recommendation 6.25 Personal activities of daily living	Rating 1 to 9 with 1 being least relevant to residents living with stroke in your care home and 9 being most relevant. Please indicate your choice by circling the relevant number										The Oaks: Individual care home consensus result scores n=4										Total relevance scores
I.	A - Every patient who has had a stroke should be assessed formally for their safety and independence in all personal activities of daily living by a clinician with the	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8	9 n=4	36 = 100%	

	appropriate expertise, and results should be recorded using a standardised assessment tool.																				
li.	<p>B - Any patient who has limitations on any aspect of personal activities after stroke should:</p> <ul style="list-style-type: none"> • Be referred to an occupational therapist with experience in neurological disability, <i>and</i> • Be seen for further assessment within 4 working days of referral, <i>and</i> • Have treatment of identified problems from the occupational therapist who should also guide and involve other members of the specialist multidisciplinary team. 	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8	9 n=4	36 = 100%
lii.	<p>C - Specific treatments that should be offered to stroke patients (according to need) include:</p> <ul style="list-style-type: none"> • Dressing practice as a specific intervention for patients with residual dressing problems • As many opportunities as appropriate for repeated practice of self-care • Assessment for provision of and training in the use of equipment and adaptations that increase safe independence • Training of family and carers in how to help the patient 	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8	9 n=4	36 = 100%

	Stroke best practice recommendation	Rating 1 to 9 with 1 being least relevant to residents living with stroke in your care home and 9 being most relevant. Please indicate your choice by circling the relevant number										The Oaks: Individual care home consensus result scores n=12									Total relevance scores
lii.	All people with stroke in care homes should receive assessment and treatment from stroke rehabilitation services in the same way as patients living in their own homes	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8	9 n=12	108 = 100%
liv.																					
lv.	All staff in care homes should have training on the physical, psychological and social effects of stroke and the optimal management of common impairments and activity limitations.	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8	9 n=12	108 = 100%
lvi.																					
lvii.	Every patient involved in the rehabilitation process should: A - Have their feelings, wishes and expectations established and acknowledged	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8 n=1	9 n=11	107 = 99%
lviii.	B - Participate in the process of setting goals unless they choose not to or are unable to participate because of the severity of their cognitive or linguistic impairments	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8 n=2	9 n=10	106 = 98%
lix.	C - Be given help to understand the nature and process of goal setting, and be given help (e.g. using established tools) to define and articulate their personal goals	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8 n=2	9 n=10	106 = 98%
lx.	D - Have goals that <ul style="list-style-type: none"> are meaningful and relevant to the patient are challenging but achievable include both short-term (days/weeks) and long-term (weeks/months) targets include both single clinicians and also the whole team 	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8 n=1	9 n=9	107 = 99%

	<ul style="list-style-type: none">• are documented, with specified, time-bound measurable outcomes• have achievement evaluated using goal attainment• include carers where appropriate																			
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	Stroke best practice recommendation 6.26 Bowel and bladder impairment	Rating 1 to 9 with 1 being least relevant to residents living with stroke in your care home and 9 being most relevant. Please indicate your choice by circling the relevant number										The Sycamores: Individual care home consensus result scores n=8									Total relevance score
lxi.	A - All wards and stroke units should have established assessment and management protocols for both urinary and faecal incontinence and for constipation in stroke patients.	1	2	3	4	5	6	7	8	9		1	2 n=1	3 n=1	4	5 n=1	6	7 n=5	8	9	45 = 63%
lxii.	B - Patients with stroke who have continued loss of bladder control 2 weeks after diagnosis should be reassessed to identify the cause of incontinence, and have an ongoing treatment plan involving both patients and carers. The patient should: <ul style="list-style-type: none"> Have any identified causes of incontinence treated Have an active plan of management documented Be offered simple treatments such as bladder retraining, pelvic floor exercises and external equipment first Only be discharged with continuing incontinence after the carer (family member) or patient has been fully trained in its management and adequate arrangements for a continuing supply of continence aids and services are confirmed and in place. 	1	2	3	4	5	6	7	8	9		1	22	3	4	5	6 n=1	7 n=6	8 n=1	9	56 = 78%
lxiii.	C - All stroke patients with a persistent loss of control over their bowels should:	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7 n=5	8 n=2	9	n=7

