Ontario Stroke System

Evaluation of the Transition Information Plan (TIP) Tool

FINAL
Evaluation Report
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For:
Southwestern Ontario Stroke System

Glossary of Terms

Term	Definition
Average +/-	average is calculated as the mean score. +/- = standard deviation, which is the average distance between individual scores from the overall average score.
BM	Bowel Movement
CCAC	Community Care Access Centre
DOC/ ADOC	Director of Care Assistant Director of Care
LHSC	London Health Sciences Centre
LTC	Long-term care
MDS-HC	Minimum Data Set – Home Care
MDS-RAI	Minimum Data Set – Resident Assessment Instrument
MRSA	Methicillin-resistant Staphylococcus Aureus
NA	Nursing Assistant
PSW	Personal Support Worker
RN/ RPN	Registered Nurse/ Registered Practical Nurse
TIP tool	Transitional Information Plan tool

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Executive Summary

The Transition Information Plan (TIP) Tool was developed by the Ontario Stroke System in response to the need for more detailed patient information for long-term care (LTC) homes accepting residents with stroke upon discharge from acute care and rehabilitation settings. The TIP tool was specifically designed to meet the needs of frontline workers so that they could begin caring for new residents with minimal disruption to continuity of care; it includes information on the resident's current status (at time of hospital discharge), care strategies and recommendations, risks and safety considerations, and the potential for improvement and gains. Motivated by a desire to maintain continuity of care across health sectors, Parkwood Hospital, London, continues to use the TIP tool; at the time of discharge to LTC from the Stroke Rehabilitation unit, LTC homes receive a discharge summary, and a completed MDS-RAI and TIP tool. This report describes the methods and results of an evaluation of the TIP tool as used in LTC homes accepting residents with stroke discharged from the Rehabilitation Unit of Parkwood Hospital, St. Joseph's Health Care London. This evaluation was sponsored by the Southwestern Ontario (SWO) Stroke Strategy (SS).

Evaluation Focusing: This evaluation was developed in collaboration with an advisory group consisting of representatives from the Ontario Stroke System (Regional Community and LTC Stroke Coordinators), the Stroke Rehabilitation Program, Parkwood Hospital, and LTC homes. Group members acted as advisors to this evaluation, providing advice and feedback on the development and implementation of evaluation tools and interpretation of results.

Evaluation Objectives: The identified objectives of the evaluation were to:

i) Describe the use of the TIP tool in LTC homes that accepted residents transferred from the Stroke Rehabilitation Program, Parkwood Hospital
ii) Describe the usefulness of the TIP tool in LTC homes
iii) Identify opportunities/ suggestions for improving communication between Parkwood Hospital and LTC homes.

Evaluation Methods

Sources of Information: A mixed methods (quantitative and qualitative methods) approach was used to meet the objectives of this evaluation, using the following sources of information:

- ***LTC homes:*** Participants were staff representing the LTC homes that accepted residents transferred from the Stroke Rehabilitation Program, Parkwood Hospital, between January 1, 2008 and February 28, 2009 and during the evaluation phase (March 1 to October 31, 2009).
- ***Key Informant Interviews*** with LTC staff who were involved in admitting new residents and/or developing or implementing a care plan upon admission.
- ***Survey of LTC staff*** who have used the TIP tool to assess their perceptions of the TIP tool.

This evaluation study was approved by the Research Ethics Board, University of Western Ontario.

Results

Response Rate: In total six LTC care homes participated in this evaluation study. Twenty-three key informant interviews were conducted with LTC staff including, Directors of Care, Care Coordinators, Registered nurses, PSWs and Nursing Assistants. In total, the survey of LTC staff was completed by three individuals (DOC, Physiotherapist, and Restorative Care Manager).

Use of the TIP Tool: Of the six LTC homes participating in this study, only one home (16.7%) was actively using the TIP tool. The remaining five homes (83.3%) were not using the TIP tool, mainly because they were not aware of the tool and had not seen it with the admission information when the residents were transferred to their home. Upon further investigation, the TIP tool was either *"buried"* in the file or it was not in the resident's chart. In at least one instance, the TIP tool was not completed for a new admission to LTC. The majority of those interviewed (70%; N = 16) had never heard of or seen the TIP tool. Although the TIP tool was known to seven individuals, only three individuals had actually ever used it; four individuals reported that they had either heard of or seen the TIP tool but have never had the opportunity to use it with a resident.

As described by the interview participants, the TIP tool is usually used directly by the staff member (usually a registered nurse or resident care coordinator) completing the admission, physiotherapists, and dietary staff, who then create a care plan that front line staff (PSWs, RPNs, Nursing Assistants) use to guide their work with residents.

Usefulness of the TIP Tool: Despite infrequent use of the tool, those who have used the tool rated it as *"extremely useful"* to their immediate care of residents with stroke. Similarly, all of the components/ sections of the TIP tool were rated as *"very"* or *"extremely important"* to their immediate care of residents with stroke. Overall, survey respondents rated the TIP tool as "very good" and "excellent" in terms of how it helps them to care for residents with stroke when they are first admitted to their home. The following comments were made regarding the usefulness of the TIP tool:

- Easier to follow and find specific information than narrative discharge reports
- Contains more detailed information about care than other sources of information
- Provides social history not otherwise provided
- Mirrors terminology used in care plans
- Relevant for all disciplines (nursing, dietary, physiotherapy)
- Facilitates seamless transition / continuity of care from acute care
- Clearly identifies goals established in rehabilitation so they can be continued
- Provides the most up-to-date source of information about the resident
- Provides contact person who can provide further information if needed
- Can be used as baseline data to measure change.

Potential/ anticipated benefits: Those interview participants who were not previously aware of the TIP tool were impressed with it and anticipated that it would be of great value at the time of admission. They predicted that the TIP tool would:

- Facilitate seamless transition and reduces resident distress at time of admission
- Be easy to read and use, and time efficient
- Increase family confidence with the care provided in LTC
- Facilitate communication among all staff

- Facilitate communication between the hospital and LTC.

Potential challenge with the TIP Tool: It was suggested that the tool may be too complicated for PSWs or Nursing Assistants, many of whom have low literacy levels or have English as their second language.

Current challenges with information sharing at the time of admission: In general (not specific to Parkwood Hospital) interview participants identified a number of challenges related to information sharing at the time that a resident with stroke is admitted to LTC. These were: limited information provided by the discharging facility and limited information available to PSWs and Nursing Assistants regarding the provision of personal care. Interview participants identified information that they would like to receive at the time that a new resident with stroke with admitted to their home, but typically is not readily or consistently available. Such information included:

- Use of special equipment/ preferences
- Goals and anticipated potential for improvement
- Strategies, both successful and unsuccessful (including memory aids, visual or verbal cues)
- Type of transfer
- Existing pain problems
- Potential for aggressive behaviour
- Triggers and strategies used to prevent aggressive behaviour.

Suggestions for improvements to the TIP tool and process of using the tool: Across all interview participants, the following suggestions for improvements were made:

- Deliver TIP tool to LTC homes prior to the admission day so homes can prepare for the admission
- Signal the presence of the TIP tool among the admission materials with a note or sticker in a prominent position (e.g., "See TIP tool for detailed information."
- Provide a version of the TIP tool specifically focused on personal care
- Include more information on dietary needs using terminology used in LTC
- Expand use of the TIP tool across sectors
- Promote use/ increase awareness of the TIP tool
- Create an electronic version
- Enhance the visual appearance of the tool by using a larger font size and coloured paper.

Suggestions for improving communication/ information sharing between acute care and LTC: Interview participants identified a number of strategies for improving communication and information sharing between all hospitals (not specific to Parkwood) and LTC care, namely related to the effective use of existing technology (e.g., videoconferencing, e-mail), regular opportunities for cross sector interaction, increasing acute care awareness of the realities of LTC, and development of effective mechanisms for communication.

Conclusions: Based on the results of this evaluation, the following conclusions can be made:

- There has been limited use of the TIP tool as prepared by Parkwood Hospital staff for patients with stroke being discharged to long-term care.

- For those not previously familiar with the TIP tool, there is much interest in having an opportunity to use tool as a vehicle for ensuring seamless transition to long-term care and facilitating continuity of care. Those who have used the tool have found it to be extremely useful.

- Although there are other sources of information available at the time of admission such as MDS-HC and hospital discharge summaries, there was general consensus that this information (in general and not specific to Parkwood Hospital) is usually inadequate for developing immediate care plans for residents with stroke. Information from the MDS-HC was described as often outdated, with updates being inconsequential, and discharge summaries were described as limited and lacking important details. There were no concerns that the TIP tool is a duplication of the MDS-RAI as the TIP tool provides a greater level of detail that is useful for care planning and provision of care.

- Identified challenges associated with information sharing at the time of admission to long-term care from acute care are not new. Many of these challenges are those that motivated the development of the TIP tool. In fact, the TIP tool contains much of the information that interview participants reported they would like to have at the time of admission, but typically is not readily or consistently available.

- Although the TIP tool was initially intended for use by PSWs and other frontline staff, in reality it used most by registered level staff (registered nurses, registered practical nurses), who then summarize in the information in a separate communication to frontline staff. Concerns were expressed that the current format of the TIP tool may not be accessible for frontline workers who have lower literacy levels or for whom English is a second language. Options for sharing information with this group of frontline workers should be explored further.

- Although many promotional strategies were implemented at the time that the tool was first launched, given the high turnover rate of staff in long-term care, it may helpful to promote and market the tool on an ongoing basis. Given that Parkwood hospital was noted to be the only Hospital still using the tool, it may be beneficial to promote and market the tool in other acute care and rehabilitation settings. However, it would be useful to first explore the factors that prevent or hinder other settings from using the TIP tool. Resolving identified barriers to use of the tool may increase its use. As well, given the time commitment required of hospital staff to complete the TIP tool, it may helpful to identify incentives associated with using the tool so these incentives could be promoted.

- Existing vehicles/ opportunities for information sharing within the long-term care sector may act as mechanisms for promoting the TIP tool. Suggestions of developing a regular newsletter as an opportunity to promote the TIP tool and to provide information related to stroke care (strategies/'tips') highlights the desire of long-term care staff to improve care for residents with stroke.

- Interview participants identified a number of suggestions for improving communication/ information sharing between acute care (in general, not specific to Parkwood Hospital) and long-term care and for improving care for residents with stroke. Again, many of

- problems at which these suggestions are targeted are not new and are well documented in the literature.[1] Although many of these challenges are beyond the scope of what the TIP tool can do, the TIP tool nonetheless has an important role to play in closing some of the existing stroke care gaps.

Limitations: There are several limitations associated with this evaluation. Although few individuals in this evaluation had used the TIP tool, it is not known if this is representative of all homes in the region; the sample size of this study represents a very small proportion of LTC homes in the region/ province. While not known for certain, it is suspected that few discharging facilities, other than Parkwood Hospital, are providing long-term care homes with completed TIP tools. As many of those interviewed had no experience with the TIP tool, many of the comments made about the TIP tool were regarding 'anticipated' benefits and not based on actual experience. Similarly, many of the comments made regarding information sharing and communication were related to their broad experience with hospitals and not specifically regarding Parkwood Hospital. Limited opportunities to conduct prospective interviews and the fact that some homes did not receive the TIP tool with new admissions from Parkwood Hospital prevented the evaluation from including more information specific to the use of the tool with newly admitted residents. Future evaluation studies should consider methodologies/ procedures that engage potential participants immediately prior to the admission to long-term care to ensure that the tool is used and opportunities for evaluation are not lost.

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[1] Reed, R.L., Gerety, M.B., Winograd, C.H. (1990). Expanded access to rehabilitation services for older people. An urgent need. *Journal of the American Geriatrics Society,* 38, 1055-1056.
Stolee, P., Hillier, L.M., Webster, F., and O'Callaghan, C. (2006). Stroke care in long-term care facilities in southwestern Ontario. *Topics in Stroke Rehabilitation,* 13 (4), 97-108.

1.0 Introduction

The Transition Information Plan (TIP) Tool was developed by the Ontario Stroke System in response to the need for more detailed patient information for long-term care (LTC) homes accepting residents with stroke upon discharge from acute care and rehabilitation settings. Typically new residents were admitted to LTC with minimal information available; hospital discharge reports often arrived several weeks after the admission, challenging homes to provide appropriate and optimal stroke care immediately upon admission. The TIP tool was designed to accompany residents as they are discharged from hospital and admitted to LTC. Completed by hospital care providers, the tool was specifically designed to meet the needs of frontline workers so that they could begin caring for new residents with minimal disruption to continuity of care and includes information needed by LTC care providers to immediately develop stroke-focused care plans andThe tool supplements information available in the Minimum Data Set for Homecare (MDS-HC), which is completed as part of the admission process to LTC. The TIP tool includes information on the resident's current status (at time of hospital discharge), care strategies and recommendations, risks and safety considerations, and the potential for improvement and gains. This information is provided related to:

- Medical Care Plan and Secondary Prevention
- Cognition and Perception
- Communication
- Nutrition and Feeding
- Mobility
- Pain
- Continence
- Behavior

It provides the names of key contact people at the transferring facility who are available to answer any care-related questions should LTC home staff require additional information or clarification. The TIP tool is presented in Appendix A.

In Southwestern Ontario, the TIP tool was successfully implemented in 2004 in four acute care pilot sites (Windsor Regional Hospital; Grand River Hospital, Kitchener; Parkwood Hospital, London; Grey Bruce Health Services, Owen Sound), three rehabilitation settings (Woodstock General Hospital; London Health Sciences Centre; and Grey Bruce Health Services, Meaford) and LTC homes (across Oxford, Grey-Bruce, London/Middlesex, Essex, Huron, and Waterloo counties). Evaluation efforts informed further development and implementation of the tool.

Motivated by a desire to maintain continuity of care across health sectors, Parkwood Hospital, London, continues to use the TIP tool (which is sent to LTC homes along with a discharge summary and MD-RAI), even though it is time consuming for staff to complete the tool at the typically busy time of discharge and creates some duplication in documentation with the discharge summary that LTC homes receive after the resident is admitted. There is interest at this time to determine whether the information provided on the TIP tool continues to be useful to and used by LTC staff.

This report describes the methods and results of an evaluation of the TIP tool as used in LTC homes that accept residents with stroke who are discharged from the Rehabilitation Unit of

Parkwood Hospital, St. Joseph's Health Care London. This evaluation was sponsored by the Southwestern Ontario (SWO) Stroke Strategy (SS).

2.0 Evaluation Methods

2.1 Evaluation Focusing

An Advisory Group was developed to focus the evaluation. Members of this Advisory Group acted as advisors to the evaluation, providing advice and feedback on the evaluation plan and tools, identifying participants, and providing feedback on the final report. Members of this Advisory Group were:

- Paula Gilmore, South Western Ontario Regional Community and LTC Stroke Coordinator
- Donna Scott, South Western Ontario Regional Community and LTC Stroke Coordinator (maternity leave coverage)
- Sharon Jankowski, Director of Rehabilitation, Parkwood Hospital
- Eileen Britt, Coordinator of the Stroke Rehabilitation Program, Parkwood Hospital
- Anna Bluvol, Clinical Nurse Specialist, Rehabilitation Program, Parkwood Hospital (Principal Investigator)
- Sharon Walker, Executive Director of Nursing and Personal Care, People Care
- Jenn Killing, Nurse Manager and RAI Coordinator, People Care
- Ruth King-Roes, Physiotherapist, Stroke Rehabilitation Program, Parkwood Hospital

Key stakeholders for this evaluation include: care providers in the Rehabilitation Program, Parkwood Hospital, care providers in the LTC homes accepting residents from the Rehabilitation Program, other care providers across the province currently using or considering use of the TIP tool , consumers (residents with stroke, their caregivers, and family members), and the Ontario Stroke System.

2.2 Evaluation Objectives

The identified objectives of the evaluation were to:

i) **Describe the use of the TIP tool in LTC homes that accepted residents transferred from the Stroke Rehabilitation Program, Parkwood Hospital in the past year and during the evaluation phase:**
   - How often is the TIP tool used? Is the TIP tool used by LTC staff each time a resident with stroke is admitted?
   - Who is using the tool? Which staff members are seeing it?
   - How is the information shared among staff? (directly? indirectly?) What information is shared?
   - What information is used by which staff members?

ii) Describe the usefulness of the TIP tool in LTC homes that accepted residents transferred from the Stroke Rehabilitation Program, Parkwood Hospital in the past year and during the evaluation phase:

- In what ways is the TIP tool useful? How useful is it?
- What parts of the TIP tool are considered most useful/ relevant for the immediate needs of LTC?
- Which parts of the tool are least useful/ relevant?
- Considering information available from the MDS-HC and hospital discharge summaries, what is the added benefit derived from the TIP tool?
- What impact does the TIP tool have on care planning and provision at the time of admission?
- What would be the implications (impact) for LTC homes of the discontinuation of the TIP?

ii) Identify opportunities/ suggestions for improving communication between Parkwood Hospital and LTC homes.

- In what ways could the TIP tool be improved?
- What information is not included on the TIP tool that would be useful to have?
- What opportunities/ strategies exist for information sharing at the time of transfer?

2.3 Design and Sources of Information

A mixed methods (quantitative and qualitative methods) approach was used to meet the objectives of this evaluation, using the following sources of information.

Participants were staff representing the LTC homes that accepted residents transferred from the Stroke Rehabilitation Program, Parkwood Hospital, between January 1, 2008 and February 28, 2009 and during the evaluation phase (March 1 to October 31, 2009). The Stroke Rehabilitation Program identified all of the LTC homes to which their patients were transferred between January 1, 2008 and February 28, 2009 for inclusion in this evaluation. The Administrators of all the LTC homes received a letter explaining the purpose of the evaluation, the role and time commitment of their staff and inviting them to participate in this evaluation study. Similarly, LTC homes that admitted a resident from Parkwood hospital during the evaluation phase, but that were not previously invited to participate in this study received a letter explaining the study and inviting them to participate.

Each LTC home that participated in this evaluation was asked to provide information about their location (urban vs. rural setting), number of beds, number of employees, types/ discipline of staff that work with residents with stroke, and whether they were an early adopter of the MDS-RAI.

Key Informant Interviews (Retrospective Data Collection)

Individual interviews were conducted with LTC staff that were involved in admitting new residents and/or developing or implementing care plan upon admission, such as Directors of Care, Care Coordinators, registered nurses, PSWs and nursing assistants. Attempts were made

to interview at least three individuals per LTC home. These interviews served to obtain in-depth information about the TIP tool in the previous year, specifically related to:

- their use of the TIP tool
- their perceptions of the usefulness of TIP tool
- suggestions for improving the TIP tool
- opportunities/ suggestions for improving communication between Parkwood Hospital and LTC homes.

It was anticipated that 6-8 homes would be invited to participate in these interviews, with a total of 18-24 interviews. The guide for this interview is presented in Appendix B.

Survey of Long-Term Care Homes

A brief survey was developed for representatives of the participating LTC homes (Directors of Care, Registered Nursing staff, frontline staff, physiotherapists[1]) to obtain their perceptions of the TIP tool. Questions were asked related to:

- frequency of their use of the tool with newly admitted residents with stroke (with none/ hardly any/ some/ most/ all new residents)
- usefulness/ relevance the TIP tool to their immediate care of the resident (5 point scale: not at all – extremely useful)
- importance of each component/section of the TIP tool to their immediate care of the resident (5 point scale: not at all – extremely important; this will yield a rank ordering of the sections based on importance/ relevance)
- overall level of satisfaction with the tool (5 point scale: poor – excellent)

Frontline staff completed this survey as part of their individual interview; Directors of Care and physiotherapists were invited to complete this survey on-line (posted on SurveyMonkey; www.surveymonkey.com). This survey is presented in Appendix C.

Key Informant Interviews (Prospective Data Collection)

During the data collection time period, the Director of Care of participating homes that admitted a resident transferred from Parkwood hospital was contacted within a week to identify the most appropriate person (e.g., frontline nursing staff, admitting nurse, Director of Care) to participate in a telephone interview about how they used the TIP tool (what information they used, how useful it was, what information they did not have they wished they had access to). The guide for these interviews is presented in Appendix D.

Note: As will be explained in the results section, this component of the study was not implemented.

2.4 Data Analysis

Individual interviews were conducted by the evaluation consultant; they were tape-recorded and transcribed. Data analysis was consistent with recommended practices for qualitative data.[2] Surveys data was analyzed using SPSS 15.0. (Chicago, IL: SPSS Inc, 2007). Descriptive statistics (frequencies, means, standard deviations) were generated for all numerical data.

[1] Physiotherapists providing stroke care within the LTC homes .
[2] Patton, M.Q. (2002). *Qualitative Evaluation and Research.* Thousand Oaks, CA: Sage.

2.5 Ethics Review Board Approval

This evaluation study was approved by the Research Ethics Board, University of Western Ontario.

3.0 Results

The following is a summary of the highlights and main themes that have emerged from the evaluation. A detailed presentation of the survey results is located in Appendix E.