																	n=2	n=6		
lxvi.	B - Patients with mild or moderate symptoms of depression should be given information, support and advice (see recommendation 6.34.1G) and considered for one or more of the following interventions: <ul style="list-style-type: none"> Increased social interaction Increased exercise Goal setting Other psychosocial interventions. 	1	2	3	4	5	6	7	8		1	2	3	4	5	6	7	8	9	62 = 86%
																	n=2	n=6		
lxvii.	C - Patients prescribed antidepressant drug treatment for depression or anxiety should be monitored for known adverse effects, and treatment continued for at least 4 months beyond initial recovery. If the patient's mood has not improved 2–4 weeks after initiating treatment, check that the patient is taking the medicine as prescribed. If they are, then consider increasing the dose or changing to another antidepressant.	1	2	3	4	5	6	7	8		1	2	3	4	5	6	7	8	9	n=7 51 = 81%
lxviii.	D - Patients receiving drug treatment for depression or anxiety should have it reviewed regularly to assess continued need.	1	2	3	4	5	6	7	8		1	2	3	4	5	6	7	8	9	65 = 90%
																	n=1	n=5	n=2	
lxix.	E - Brief, structured psychological therapy should be considered for patients with depression. Therapy will need to be adapted for use in those with neurological conditions.	1	2	3	4	5	6	7	8		1	2	3	4	5	6	7	8	9	57 = 79%
															n=2		n=1	n=5		
lxx.	F - Antidepressant treatment should not be used routinely to prevent the onset of depression	1	2	3	4	5	6	7	8		1	2	3	4	5	6	7	8	9	n=7 56 = 89%
																	n=1	n=5	n=1	
	6.36 Emotionalism																			
lxxi.	A - Any patient who persistently cries or laughs in unexpected situations or who is upset by their fluctuating emotional state should be assessed by a specialist or member of the stroke team trained in the assessment of emotionalism.	1	2	3	4	5	6	7	8		1	2	3	4	5	6	7	8	9	62 = 86%
																	n=3	n=4	n=1	

lxxii.	B - Any patient diagnosed with emotionalism should, when they show increased emotional behaviour, be appropriately distracted from the provoking stimuli.	1	2	3	4	5	6	7	8		1	2	3	4	5	6	7	8	9	n=7 52 = 83%
lxxiii.	C - Patients with severe, persistent or troublesome emotionalism should be given antidepressant drug treatment, monitoring the frequency of crying to check effectiveness. Patients should be monitored for known adverse effects. If the emotionalism has not improved 2–4 weeks after initiating treatment, check that the patient is taking the medicine as prescribed. If they are, then consider increasing the dose or changing to another antidepressant.	1	2	3	4	5	6	7	8		1	2	3	4	5	6	7	8	9	n=7 44 = 70%

	Stroke best practice recommendation 7.1 Further rehabilitation	Rating 1 to 9 with 1 being least relevant to residents living with stroke in your care home and 9 being most relevant. Please indicate your choice by circling the relevant number										The Sycamores: Individual care home consensus result scores n=8									Total relevance scores
lxxiv.	A - Any patient whose situation changes (e.g. new problems or changed environment) should be offered further assessment by the specialist stroke rehabilitation service.	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8 n=8	9	64 = 89%
lxxv.	B - A named person and/or contact point should be identified and communicated to the patient to provide further information and advice if needed	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8 n=8	9	64 = 89%
lxxvi.	C - Any patient with residual impairment after the end of initial rehabilitation should be offered a formal review at least	1	2	3	4	5	6	7	8	9		1	2	3	4	5 n=1	6	7	8 n=7	9	61 = 85%

	every 6 months, to consider whether further interventions are warranted, and should be referred for specialist assessment if: <ul style="list-style-type: none">• New problems, not present when last seen by the specialist service, are present• The patient’s physical state or social environment has changed																				
lxxvii.	D - Further therapy following 6-month review should only be offered if clear goals are agreed.	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6 n=2	7	8 n=6	9	60 = 83%
xxviii.	E - Patients should have their stroke risk factors and prevention plan reviewed at least every year <ul style="list-style-type: none">•	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6 n=2	7	8 n=6	9	60 = 83%

	Stroke best practice recommendation 6.25 Personal activities of daily living	Rating 1 to 9 with 1 being least relevant to residents living with stroke in your care home and 9 being most relevant. Please indicate your choice by circling the relevant number										The Sycamores: Individual care home consensus result scores n=8									Total relevance scores
lxxix.	A - Every patient who has had a stroke should be assessed formally for their safety and independence in all personal activities of daily living by a clinician with the appropriate expertise, and results should be recorded using a standardised assessment tool.	1	2	3	4	5	6	7	8	9		1	2	3	4	5 n=2	6 n=1	7 n=1	8 n=4	9	55 = 76%
lxxx.	B - Any patient who has limitations on any aspect of personal activities after stroke should: <ul style="list-style-type: none">Be referred to an occupational therapist with experience in neurological disability, <i>and</i>	1	2	3	4	5	6	7	8	9		1	2	3	4	5 n=3	6	7	8 n=3	9 n=2	57 = 79%