3.1 Response Rates

Long-Term Care Homes: Eleven long-term care homes in the London and surrounding area were identified as having admitted a patient from the Stroke Rehabilitation Unit, Parkwood Hospital, between January 1, 2008 and February 28, 2009. Of these homes, 7 (64%) accepted the invitation to participate in this evaluation study. Four of these homes participated in the study and three homes did not; these homes had cancelled scheduled interview dates but were unable to reschedule either because they were too busy with other initiatives (N = 2) or because they did not respond to attempts to reschedule (N = 1). Of the 4 homes that declined to participate, being too busy with other initiatives, and in particular the implementation of the MDS-RAI, was cited as the primary reason for their inability to participate.

Three additional homes were invited to participate in the study as they had accepted a patient from the Stroke Rehabilitation Unit during the course of data collection (March 01 – October 31, 2009. Two of these homes participated in the study. In total six LTC homes participated in this evaluation study, representing a 43% response rate. Demographic Information on these homes is presented in Table 1.

Table 1: Description of Participating Home (N= 6)

Demographic Variable		Number (%)
Location :	Urban	66.7% (4)
	Rural	33.3% (3)
Number of beds:	Average (+/-)	149 beds (58)
	Range	90 – 247 beds
Number of employees:	Average (+/-)	160 (63)
	Range	95-250
Types of staff working with residents with stroke:		
	Personal Support Workers/ Resident Care Aides	100% (6)
	Registered Nurses/ Registered Practical Nurses	100% (6)
	Physiotherapists*	100% (6)
	Restorative Care Aides/Activation Program Aides	100% (6)
	Other**	66.7% (4)

Demographic Variable	Number (%)
Early Adopter of MDS RAI:	66.7% (4)

* Contracted from local provider agencies.

** Other types of staff included: Occupational and physical therapy assistants, social workers, and outsourcing for speech and language and other services through CCAC as needed.

Survey Respondents: As will be discussed later, surveys were distributed only to those individuals who reported having used the TIP tool. A total of three surveys were completed. Respondents were a Director of Care, physiotherapist, and a Restorative Care Manager. There was much variability in the amount of time that these respondents had worked with residents with stroke (range = 4 – 32 years), with the average being 14 years.

Interview Participants (Retrospective Interviews): A total of 23 individuals participated in these interviews: Directors of Care/Assistant Directors of Care (17.4%, N = 4), Registered Nurses (8.7%; N = 2), Registered Practical Nurses (13.0%; N = 3), Nursing Assistants (8.7%; N=2), Personal Support Workers (17.4%, N = 4), Physiotherapists (8.7%; N = 2), Restorative Care Aides (8.7%; N = 2), and others (Health Information Manager, Clinical Coordinator, Resident Care Coordinator, Dietary Manager, one of each).The number of individuals per home that participated in these interviews ranged from to 2 to 8 (an average of 4 per home). In three instances, group interviews were conducted; two with two individuals, and one with three individuals. Interviews ranged in length from 10 to 50 minutes, with an average of 17 minutes.

Interview Participants (Prospective Interviews): During the study time period (March 1 to October 31, 2009) five homes had an admission from Parkwood Hospital. Two homes did not receive the TIP tool and the remaining homes, though they may have been provided with a TIP tool, did not access it at the time of admission. Thus, there were no opportunities during the study time period to implement this component of the study.

3.2 OBJECTIVE I: Describe the use of the TIP tool in LTC homes that accepted residents transferred from the Stroke Rehabilitation Program, Parkwood Hospital in the past year and during the evaluation phase.

Of the six LTC homes participating in this study, only one home (16.7%) was actively using the TIP tool (See Figure 1). The Director of Care of this home had been involved in the pilot testing of the tool and thus was aware of it. It was noted that Parkwood was the only hospital from which they accept admissions that is currently still using the TIP tool.

The remaining five homes (83.3%) were not using the TIP Tool, the primary reason being that they were not aware of the tool and had not seen it with the admission information when the residents were transferred to their home. Representatives from several of these homes searched the files of residents admitted from Parkwood in the previous year and reported either finding the TIP tool *"buried"* in the file (they did not recall seeing it at the time of admission), or reporting that it was not in the chart. In at least one instance, the TIP tool was not completed for a new admission to LTC. It was suggested that some patients transferred out of Parkwood Hospital may go to the local hospital for a brief period of time prior to being transferred to the LTC home, so the TIP tool may have been entered into the hospital medical record and not forwarded on to the LTC home. However, it is important to note that Parkwood Hospital staff do not complete a TIP tool for patients being transferred to another hospital, regardless if their end

destination is LTC, because their status may change in the interim and the TIP tool could potentially be outdated.

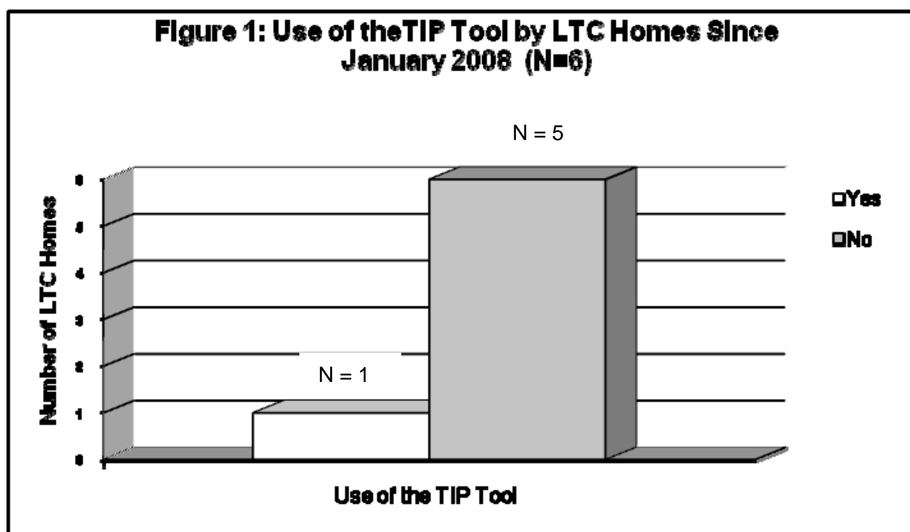


Table 2 presents interview participants' use of and awareness of the TIP tool. The majority of those interviewed (70%) had never heard of or seen the TIP tool. Although three individuals had either heard of or seen the TIP tool, they had never had the opportunity to use it with a resident. Three of the four individuals who had used the TIP tool at least once since January 2008 completed a survey about the tool.

Table 2: Interview Participant's Use of and Awareness of the TIP Tool (N= 23)

Level of Use/ Awareness	Number (%)
Used the TIP tool at least once since January 2008	17.4% (4)*
Had previously heard of or seen the TIP tool but have never used it	13.0% (3)
Had never heard of or seen the TIP tool	69.6% (16)

*Two of these individuals worked in the same LTC home noted to be actively using the TIP tool (as described in Figure 1), two had used it in a home in which they were previously or concurrently employed.

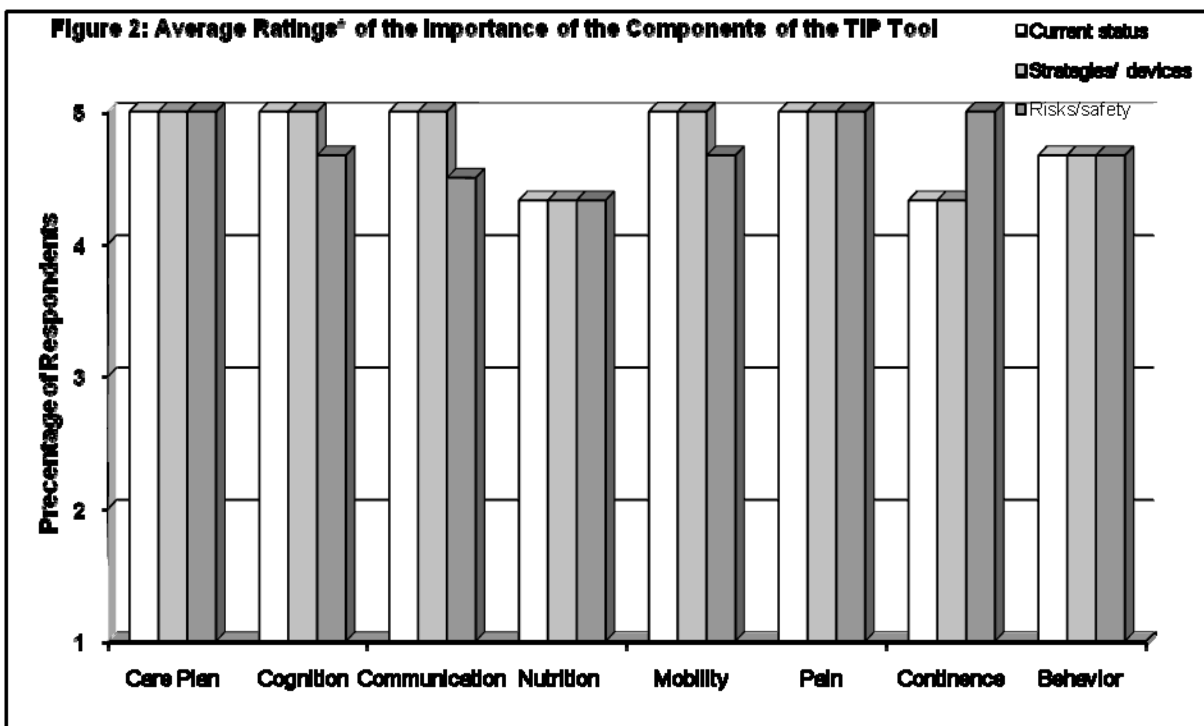
Use of the TIP Tool in the Admission Process

As described by the interview participants, the TIP tool is usually used directly by the staff member (usually a registered nurse or resident care coordinator) completing the admission, physiotherapists, and dietary staff, who then create a care plan that front line staff (PSWs, RPNs, Nursing Assistants) use to guide their work with residents. An admission assessment, assessing cognitive function, mobility, activities of daily living, medications, and self care is conducted with the aim of determining how much residents are able to do independently and how much assistance they require. This assessment is used to develop the care plan as

specified by the Ministry of Health and Long-Term Care and to verify the information that has been provided by the discharging facility. Those involved in completing admissions noted that they use a number of sources of information to develop the care plan and to verify the information they have received, including hospital discharge summaries/ notes, CCAC notes/ assessments, the resident assessment, and information obtained from family members. PSWs and Nursing Assistants working directly with residents learn information about the new resident either verbally from the staff member who completed the admission, but primarily as conveyed via a communication book in which the resident's care needs are summarized. This information is based on the information that was available at the time of admission.

3.3 OBJECTIVE 2: Describe the usefulness of the TIP tool in LTC homes that accepted residents transferred from the Stroke Rehabilitation Program, Parkwood Hospital in the past year and during the evaluation phase.

The results of the survey of completed by individuals familiar with the TIP tool are presented in Appendix E. This survey was completed by three individuals who had used the TIP tool, the majority of whom reported infrequent use of the tool (67%; "with hardly any residents with stroke"). Despite their infrequent use of the tool, they all rated the usefulness of the TIP tool to their immediate care of residents with stroke as *"extremely useful"* (rating of 5 on a 1 – 5 scale where 1 = not at all useful, 5 = extremely useful). Similarly, all of the components/ sections (various topic areas with information on current status, care strategies/ devices, and risks and safety) of the TIP tool were rated as *"very"* or *"extremely important"* to their immediate care of residents with stroke (ratings of 4 and 5 on a 1 – 5 scale where 1 = not at all important, 5 = extremely important; See Figure 2). Although still high, average ratings were lowest for nutrition (average = 1.33; +/- 1.2). Overall, survey respondents rated the TIP tool as *"very good"* and *"excellent"* in terms of how it helps them to care for residents with stroke.



* 5-point scale: 1 not at all important, 5 = extremely important

Table 3 summarizes the ways in which the TIP tool is useful. Interview participants familiar with the TIP tool noted that although they will sometimes get detailed discharge summaries from hospitals (not specifically Parkwood Hospital), it is very difficult for staff to follow narrative reports. In contrast to detailed narrative reports, the TIP tool is easier for staff to follow, clear, and concise.

> *"This* [the TIP tool] *hi-lites the information quickly for you and you can zero in on certain areas, you can quickly see them if you need to.*" [ID1/2; DOC; Health Informatics Manager]

Table 3: Summary of the Ways in Which the TIP Tool is Useful

Comments regarding the usefulness of the TIP Tool:

- Easier to follow and find specific information than narrative discharge reports
- Contains more detailed information about care than other sources of information
- Provides social history not otherwise provided
- Mirrors terminology used in care plans
- Relevant for all disciplines (nursing, dietary, physiotherapy)
- Facilitates seamless transition / continuity of care from acute care
- Clearly identifies goals established in rehabilitation so they can be continued
- Provides the most up-to-date source of information about the resident
- Provides contact person who can provide further information if needed
- Can be used as baseline data to measure change

Moreover, the TIP tool was described as facilitating care planning across all disciplines (nurses, dietary, physiotherapy) because it mirrors the terminology used in the care plan. The information provided in the tool facilitates a seamless and smoother transition / continuity of care from acute care as an accurate care plan is immediately in place consistent with the care provided in the transferring facility, with the equipment and supplies used by the resident, as reflected in the following comment:

> *"It just can be a much more seamless transition; they can get the same care that they got yesterday in the rehab facility, as in our long term care facility, within the day… I think a really important thing that allows a seamless transition is that the TIP tool has the goals, so what is nice about it is Parkwood had established goals and if those goals had not been met then the person could come here and we could continue to work on those goals instead of us starting anew and maybe working on totally different goals, and you know the things that they've been working have been lost."* [ID1/2; DOC; Health Informatics Manager

This has the effect of reducing the emotional distress of residents and their families, at a time that is typically very stressful.

> *It makes the transition from one place to another not nearly as stressful and doesn't take nearly as long to feel like people they're at home. That must be a scary thing, you come from one to a second place and these people don't know you.…*

Yes, because I think it's really, really important for them if we knew what their physio plan is. They will notice that right away it continues on instead of waiting for an assessment and they stress physio after a stroke and they're thinking I have to do this in order to keep what I have. It just shows them that that's what happens, that we know what to do…

And it's pretty chaotic, an admission can be really stressful and there's a lot of things happening. So if they showed up and the wheelchair is waiting for them and there's a grab bar in the bathroom, whatever, then it's actually better for them…" [ID1/2I DOC; Health Informatics Manager]

It was noted that the TIP tool provides the most up-to-date information regarding the resident. Although the CCAC provides the MDS-HC assessment, that information was mostly collected at the time that the resident applied for a long-term placement and is often out-dated given gains made in rehabilitation. The CCAC updates this MDS-HC assessment prior to the placement, but it was noted that the up-date is not detailed and does not consist of the same level of detail as the TIP tool. As an example, it was noted that the update may simply state that the resident had participated in a rehabilitation program resulting in functional gains, but the details of these gains will not necessarily be specified.

In terms of understanding changes in a resident's status, it was noted that the TIP tool can be used as baseline data upon which to measure changes; decline and improvements are clearly evident. The TIP tool also provides information on the residents' social history, which was noted to be of benefit in understanding behaviors. This information is not usually provided in discharge summaries. The level of detail provided in the TIP tool saves LTC home staff time, as they do not need to reassess the resident in order to provide immediate care, as illustrated in the following comment:

"There was some instructions about like the foam handles on, on utensils you know, like very little things but it would have taken, it would have taken us a while to get there in this, in to assess them that way ourselves, for sure." [ID1/2]

One of the key benefits of the TIP tool is that it provides the name and telephone number of a key contact person should LTC home staff have any questions about the resident or care planning.

"I think another really important thing is the contact information at the facility that they come from, that they came from. If you don't have that and you have your physio has a question then they can call. If not and you're calling London, or LHSC, there's a whole bunch of names and you're trying to find one person. Sometimes that's just daunting to even try to call. If you have a number and a name and an extension, it's an easy 5 minute thing." [ID1/2]

Comparison with MDS-RAI tool: Many of those interviewed for this evaluation were not familiar enough with the MDS-RAI tool to comment on potential duplication with the TIP tool. This was particularly true of PSWs and nursing assistants who would normally not have access to the MDS-RAI, Those familiar with the MDS-RAI indicated that duplication of information was not an issue. It was noted that although the MDS-RAI provides similar information, the TIP tool

provides a greater level of detail that is needed for care planning and provision of care, as illustrated in the following comment:

> *"It's an addition and it's more specific, so the MDS might say do they use aids for transferring, and there's five different ones on the list and you just check the box. Where this* [the TIP tool] *actually says what they need and how they use it. So it's a little bit more. It's important to know yes they need aids. But it's really important to know exactly what and how they use it, so there's lots more information in here* [TIP tool]*."* [ID1/2]

Perceptions of the tool by those not previously aware of it

Overall, those interview participants who were not previously aware of the TIP tool were impressed with it and predicted that it would be of great value at the time of admission. Identified potential/ anticipated benefits are summarized in Table 4.

Table 4: Potential/ Anticipated Benefits Associated with the TIP Tool as Identified by Those Not Previously Aware of It

It was predicted that the TIP tool would: • Facilitate seamless transition and reduces resident distress at time of admission • Be easy to read and use, and time efficient • Increase family confidence with the care provided in LTC • Facilitate communication among all staff • Facilitate communication between the hospital and LTC ***Potential challenge with the TIP Tool:*** Too complicated for PSWs or Nursing Assistants, many of whom have low literacy levels or English is their second language.

- ***Facilitate seamless transition,*** which would reduce resident distress associated with a change in environment.

  > *"It* [TIP tool] *would be very helpful because it makes the transition easier for you as the patient, easier for me as the care giver. Easier if I know that you like to be approached from the right or you're going to punch me because you don't have vision after your stroke or there's something wrong with your hearing. Let me know these things, A) I don't need to have a punch in the head, and B) the resident doesn't want to do that, they don't like to be scared or, or startled."* [ID20; RN]

- ***Easy to read and use:*** Many of those interviewed commented that with time constraints they do not have a lot of time to go searching through the medical chart for a specific piece of information. The TIP tool provides detailed information that is easy and quick to access.

  > *"Activities of daily living is taking up a lot of their* [resident's] *care time and the problem with paper work is that you have to find the time to go through it all and the time cuts right into their care and they're the ones that suffer. I realize that people*

need information but they're the ones left out because I have to go searching for information." [ID13; Nursing Assistant]

- ***Time efficient:*** Access to the TIP tool would save LTC staff time in having to reassess or find out needed but unavailable information. It would also save the family from having to provide/ repeat information.

  "Well it would certainly save us from re-inventing the wheel, because we sometimes have to figure out all this on our own." [ID10/11/12; ADOC; RPN]

- ***Increase family confidence with the care provided in LTC:*** Families are reassured of the home's ability to care for their loved one when there is continuity of care and when LTC has all the needed information to provide immediate care to their loved one.

  "I think that families would feel better about what we can do here when they see that we have all the information, that we know all about their loved one. When we ask a lot of questions I wonder if they think we don't know what we're doing." [ID16; PSW]

- ***Facilitate communication among all staff:*** The TIP tool could be included in existing communication methods (e.g., communication/ shift binders) in order to share information among all staff members.

  "It would be amazing and a very nice communication tool to leave right in the shift report binder, so that all three shifts coming on right away can have a full update." [ID10/11/12; ADOC; RPN]

- ***Facilitate communication between the hospital and LTC:*** The availability of information for a contact person is efficient and works to facilitate communication between the facilities.

  "A contact name, that's huge! Because if you want to find out something about a new resident, you just call the hospital and you work your way to this pyramid of hierarchy… It can take such a long time to finally get someone, to get the right person who actually knows something." [ID10/11/12; ADOC; RPN]

Potential challenges with the TIP Tool: Several PSWs noted that while the TIP tool may provide more detailed information than would be otherwise available, it provides too much information for PSWs or Nursing Assistants, many of whom have low literacy levels or English is their second language. It was suggested that key information directly relevant for these frontline staff members should be summarized into the communication book for it to be meaningful and accessible, or as discussed later (section on suggestions for improvement), included in a form specifically related to personal care.

Current challenges with information sharing at the time of admission

Interview participants identified a number of challenges related to information sharing at the time that a resident with stroke is admitted to LTC, primarily related to limited information provided by the discharging facility and limited information available to PSWs and Nursing Assistants regarding the provision of personal care. The following challenges were identified:

- ***Limited information provided by discharging facility:*** It was noted that, generally LTC homes will receive highlights of key information but details will be lacking, the exception being information from Parkwood Hospital, which quite detailed. For example, discharge notes may note that a resident has hemiplegia, but fail to mention on which side, or may note that the resident is incontinent but fail to note the whether this is bladder, bowel, or both, to what extent, what products are being used, and what, if any, strategies have been used to facilitate re-training.