	<ul style="list-style-type: none"> Be seen for further assessment within 4 working days of referral, <i>and</i> Have treatment of identified problems from the occupational therapist who should also guide and involve other members of the specialist multidisciplinary team. 																				
lxxxi.	<p>C - Specific treatments that should be offered to stroke patients (according to need) include:</p> <ul style="list-style-type: none"> Dressing practice as a specific intervention for patients with residual dressing problems As many opportunities as appropriate for repeated practice of self-care Assessment for provision of and training in the use of equipment and adaptations that increase safe independence Training of family and carers in how to help the patient 	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6 n=1	7 n=4	8 n=1	9 n=2	60 = 83%

	Stroke best practice recommendation	Rating 1 to 9 with 1 being least relevant to residents living with stroke in your care home and 9 being most relevant. Please indicate your choice by circling the relevant number										The Sycamores: Individual care home consensus result scores n=7										Total relevance scores
lxxxii.	All people with stroke in care homes should receive assessment and treatment from stroke rehabilitation services in the same way as patients living in their own homes	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8	9 n=7	63 = 100%	
xxxiii.																						

xxxiv.	All staff in care homes should have training on the physical, psychological and social effects of stroke and the optimal management of common impairments and activity limitations.	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8	9 n=7	63 = 100%
lxxxv.																					
xxxvi.	Every patient involved in the rehabilitation process should: A - Have their feelings, wishes and expectations established and acknowledged	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8	9 n=7	63 = 100%
xxxvii.	B - Participate in the process of setting goals unless they choose not to or are unable to participate because of the severity of their cognitive or linguistic impairments	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8	9 n=7	63 = 100%
xxviii.	C - Be given help to understand the nature and process of goal setting, and be given help (e.g. using established tools) to define and articulate their personal goals	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8	9 n=7	63 = 100%
xxxix.	D - Have goals that <ul style="list-style-type: none"> are meaningful and relevant to the patient are challenging but achievable include both short-term (days/weeks) and long-term (weeks/months) targets include both single clinicians and also the whole team are documented, with specified, time-bound measurable outcomes have achievement evaluated using goal attainment include carers where appropriate 	1	2	3	4	5	6	7	8	9		1	2	3	4	5	6	7	8	9 n=7	63 = 100%

Appendix 6:2: original and tailored best practice recommendations

Bowel and bladder tailored recommendations	
Intercollegiate original recommendation 6.24: Bowel and bladder impairment	Tailored recommendations for care home setting: Bowel and bladder impairment
A - All wards and stroke units should have established assessment and management protocols for both urinary and faecal incontinence and for constipation in stroke patients.	Recommendation does not apply to care home setting
<p>B - Patients with stroke who have continued loss of bladder control 2 weeks after diagnosis should be reassessed to identify the cause of incontinence, and have an ongoing treatment plan involving both patients and carers. The patient should:</p> <ul style="list-style-type: none"> • Have any identified causes of incontinence treated • Have an active plan of management documented • Be offered simple treatments such as bladder retraining, pelvic floor exercises and external equipment first • Only be discharged with continuing incontinence after the carer (family member) or patient has been fully trained in its management and adequate arrangements for a continuing supply of continence aids and services are confirmed and in place. 	<p>B – Residents with stroke who have continued loss of bladder control 2 weeks after diagnosis should be reassessed to identify the cause of incontinence, and have an ongoing treatment plan involving both patients and care practitioners.</p> <p>The care practitioners should be given relevant information in order to care for the residents' continence needs.</p> <p>The patient should:</p> <ul style="list-style-type: none"> • Have any identified causes of incontinence treated • Have an active plan of management documented, such as a continence pathway • Be offered simple treatments such as bladder retraining, pelvic floor exercises and external equipment as appropriate
<p>C - All stroke patients with a persistent loss of control over their bowels should:</p> <ul style="list-style-type: none"> • Be assessed for other causes of incontinence, which should be treated if identified • Have a documented, active plan of management • Be referred for specialist treatments if the patient is able to participate in treatments • Only be discharged with continuing incontinence after the carer (family member) or patient has been fully trained in its management and adequate arrangements for a continuing supply of continence aids and services are confirmed and in place. 	<ul style="list-style-type: none"> • Recommendations fall into the remit of other professionals and do not therefore apply to the care home
<p>D - Stroke patients with troublesome constipation should:</p> <ul style="list-style-type: none"> • Have a prescribed drug review to minimise use of constipating drugs • Be given advice on diet, fluid intake and exercise • Be offered oral laxatives • Be offered rectal laxatives only if severe problems remain. 	<p>D - Stroke residents with troublesome constipation should:</p> <ul style="list-style-type: none"> • In collaboration with care practitioners the resident's G.P. should perform a prescribed drug review to minimise use of constipating drugs • Be given advice on diet, fluid intake and exercise • Be offered oral laxatives • Be offered rectal laxatives only if severe problems remain.