  Discharge summaries were described as sometimes not providing an accurate "picture" of the residents' ability; descriptions can be unclear or inconsistent with what is observed at the time of admission. It was noted that this occurs frequently when subjective rather than standardized assessments are used, particularly as related to describing the severity of a particular problem (e.g., wounds, obesity). Care plans are developed by filling in the gaps in information from various sources (discharge notes, residents, family members). Generally, the usefulness of existing discharge summaries were described as variable, as reflected in the following comments:

  > *"Sometimes its trial and error….It's not always that everything we get is 100% accurate. We do have to kind of figure some of it out ourselves as we go along."* [ID21; Resident Care Coordinator]
  >
  > *"And are the discharge summaries helpful? Sometimes yes, and sometimes no, it just depends who does them. The forms that we get, there's pages and pages and pages and sometimes you get from the hospital a discharge summary with meds and if there's any treatments. But it doesn't really give you an accurate sense of their mobility, an independent picture of the person who you think you're getting and the person that you actually get. You're like, 'Well that's not what this says.' So that's very different sometimes."* [ID10/11/12; ADOC; RPN]
  >
  > *"We see this with wounds… its various subjective data in the information that you get and you're thinking well if it's not that bad, then they get here and it's like whoa! And then you're running around trying to find a mattress for them."* [ID 5; Clinical Coordinator]
  >
  > *"The hospital ones [Discharge summary], theirs is crappy. I think it's never complete enough. It won't be current and it doesn't match what we see, or there's something wrong with the meds…. A lot of things I'm finding we're getting a pop to the head before we figure out that there's a safety issue or an aggression…. There are things like, really obscure stupid stuff that we sit and scratch our heads about. Like BMs, for example. You know, they have their 3 day laxative well if you haven't had a BM on the 3rd day, you're going to get a laxative, and it'll say 'BM x 2.' What do you mean? Today? Last month? In the last hour? What?"* [ID20; RN]

- ***Lack of immediate/ timely access to important information:*** It was noted that sometimes there is a lag in transfer of information to front line staff because the resident requires care while the admission process is being completed. For example, as illustrated in the following comment, a resident was given an inappropriate snack because frontline had not yet been informed of the resident's swallowing abilities:

"Once the patient/resident is admitted their pertinent needs are put in the communication book, but sometimes there is that lag in communication sometimes when the nursing staff is so inundated with the admission process. I guess the most pertinent thing with stroke patients is their swallowing abilities. I know one time where somebody was on a honey thickened fluid and when we gave out snacks and stuff, we didn't have that information on the book so you just give them a straw and thin fluid. Meanwhile, you know after the fact, it's like 'Oh no, they're supposed to be on thickened fluids.' So you don't want to get into that, giving them the wrong stuff and them getting pneumonia or something." [ID16; PSW]

- ***Lack of information specifically relevant for personal care:*** PSWs and Nursing Assistants, in particular, commented on the need for information to guide their interactions with the residents, such as life/ social history, disease process/ prognosis in terms of helping them to understand what expectations they should have for the resident and what they should realistically be encouraging residents to do independently. As an example, one interview participant noted that while they may need to assist residents to dress, with support, encouragement and training, some residents are able to partially dress themselves independently. However, there was concern about doing this if the resident does not have the potential for these kinds of improvements.

It was noted by several participants that information provided in the communication book does not always meet the needs of frontline staff to provide personal care.

"We're hands on with them [residents] e*very day. We're doing their care and their feeding and everything like that. Sometimes the stuff in the communication book is nice to know, but it's not the hands on stuff that you need to know."* [ID19; PSW]

PSWs and Nursing Assistants reported that although the resident's chart is available to them should they have questions, they rarely access the chart because of time constraints, the belief that what they need to know will not be available in the chart, and perceptions that the charts are too complicated to read through.

Most PSWs and Nursing Assistants reported that if they have questions about how to care for a new resident with stroke they will either ask the admitting nurse, nurse in charge, other staff members, the resident or a family member.

"It's mostly through other workers, that's how you would actually find out. So other people would be like 'Oh, you know, he's like this, or he needs this, or he likes it this way, because everybody has their own way of what they like." [ID19; PSW]

It was noted that given the busy nature of work in LTC, accessing nurses for additional information is not always easy.

"The nurses have enough on their plate as far as the meds go and sometimes I feel like we're the eyes and the ears of these people. And to go to a nurse and say 'his behaviour's like this or whatever, is there anything you can do?' It's almost that sometimes you're bothering them because they're so focused on different things." [ID19; PSW]

Interview participants identified the information as what they would ideally like to know at the time that a new resident with stroke with admitted to their home, but that are currently not readily or consistently available. These are summarized in Table 5.

Table 5: Information Useful to Frontline Staff But Not Always Available at the Time of Admission

Useful Information Not Always Available:

- Use of special equipment/ preferences
- Goals and anticipated potential for improvement.
- Strategies, both successful and unsuccessful (including memory aids, visual or verbal cues)
- Potential for aggressive behaviour; triggers and strategies used to prevent aggressive behaviour
- Dietary needs (diet and texture of foods).
- Ability to bear weight
- Side of hemiplegia
- Type of transfer (one or two person)
- Life / social history, including employment history, hobbies, significant life and family events.
- Preferences ("like and dislikes") particularly for those residents who are unable to speak
- Reasons for contact precautions and anticipated duration
- Pain issues and pain management
- Follow-up appointments (with whom, when, where and for what purpose)

- Use of special equipment: special utensils for eating, preferences (e.g., two handled cup or straw). It was noted by one participant that Parkwood Hospital will call prior to an admission to ensure that the appropriate equipment is available however, no other hospitals do this.

- Goals and anticipated potential for improvement.

  "All they're [hospital staff] *telling you is where they* [residents] *are right now, and what you should be doing right this second. It* [discharge summary] *doesn't tell you what they've done, what they were working towards. 'This is what we've done, this was our long term goal, this is where we're at right now. We don't know what the progression is. That's the hardest part. A lot of times you don't know what they were working towards. Is our goal to get this person doing this? Or are they as far as they're going to go?"* [ID 21; Resident Care Coordinator]

- Strategies, both successful and unsuccessful, including memory aids, visual or verbal cues that are used

  "I think it would be nice to know if they've been through a process, what it is they've done, what they've tried and what hasn't worked, so we don't try it again." [ID21; Resident Care Coordinator]

- Behaviors; potential for aggressive behaviour and strategies used to prevent aggressive behaviour.

> *"Let me know that someone that may have vision issues: 'don't approach from the right side, it frightens them and then they tend to strike out.' Well thanks, that saves me from getting punched and it saves the resident being upset. … and techniques: 'Remove to a quiet area, reapproach in 10 minutes'… If you already know at Parkwood that Bob hates loud noises and maybe he always did, he was a person who was always bothered by that and now that he's had a stroke, he's going to start swinging or yelling. He just panics. Let me know that please, rather than let me find out. Not that I don't mind to find out, but why should Bob have to go through that."* [ID20;RN]

- Dietary needs (diet and texture of foods).

> *"Dysphagia, knowing that. Where are they at with their dysphagia? If they've had swallowing yet, what consistency are they at? If they're nectar, honey, pudding. What is it? If they're on texture modified foods, we need to know what they are. Can they assist themselves? What side the stroke is on? Do they need a built up plate? Do they need nosey cups? All of those things that would be beneficial to help us, but we don't always get that information."* [ID23; Dietary Manager]

- Ability to bear weight
- Side of hemiplegia
- Type of transfer (one or two person)

> *"Now with some things, some of its going to be stuff that's been established already with their stay there, they restart from scratch, I'm just looking here at mobility and transfers, for instance we have a very strict no lift policy so it would be a very good starting point for us to be able to see what they're doing with the individual before, but the fact of the matter is that if they're not able to weight bear here then they're obviously going to become a mechanical lift, however, because you would still be involved in assessing, working towards making them more independent if there's potential, so the information is great, I mean we would know right from the get go what they, what they need."* [ID10/11/12; ADOC; RPN]

- Life / social history, including employment history, hobbies, significant life and family events.
- Preferences ("like and dislikes") particularly for those residents who are unable to speak.

> *"Tell us what to do to make their life easier. It's all about the resident, right? … It would be the same with anyone. What's the point in trying to feed me liver when I hate liver? Then I don't eat and you write down that I'm possibly depressed or uncooperative. I just can't stand liver. I don't care if I've had a stroke or not, I'm not eating it, right? … But a little something right out of the gate that would be helpful. 'Afraid of the dark, likes to have the bathroom light left on.' You were a married lady, with 9 children so you had a busy home, and you don't like to be in a room with the lights out, quiet. You didn't have that in your whole life and you like the company. Just a little something. And what gets you going, what upsets you, what you enjoy,*

what we can do to calm you down, what we can do to comfort you. That's what we need to know." [ID20; RN]

- Reasons for contact precautions and anticipated duration

  "Sometimes when they [residents] c*ome with MRSA or something like that, we don't know what degree it is or, or where. It'll* [discharge note] *just say contact precautions, but sometimes they don't really tell us what they have or how long it would last. We sometimes have it for months at a time, they may not be MRSA for months at a time, but nobody tells us when the period is over."* [ID17/18; NA, PSW}

- Pain issues and pain management

  "Very seldom do we get anything on pain other than a little 'x', so it's awesome that it's in the TIP tool." [ID10/11/12]

- Follow-up appointments: It was noted that sometimes a discharge summary may state that a "follow-up" is needed, but it will not be clear whether this has been scheduled, who this should be scheduled with, when, where, and for what purpose.

3.4 OBJECTIVE 3: Identify opportunities/ suggestions for improving communication between Parkwood Hospital and LTC homes.

3.4.1 Suggestions for Improvements to the TIP Tool and Process of using the tool

The following suggestions for improving the TIP tool were identified by interview participants, both those familiar, and those not previously familiar with the tool. These suggestions are summarized in Table 6.

Table 6: Suggestions for Improving the TIP Tool and Process of Using the Tool

Suggestions for improvements:

- Deliver TIP tool to LTC homes prior to the admission day so homes can prepare for the admission
- Signal the presence of the TIP tool among the admission materials with a note or sticker in a prominent position (e.g., "See TIP tool for detailed information."
- Provide a version of the TIP tool specifically focused on personal care
- Include more information on dietary needs using terminology used in LTC
- Expand use of the TIP tool across sectors
- Promote use/ increase awareness of the TIP tool
- Create an electronic version
- Enhance the visual appearance of the tool by using a larger font size and coloured paper.

- ***Deliver TIP tool to LTC homes prior to the admission day:*** Earlier access to the TIP tool information would assist LTC homes to prepare for the admission in advance to

make sure that they have the information and necessary equipment in place to ensure a seamless transition.

> *"I think it would be really nice if you got it* [TIP tool] *the day before. If we know where the patients are coming from we'll get a really current list of meds like the day before so we can prepare. But the TIP tool would I think provide you with a lot of good information. Do they have their own wheelchair? Do they need a wheelchair? What do they need? So instead of the person coming and its half an hour till lunch time and you find out they need special utensils. If you know the day before you have a chance to go to your people and have things in place."* [ID1/2; DOC; Health Informatics Manager]

- ***Signal the presence of the TIP tool among the admission materials:*** As some homes were not aware to look for the tool, it was suggested that a note/ sticker be placed on the discharge summary or somewhere prominent reminding LTC staff to look at the TIP tool. For example: "Please refer to the TIP tool for detailed information."

- ***Provide a version of the TIP tool specifically focused on personal care:*** It was suggested that a brief, one page version of the TIP tool should be created specifically tailored to the needs of PSWs/ Nursing Assistants. This version would focus on pertinent information that is immediately needed to provide personal care. It was noted that many PSWs/ Nursing Assessment have low literacy levels or English may be their second language so they need the information supplied to them in an extremely easy and clear way.

> *"This one* [TIP tool] *goes for the nurses, it doesn't go for the personal care people. It would be useful to have one just for personal care. This* [TIP tool] *would be too much. If you had just a plain sheet of paper that would tell us what they need. With their symptoms, what they like and dislike and they could throw it in our communication book. 'Likes having naps after breakfast, but not after lunch.'…*
>
> *"Silly things like that are very helpful to us. With one lady we have, the left side of her brain doesn't work even work or anything, so when her food is in front of her you've got to turn it. If this side is empty it's because she doesn't see what's on the left side. I couldn't figure out why she wasn't eating but then I realized she doesn't see it. How many meals did she have where she only ate half of her meal? People probably thought she was just not hungry. So we need to know this: 'Left side doesn't work, turn plate at meal time. Prefers naps in the afternoon.' The more information we can have about them the easier it is for them and the easier it is for us."* [ID17/18; NA, PSW]

- ***Include more information on dietary needs using terminology used in LTC:*** It was noted that there is currently limited information on diet and texture in the TIP tool, with more information required about the specific type of texture required. In addition, information currently provided to LTC homes is inconsistent with the language used in LTC to describe texture, resulting in confusion about what is needed.

> *"The only thing that I question is the section on the diet…It doesn't have diet and texture. Diet is easy because there's only a limited amount: regular, diabetic. But when it comes to texture, I sometimes find that I'm getting clients that are coming in*

and they are 'soft.' Well what's soft? Does that mean meat? The terminology needs to focus on what the terminology the long term care are using… Texture wise it would be regular, minced meat, mince puree, or thickened puree. So that's what we use in-house. And then diets would be just like your regular diet, your diabetic diet, your renal diet, or if they're lactose intolerant, if they're vegetarian, you know, those kinds of things." [ID23; Dietary Manager]

- ***Expand use of the TIP tool across sectors:*** Several individuals suggested that the TIP tool be used across all health sectors o improve continuity of care. The tool could be used not only to facilitate discharges from hospital (acute care, rehabilitation) to LTC, but also discharges from LTC to acute care or other facilities and between LTC homes and with the community sector.

- ***Promote use/ increase awareness of the TIP tool**:* Given the limited staff awareness of the TIP tool, it was suggested that there be activities/ strategies to increase awareness of and promote the use of the TIP tool, so that all hospitals are using it so that staff know to look for it. Suggested strategies included:

    - Inservice/ education sessions on the tool in both hospitals and LTC.
    - Posters, handouts
    - Regular newsletter related to stroke care – tips for care, case examples illustrating how the TIP tool has been used effectively.

- ***Create an electronic version*** of the TIP tool to facilitate ease of completion for hospitals and to facilitate use within LTC when resident are transferred to hospital or other facilities. With the advent of electronic medical records, it was suggested that the TIP tool be incorporated into the electronic medical record.

- ***Enhance the visual appearance of the tool:*** It was suggested that a larger print (font) size and use of coloured paper (so it stands out and people can readily identify it) would improve the visual appearance of the TIP tool form to promote its use:

3.4.2 Suggestions for improving communication/ information sharing between acute care and LTC

Interview participants identified a number of strategies for improving communication and information sharing between acute and LTC care, namely related to the effective use of existing technology (e.g., videoconferencing, e-mail), regular opportunities for cross sector interaction, increasing acute care awareness of the realities of LTC, and development of effective mechanisms for communication.

- ***Use technology more effectively:*** It was noted that existing technology could be used more effectively as a vehicle for sharing information at the time of admission, such as the use of videoconferencing and internet based vehicles to facilitate pre-admission case conferencing/ information sharing. Similarly, it was noted that e-mail is a more efficient (quick and easy) way for frontline workers in acute care and LTC to communicate as they often unavailable by telephone. E-mail reduces time wasted playing *"telephone tag"*.

- ***Provide regular opportunities for interaction:*** It was noted that communication problems with acute care are long-standing and pervasive, and not limited to the admission of residents with stroke. It was suggested that here be opportunities for relationship building between acute care and LTC and opportunities to share perspectives and problem-solve common issues (e.g., meetings, shared continuing education opportunities, both formal and informal).

  "In my ideal world we would all have, we would be meeting probably at least quarterly if not more, acute care and long term care and discuss this kind of stuff [challenges].*We all sit in our little bubbles and try to figure out the world. I think sometimes that if we just sat down for five minutes with each other it would be like 'well, why don't we do it this way' or 'why can't we do this?' and some good suggestions could come out of it....It's definitely a forum and if concerns came up with something directly with the hospital, if they had concerns about then they could be addressed rather than us just kind of under our breath mutter about acute care and you mutter under your breath about long term care, so there is a place that you could start doing something about it…. We're all pretty bright people, I'm sure we could figure it out."* [ID5; Clinical Coordinator]

- ***Increase awareness of acute care staff of the realities of LTC:*** It was noted that there are many misconceptions about LTC, particularly that LTC is more/ better resourced than it actually is.

  "They have no idea about what we're about in our limited resources and the questions I'm always getting: 'well do they need their own wheelchair? Well they can't walk, yes they do! They think we have this sort of trunk full of equipment and things like that. We don't have that. And then vice versa, we don't understand what sometimes what they need from us, so it works both ways and I know we've met at the table with the Emerg girls going 'Oh wow, I didn't know that, they have one RN for 60 people, no wonder why when I want to talk to the RN, well there's one for 60, you're chances of getting her are pretty limited." [ID10/11/12; ADOC; RPN]

- ***Create a mechanism for information sharing between acute care and LTC:*** In cases where LTC residents with stroke are admitted to acute care for short lengths of stay, it is difficult to access information on the resident's status, with some hospital staff members citing the Privacy Act; they will not provide information to non-family members.

  "If they were to have a stroke and go in [to hospital], and they were coming back to us, a lot of times getting that information from them is very difficult and a lot of it they put down to the privacy act. If we call to try to get updates, it's very difficult to get information because we're not a family member. And even though we will be the person providing care again, until that moment when they come back, and sometimes you get a phone call that says, they're on their way now, this is what they have, this is what you're going to need, and you're scrambling then." [ID21; Resident Care Coordinator]

Suggestions for improving care for residents with stroke

Interview participants identified a number of suggestions for generally improving care for residents with stroke, namely related to improving the admission process, increasing access to rehabilitation and speech and language, and reducing ageism.

- ***Ensure that transfers from acute care occur early in the day:*** It was noted that new admissions are very time consuming and often require contact with physicians for medication orders, consultation with hospital staff when discharge summaries are not clear, and ensuring all the appropriate equipment is in place. Admissions later in day limit the amount of time available to do this, with the resident bearing the consequences when care plans or equipment is not adequately prepared.

- ***Appoint specific individuals that act as the liaison between acute care and LTC –*** they are contacted with questions/ concerns

- ***Improve access to rehabilitation for LTC residents:*** It was noted that few residents access rehabilitation although it could potentially improve their functional status and quality of life.

  "I think that, for the most part, most of our, because I think we have like a geriatric population, most of our strokes, like a high percentage do not get re, rehab or have opportunities for good rehab after their stroke, and a few that we've gotten from Parkwood you can really tell, when we've actually had one lady we sent back to Parkwood after she was here for a bit, she did more physio and came back and then we actually discharged her home, which is like, that's like really." [ID1/2; DOC; Health Informatics Manager]

- ***Improve timeliness of access to speech and language therapy:*** It was noted that although speech and language therapy is available through the CCAC (contracted services), it is generally limited and takes a long time before it initiated. With this is delay is the increased risk of decline in gains made while in rehabilitation.

  "I mean, and I don't even know, with the recent admission they have it just that she has to wait for so long to get some speech therapy…But I'm trying to think, I think she had her stroke the end of last year, she just recently came to us, and yea, now we're waiting and it's a shame because you'd like her to keep going so that she doesn't fall back at all or lose anything, but I don't know, that's something you guys can change and that's kind of, you know, people have to wait, unfortunately, it's not the way we'd like it." [ID5; Clinical Coordinator]

- ***Improve use of existing technologies:*** It was noted that many technological strategies available for enhancing communication for children or younger adults with communication impairments, such as computerized devices, symbol boards, are not used with older adults, but could significantly improve their quality of life.

- ***Reduce ageism in acute care settings:*** It was suggested that LTC residents are not considered a priority for additional services/ rehabilitation because of ageism.

“Sometimes I think it’s because we’re in a different spot here, like maybe when you’re in the acute care setting, our population are the most elderly and sometimes they have behavioural issues and things, so maybe they’re not the priority in that setting and then they come to us and we’re used to kind of dealing with that population and that’s how everybody is, they’re not higher functioning, so maybe we have higher expectations and push them a little bit more because we often do get, I honestly think in physio or OT notes and that, a lot of the people who come to us, this doesn’t sound very good for lack of phrasing it better, they’ve kind of been written off and in the other.” [ID1/2; DOC; Health Informatics Manager]

Conclusions

Based on the results of this evaluation, the following conclusions can be made:

- There has been limited use of the TIP tool as prepared by Parkwood Hospital staff for patients with stroke being discharged to long-term care.

- For those not previously familiar with the TIP tool, there is much interest in having an opportunity to use tool as a vehicle for ensuring seamless transition to long-term care and facilitating continuity of care. Those who have used the tool have found it to be extremely useful.

- Although there are other sources of information available at the time of admission such as MDS-HC and hospital discharge summaries, there was general consensus that this information (in general and not specific to Parkwood Hospital) is usually inadequate for developing immediate care plans for residents with stroke. Information from the MDS-HC was described as often outdated, with updates being inconsequential, and discharge summaries were described as limited and lacking important details. There were no concerns that the TIP tool is a duplication of the MDS-RAI as the TIP tool provides a greater level of detail that is useful for care planning and provision of care.