Care homes tailored recommendations: Care homes	
Intercollegiate original recommendation: Care homes	Tailored recommendations for care home setting: Care homes
All people with stroke in care homes should receive assessment and treatment from stroke rehabilitation	All people with stroke in care homes should receive assessment and treatment from stroke rehabilitation

services in the same way as patients living in their own homes	services in the same way as patients living in their own homes
All staff in care homes should have training on the physical, psychological and social effects of stroke and the optimal management of common impairments and activity limitations.	All staff in care homes should have training on the physical, psychological and social effects of stroke and the optimal management of common impairments and activity limitations.
Every patient involved in the rehabilitation process should:	Every patient involved in the rehabilitation process should:
A. Have their feelings, wishes and expectations established and acknowledged	A. Have their feelings, wishes and expectations established and acknowledged
B. Participate in the process of setting goals unless they choose not to or are unable to participate because of the severity of their cognitive or linguistic impairments	B. Participate in the process of setting goals unless they choose not to or are unable to participate because of the severity of their thought process and ability to communicate
C. Be given help to understand the nature and process of goal setting, and be given help (e.g. using established tools) to define and articulate their personal goals	C. Be given help to understand the nature and process of goal setting, and be given help (e.g. using established tools) to define and articulate their personal goals
D. Have goals that <ul style="list-style-type: none"> • are meaningful and relevant to the patient • are challenging but achievable • include both short-term (days/weeks) and long-term (weeks/months) targets • include both single clinicians and also the whole team • are documented, with specified, time-bound measurable outcomes • have achievement evaluated using goal attainment • include carers where appropriate • are used to guide and inform therapy and treatment. 	D. Have goals that <ul style="list-style-type: none"> • are meaningful and relevant to the resident • are challenging but achievable • include both short-term (days/weeks) and long-term (weeks/months) targets • include care practitioners • are documented, with specified, time-bound measurable outcomes • have achievement evaluated using goal attainment • include family and significant others where appropriate • Goals are communicated within the team who provide care.

Personal activities of daily living tailored recommendations	
Intercollegiate original recommendation: 6.25 Personal activities of daily living	Tailored recommendations for care home setting: Personal activities of daily living
A - Every patient who has had a stroke should be assessed formally for their safety and independence in all personal activities of daily living by a c with the appropriate expertise, and results should be recorded using a standardised assessment tool.	A - Every resident who has had a stroke should be assessed formally for their safety and independence in all personal activities of daily living by a care practitioner with the appropriate expertise, and results should be recorded using a standardised assessment tool.
B - Any patient who has limitations on any aspect of personal activities after stroke should: <ul style="list-style-type: none"> • Be referred to an occupational therapist with experience in neurological disability, <i>and</i> • Be seen for further assessment within 4 working days of referral, <i>and</i> • Have treatment of identified problems from the occupational therapist who should also guide and involve other members of the specialist multidisciplinary team. 	B - Any resident who has limitations on any aspect of personal activities after stroke should: <ul style="list-style-type: none"> • Be referred to an occupational therapist with experience in neurological disability, <i>and</i> • Be seen for further assessment within 4 working days of referral (N.B. meeting this time frame is out of the care home's control), <i>and</i> • Have treatment of identified problems from the occupational therapist who should explain any prescribed care regimen to the care practitioners within the care home.
C - Specific treatments that should be offered to stroke patients (according to need) include:	C - Specific treatments that should be offered to stroke patients (according to need) include:

<ul style="list-style-type: none"> • Dressing practice as a specific intervention for patients with residual dressing problems • As many opportunities as appropriate for repeated practice of self-care • Assessment for provision of and training in the use of equipment and adaptations that increase safe independence • Training of family and carers in how to help the patient 	<ul style="list-style-type: none"> • Dressing practice as a specific intervention for patients with residual dressing problems • As many opportunities as appropriate for repeated practice of self-care • Assessment for provision of and training in the use of equipment and adaptations that increase safe independence • When required care practitioners should refer to other agencies for specialist advice and equipment. • Training of family and care practitioners in how to help the resident.
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Depression and anxiety tailored recommendations	
Intercollegiate original recommendation: 6.35 Depression and anxiety	Tailored recommendations for care home setting: Depression and anxiety
A - Any patient considered to have depression or anxiety should be assessed for other mood disorders.	A - Any patient considered to have depression or anxiety should be referred to their GP for further assessment.
B - Patients with mild or moderate symptoms of depression should be given information, support and advice (see recommendation 6.34.1G) and considered for one or more of the following interventions: <ul style="list-style-type: none"> • Increased social interaction • Increased exercise • Goal setting • Other psychosocial interventions. 	B - Patients with mild or moderate symptoms of depression should be given information, support and advice (see recommendation 6.34.1G) and considered for one or more of the following interventions: <ul style="list-style-type: none"> • Increased social interaction • Increased exercise/activities • Goal setting
C - Patients prescribed antidepressant drug treatment for depression or anxiety should be monitored for known adverse effects, and treatment continued for at least 4 months beyond initial recovery. If the patient's mood has not improved 2–4 weeks after initiating treatment, check that the patient is taking the medicine as prescribed. If they are, then consider increasing the dose or changing to another antidepressant.	C – Care home will monitor resident's mood and impact of prescribed drug regimen and feedback to GP.
D - Patients receiving drug treatment for depression or anxiety should have it reviewed regularly to assess continued need.	D – For residents receiving drug treatment for depression or anxiety Care homes will request a 6 monthly medications review by GP.
E - Brief, structured psychological therapy should be considered for patients with depression. Therapy will need to be adapted for use in those with neurological conditions.	N/A
F - Antidepressant treatment should not be used routinely to prevent the onset of depression	N/A

Table 6... Emotionalism

Emotionalism tailored recommendations	
Intercollegiate original recommendation: 6.36 Emotionalism	Tailored recommendations for care home setting: Emotionalism
A - Any patient who persistently cries or laughs in unexpected situations or who is upset by their fluctuating emotional state should be assessed by a specialist or member of the stroke team trained in the assessment of emotionalism.	A - Any resident who persistently cries or laughs in unexpected situations or who is upset by their fluctuating emotional state should be referred to their GP or member of the stroke team trained in the assessment of emotionalism.

B - Any patient diagnosed with emotionalism should, when they show increased emotional behaviour, be appropriately distracted from the provoking stimuli.	B - Any resident diagnosed with emotionalism should, when they show increased emotional behaviour, be supported by care staff and appropriately distracted to reduce the impact of the cause of their emotional distress.
C - Patients with severe, persistent or troublesome emotionalism should be given antidepressant drug treatment, monitoring the frequency of crying to check effectiveness. Patients should be monitored for known adverse effects. If the emotionalism has not improved 2–4 weeks after initiating treatment, check that the patient is taking the medicine as prescribed. If they are, then consider increasing the dose or changing to another antidepressant.	Recommendations fall into the remit of other professionals and do not therefore apply to the care home

Further rehabilitation tailored recommendations	
Intercollegiate original recommendation: 7.1 Further rehabilitation	Tailored recommendations for care home setting: Further rehabilitation
A - Any patient whose situation changes (e.g. new problems or changed environment) should be offered further assessment by the specialist stroke rehabilitation service.	A - Any resident whose situation changes (e.g. new problems) should be referred to their GP in order to be offered further assessment by the specialist stroke rehabilitation service.
B - A named person and/or contact point should be identified and communicated to the patient to provide further information and advice if needed	B - A care home stroke champion and named carer should be identified and communicated to the resident to provide further information and advice if needed
C - Any patient with residual impairment after the end of initial rehabilitation should be offered a formal review at least every 6 months, to consider whether further interventions are warranted, and should be referred for specialist assessment if: New problems, not present when last seen by the specialist service, are present The patient's physical state or social environment has changed	C - Any resident with residual impairment after the end of initial rehabilitation should be referred to their GP for a formal review at least every 6 months, to consider whether further interventions are warranted.
D - Further therapy following 6-month review should only be offered if clear goals are agreed.	Recommendations fall into the remit of other professionals and do not therefore apply to the care home
E - Patients should have their stroke risk factors and prevention plan reviewed at least every year	E – Resident's should have their stroke risk factors and prevention plan reviewed by their GP at least every year