- Identified challenges associated with information sharing at the time of admission to long-term care from acute care are not new. Many of these challenges are those that motivated the development of the TIP tool. In fact, the TIP tool contains much of the information that interview participants reported they would like to have at the time of admission, but typically is not readily or consistently available.

- Although the TIP tool was initially intended for use by PSWs and other frontline staff, in reality it used most by registered level staff (registered nurses, registered practical nurses), who then summarize in the information in a separate communication to frontline staff. Concerns were expressed that the current format of the TIP tool may not be accessible for frontline workers who have lower literacy levels or for whom English is a second language. Options for sharing information with this group of frontline workers should be explored further.

- Although many promotional strategies were implemented at the time that the tool was first launched, given the high turnover rate of staff in long-term care, it may helpful to promote and market the tool on an ongoing basis. Given that Parkwood hospital was noted to be the only Hospital still using the tool, it may be beneficial to promote and market the tool in other acute care and rehabilitation settings. However, it would be useful to first explore the factors that prevent or hinder other settings from using the TIP tool. Resolving identified barriers to use of the tool may increase its use. As well, given the time commitment required of hospital staff to complete the TIP tool, it may helpful to identify incentives associated with using the tool so these incentives could be promoted.

- Existing vehicles/ opportunities for information sharing within the long-term care sector may act as mechanisms for promoting the TIP tool. Suggestions of developing a regular newsletter as an opportunity to promote the TIP tool and to provide information related to stroke care (strategies/'tips') highlights the desire of long-term care staff to improve care for residents with stroke.

- Interview participants identified a number of suggestions for improving communication/ information sharing between acute care (in general, not specific to Parkwood Hospital) and long-term care and for improving care for residents with stroke. Again, many of problems at which these suggestions are targeted are not new and are well documented in the literature.[3] Although many of these challenges are beyond the scope of what the TIP tool can do, the TIP tool nonetheless has an important role to play in closing some of the existing stroke care gaps.

Limitations: There are several limitations associated with this evaluation. Although few individuals in this evaluation had used the TIP tool, it is not known if this is representative of all homes in the region; the sample size of this study represents a very small proportion of LTC homes in the region/ province. While not known for certain, it is suspected that few discharging facilities, other than Parkwood Hospital, are providing long-term care homes with completed TIP tools. As many of those interviewed had no experience with the TIP tool, many of the comments made about the TIP tool were regarding 'anticipated' benefits and not based on actual experience. Similarly, many of the comments made regarding information sharing and communication were related to their broad experience with hospitals and not to specifically regarding Parkwood Hospital. Limited opportunities to conduct prospective interviews and the fact that some homes did not get the TIP tool with new admissions from Parkwood Hospital prevented the evaluation from including more information specific to the use of the tool with newly admitted residents. Future evaluation studies should consider methodologies/ procedures that engage potential participants immediately prior to the admission to long-term care to ensure that the tool is used and opportunities for evaluation are not lost.

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[3] Reed, R.L., Gerety, M.B., Winograd, C.H. (1990). Expanded access to rehabilitation services for older people. An urgent need. *Journal of the American Geriatrics Society,* 38, 1055-1056.
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Appendix B Guide for the Interviews with Key Stakeholders (Retrospective)

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Appendix A

The TIP Tool

TRANSITION INFORMATION PLAN (TIP)
STROKE TRANSFER TO LONG-TERM CARE

CURRENT DATE: ______________________ (YEAR / MONTH / DAY)

TRANSFER FROM: ______________________ (NAME OF FACILITY)

TO: ______________________ (NAME OF FACILITY)

DATE OF TRANSFER: ______________________ (YEAR / MONTH / DAY)

ADDRESSOGRAPH

KEY CONTACT PERSON(S) AT THE TRANSFERRING FACILITY:

Name: ____________ Discipline: ____________ Telephone: ____________

Name: ____________ Discipline: ____________ Telephone: ____________

A. MEDICAL CARE PLAN AND SECONDARY STROKE PREVENTION:

MDS-HC Section K; Health Conditions and Preventive Health Measures (Current Status)

Tips and Tools for Everyday Living, Page 67 (Care Strategies)

CURRENT STATUS	CARE STATEGIES AND RECOMMENDATIONS
Type of stroke: ☐ Ischemic ☐ Hemorrhagic	**Strategies for Secondary Prevention:** ☐ Stroke prevention medications being taken
Side of brain affected by stroke: ☐ R ☐ L ☐ Both	☐ Heart healthy nutrition
	☐ Activity program
Area of brain affected by stroke:	☐ Smoking cessation
☐ Frontal lobe ☐ Temporal lobe ☐ Parietal lobe	☐ Provide education
☐ Occipital lobe ☐ Brain stem ☐ Cerebellum	☐ Education initiated (specify):
	Other Strategies (specify):

RISKS AND SAFETY

Stroke Complications to Date

☐ Recurrent stroke ☐ Deep vein thrombosis ☐ Pulmonary embolism ☐ Myocardial infarction ☐ Other (specify):

Risk Factors for Further Events

☐ Hypertension ☐ Atrial fibrillation ☐ Diet ☐ Obesity ☐ Smoking ☐ Physical inactivity ☐ Hyperlipidemia ☐ Other (specify):

Signature: ____________ Printed Name: ____________ Status: ______ Date: ____________ (YEAR / MONTH / DAY) Time: ______

B. COGNITION/PERCEPTION: ☐ **Within Normal Limits**

MDS-HC Section B: Cognitive Patterns (Current Status) ***Tips and Tools for Everyday Living, Pages 43-51 (Care Strategies)***

CURRENT STATUS	CARE STRATEGIES AND RECOMMENDATIONS
☐ **Memory impairment**	**Strategies:**
☐ Pre-stroke ☐ Post-stroke ☐ Short term ☐ Long term	☐ Provide short, direct and simple instructions
Post Stroke Condition:	☐ Provide information one step at a time
☐ **Impaired orientation to:**	☐ Make direct eye contact
☐ Time ☐ Person ☐ Place	☐ Use memory aids
☐ Day ☐ Night ☐ Day and Night	☐ Maintain consistent routine/environment
☐ **Impaired insight and judgement**	☐ Provide supervision
☐ **Perseveration**	☐ Acknowledge perception but present reality
☐ **Impaired abstract thinking skills**	☐ Arrange stimulating environment on affected side
☐ **Impaired ability to understand and follow directions**	☐ Use visual, and verbal cues
☐ **Impulsivity** ☐ **Impaired ability to sequence**	☐ Position affected limb so in survivor's view
☐ **Neglect:** ☐ Visual ☐ Body ☐ Environmental	☐ Hand over hand guidance to assist initiation
☐ Auditory	☐ Other (specify):
☐ **Impaired initiation**	

Trial 2005 April Page 1 of 6 Transition Information Plan (TIP)

Patient's Name: ______________________ Chart Record Number: ______________________

B. COGNITION/PERCEPTION: ***(continued from page 1)***

CURRENT STATUS	CARE STRATEGIES AND RECOMMENDATIONS
☐ Other (specify):	Strategies Tried and Responses (specify):
	Assistive Devices Used/Recommended (specify):

RISKS AND SAFETY

Risks Associated with Cognitive/Perceptual Impairments (specify):

POTENTIAL FOR IMPROVEMENT AND GOALS

In Cognition (describe):

In Perception (describe):

Signature: ______________ Printed Name: ______________ Status: ______ Date: ______________ Time: ________
YEAR/MONTH/DAY

C. COMMUNICATION:

MDS-HC Section C: Communication/Hearing Patterns (Current Status) ☐ **Within Normal Limits**

Tips and Tools for Everyday Living, Pages 16, 69-74 (Care Stratgies)

CURRENT STATUS	CARE STRATEGIES AND RECOMMENDATIONS
☐ Expressive language deficits (describe):	Strategies:
	☐ Provide one direction at a time
	☐ Use short sentences and pause between each ☐ Speak slowly
	☐ Provide the first sound/syllable person is trying to say
☐ Receptive language deficitis (describe):	☐ Use large print ☐ Verify response
	☐ Other (specify):
☐ Motor speech deficits (describe):	Assistive Devices Used/Recommended (specify):
	☐ Communication board
	☐ Alphabet board ☐ Maps, calendars and schedules
	☐ Communication book ☐ Yes/No cards
☐ Reading/writing deficits (describe):	☐ Other (specify):

RISKS AND SAFETY

Risks Associated with Communication Impairment

☐ Isolation ☐ Frustration ☐ Difficulty expressing needs ☐ Other (specify):

Risks Associated with Vision/Hearing Deficits: ☐ Vision deficits (describe):

☐ Hearing deficits (describe):

POTENTIAL FOR IMPROVEMENT AND GOALS

Describe:

Signature: ______________ Printed Name: ______________ Status: ______ Date: ______________ Time: ________
YEAR/MONTH/DAY

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Patient's Name: ____________________ Chart Record Number: ____________

D. NUTRITION AND FEEDING:

MDS-HC Section L: Nutrition/Hydration Status (Current Status)

Tips and Tools for Everyday Living, Pages 53-58 (Care Strategies)

CURRENT STATUS	CARE STRATEGIES AND RECOMMENDATIONS
Feeding Ability/Method	**Strategies:**
Feeds self: ☐ Yes ☐ No	☐ Present one item at a time ☐ Check for complete swallow
If No: ☐ Supervision ☐ Assistance ☐ Dependent	☐ Cueing regarding neglect
Tube feeding: ☐ Yes ☐ No Describe:	☐ Set up required
	☐ Positioned upright with aligned head and body
	☐ Avoid lying down immediately after eating
Time required for feeding:	☐ Special attention to oral hygiene
	☐ Other (specify):
Diet	
☐ Current diet and texture (describe):	**Assistive Devices Used/Recommended (specify):**
	☐ Rimmed plates
☐ Special religious or cultural preferences or practices (specify):	☐ Gripper pad/Dycem ☐ Modified cups
	☐ Rocker knife ☐ Built-up or bent handle utensils
	☐ Other (specify):
Assessments	**Administering Medications**
Nutritional assessment completed: ☐ Yes ☐ No Comments:	If medications taken, method of administration:
	☐ No restrictions
	☐ No liquid medication ☐ Give pills with thickened liquids
Swallowing assessment completed: ☐ Yes ☐ No Comments:	☐ Give pills with apple sauce ☐ Crush pills (provided they are NOT
	☐ Via tube only enteric-coated or do NOT possess
	extended-release formulations)
	Other recommendations for feeding and swallowing difficulties:

RISKS AND SAFETY

Person at risk for: ☐ Malnutrition ☐ Dehydration ☐ Silent aspiration or choking

☐ **Food allergies/intolerances (specify):**

Other risks (specify):

POTENTIAL FOR IMPROVEMENT AND GOALS

Describe:

Signature: ____________ Printed Name: ____________ Status: ____ Date: ____________ Time: ______
YEAR/MONTH/DAY

E. MOBILITY:

MDS-HC Section H: Physical Functioning (Current Status) ☐ **Within Normal Limits**

Tips and Tools for Everyday Living, Pages 9, 23-36 (Care Strategies)

NOTE: Min Assist - Patient does 75% of the work of the transfer, the health care provider 25%. **Mod Assist** - Patient does 50% of the work of the transfer, health care provider 50%. **Max Assist** - Patient does 25% of the work of the transfer, the health care provider does 75%.

CURRENT STATUS				CARE STRATEGIES AND RECOMMENDATIONS
Motor Deficits				**Positioning Strategies for Motor and Balance Deficits:**
• **Upper limb:**	**R**	**L**	**Both**	☐ Provide upper limb support (specify):
Motor deficit	☐	☐	☐	
Sensory deficit	☐	☐	☐	☐ Avoid passive range of motion
• **Lower limb:**	**R**	**L**	**Both**	☐ Positioning (describe):
Motor deficit	☐	☐	☐	
Sensory deficit	☐	☐	☐	☐ Other (specify):

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Patient's Name: ______________________ Chart Record Number: ______________

E. MOBILITY *(continued from page 3)*

CURRENT STATUS	CARE STRATEGIES AND RECOMMENDATIONS
Balance Deficits: ☐ Yes ☐ No	**Assistive Devices Used for Motor and Balance Deficits:**
• **Sitting** ☐ Supported ☐ Unsupported Describe:	☐ Tray ☐ Arm trough
	☐ Positioning belt ☐ Foam wedges
• **Standing** ☐ Supported ☐ Unsupported Describe:	☐ Other (specify):
Bed Mobility and Transfers	**Assistive Devices Used for Bed Mobility and Transfers:**
Bed Mobility	☐ Sliding board
☐ Independent ☐ Assisted Roll (R) ☐ Assisted Roll (L)	☐ Raised toilet seat
☐ Assisted Lie <-> Sit	☐ Versa-Frame
☐ **Other Comments (specify):**	☐ Commode
	☐ Mechanical lift
	☐ Walker

Transfers:	Independent	Supervised	Min Assist	Mod Assist	Max Assist
• Bed <-> Chair	☐	☐	☐	☐	☐
• Toilet Transfer	☐	☐	☐	☐	☐
• Car Transfer	☐	☐	☐	☐	☐
☐ **Other Comments (specify):**					

☐ Other (specify):

Please indicate what mobility devices have been prescribed, ordered or purchased and what follow-up is required:

Ambulation	**Assistive Devices Used for Ambulation:**
Weight bearing status (specify):	☐ Walker
	☐ Rollator
Distance (specify):	☐ Cane
☐ Independent ☐ Supervised	☐ Other (specify):
☐ Min Assist ☐ Mod Assist ☐ Max Assist	Please indicate what mobility devices have been prescribed, ordered or purchased and
☐ **Other Comments (specify):**	what follow-up is required:
Wheelchair Mobility: ☐ Yes ☐ No	**Assistive Devices Used for Wheelchair Mobility:**
☐ Independent mobility ☐ Dependent mobility	☐ Seatbelt or lap belt
☐ Safe ☐ Unsafe	☐ Other (specify):
☐ Manual ☐ Electric	

Please indicate if wheelchair and seating devices have been prescribed, ordered or purchased and what follow-up is required:

RISKS AND SAFETY

Risks Associated with Reduced Mobility: ☐ Falls/safety ☐ Pressure ulcer ☐ De-conditioning ☐ Deep vein thrombosis ☐ Other (specify):

POTENTIAL FOR IMPROVEMENT AND GOALS

Motor and Balance (describe):

Bed Mobility and Transfers (describe):

Ambulation and Wheelchair Mobility (describe):

Signature: ______________________ Printed Name: ______________ Status: ____ Date: __________ Time: ______
YEAR/MONTH/DAY

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Patient's Name: ______________________________ Chart Record Number: ____________________

F. PAIN:

MDS-HC Section K: Health Conditions and Preventive Health Measures (Current Status) ☐ **Not Applicable**

Tips and Tools for Everyday Living, Pages 25-26 (Care Strategies)

CURRENT STATUS		CARE STRATEGIES AND RECOMMENDATIONS
Pre-Stroke pain	**Post-stroke pain**	**Strategies:**
Describe:	Describe:	☐ Pain medication prescribed (specify):
		Non-medication strategies used/recommended:
		☐ Positioning/support
		☐ Therapy/activity
Controlled: ☐ Yes ☐ No	Controlled: ☐ Yes ☐ No	☐ Other (specify):

RISKS AND SAFETY

Pain Increases Risks for:

☐ Isolation ☐ Inactivity ☐ Withdrawal ☐ Agitation ☐ Defensive behaviour ☐ Pain impacts on activities of daily living ☐ Person has difficulty self reporting pain

Signature: ______________________ Printed Printed Name: ______________________ Status: ________ Date: ____________ Time: ________
YEAR/MONTH/DAY

G. CONTINENCE:

MDS-HC Section I: Continence in Last Seven Days (Current Status)

Tips and Tools for Everyday Living, Pages 63-66 (Care Strategies)

CURRENT STATUS		CARE STRATEGIES AND RECOMMENDATIONS
Bladder		**Bladder Strategies:**
☐ Continent	☐ Continent with catheter	☐ Day routine
☐ Usually continent	☐ Occasionally incontinent	☐ Night routine
☐ Frequently incontinent	☐ Incontinent	☐ Intermittent catheterization
☐ Urinary Retention		☐ Urinal at bedside
		☐ Other (specify):
Bowel		**Bowel Stratgies:**
☐ Continent	☐ Continent with ostomy	☐ Day routine
☐ Usually continent	☐ Occasionally incontinent	☐ Night routine
☐ Frequently incontinent	☐ Incontinent	☐ Other (specify):
☐ Constipation		
Comments:		

RISKS AND SAFETY	ASSISTIVE DEVICES USED
Risks Associated with Managing Continence:	☐ Incontinence products
☐ Falls/safety	☐ Urinal
☐ Skin breakdown	☐ Catheter (details of type and size)
☐ Urinary Tract Infection	☐ Ostomy (product details)
☐ Other (specify):	☐ Other (specify):

POTENTIAL FOR IMPROVEMENT AND GOALS

Describe:

Signature: ______________________ Printed Printed Name: ______________________ Status: ________ Date: ____________ Time: ________
YEAR/MONTH/DAY

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Patient's Name: ______________________ Chart Record Number: ______________________

H. BEHAVIOUR:

MDS-HC Section E: Mood and Behaviour Patterns (Current Status) ☐ **Within Normal Limits**

Tips and Tools for Everyday Living, Pages 59-62 (Care Strategies)

CURRENT STATUS	CARE STRATEGIES AND RECOMMENDATIONS
☐ Change in Behaviour After the Stroke	**Strategies:**
	☐ Medications used for behaviour issues (specify):
Current Behaviour: Triggers may lead to:	
☐ Agitation	☐ Behaviour triggers, if known (specify):
☐ Loss of emotional control	
☐ Withdrawal	☐ Specific techniques to address behaviours (specify):
☐ Low mood	
☐ Defensive behaviour	
☐ Verbal response ☐ Physical response	
☐ Other (specify):	

RISKS AND SAFETY

☐ Potential risk to self/others ☐ Risk of wandering ☐ Other risks (specify):

Signature: ______________ Printed Printed Name: ______________ Status: _______ Date: ____________ Time: _______
YEAR/MONTH/DAY

I. POTENTIAL FOR IMPROVEMENT AND GOALS IN ADDITION TO THOSE NOTED ABOVE:

Recommended Follow-up Clinics (specify):

Other Comments:

Signature: ______________ Printed Printed Name: ______________ Status: _______ Date: ____________ Time: _______
YEAR/MONTH/DAY

For further information on the person being transferred to long-term care, please see the MDS-HC. In addition to the MDS sections referenced above, other sections include D (Vision Patterns), F (Social Functioning), G (Informal Support Services), H (Physical Functioning: IADL Performance in Seven Days; ADL Performance in Three Days), M (Dental Status), N (Skin Condition), O (Environmental Assessment), P (Service Utilization in Last Seven Days) and Q (Medications).

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Appendix B

Guide for the Interviews with Key Stakeholders (Retrospective)

As part of the interview, participants will complete the brief quantitative questionnaire for long-term care homes, which will be accompanied by a copy of the TIP tool.

Use of the TIP Tool

I'd like to start this interview by talking about the use of the TIP tool in your long-term care home at the time that residents with stroke are admitted. Let's focus attention on the use of the TIP tool in the past 6 to 12 months.

1. Is the TIP tool information available to you each time a resident with stroke is admitted from Parkwood hospital? If not: Is there a reason it is not available each time?

    1.1 Is this different from when residents are admitted from other hospitals? (Prompt: Do you get the TIP tool from other hospitals?)

2. Are there some staff members who are more likely to use the tool then others? Which staff members usually review or use the TIP tool information?

3. How do you get the information – do you review the TIP tool directly or do you get the information indirectly from someone else?

    3.1 Do you have any comments you would like to make about this?

For those who had not used the TIP Tool, questions were modified to determine the process by which admissions facilitated (who completed the admission and developed the care plan) and how was information about the new resident disseminated to staff.

Usefulness of the TIP Tool

For those who review the TIP Tool directly:

4.0 What information or parts of the TIP Tool do you find most useful or relevant to your work?
4.1 Do you get this same information from other sources of information? (Determine where)
4.2 What information or parts of the TIP Tool do you find least useful or relevant to your work?
4.3 In general, is the information useful to your immediate care of residents? In what ways is it useful to you?

For those who get the information indirectly:

4.0 Who gives you the information?
4.1 What information do you get?
4.2 Is this sufficient for your needs?
4.3 If you need more information, are you able to access it?

5. In what ways does the resident benefit from your access to the TIP tool?

6. Can you provide an example based on your experience to illustrate a key impact of the TIP tool? Can you share with me any cases (residents or staff-related) that stand out in your mind as being particularly illustrative of the benefits associated with the TIP tool? You do not need to provide any information that would identify the resident or staff member.

7. Does the usefulness of the TIP Tool information depend on whether you need the information for immediately providing care, or for longer-term care planning? That is, do you find it more useful for providing care as soon as residents with stroke arrive to your home, or is it more useful for planning care in the longer-term?

8. Considering all the other sources of information that have recently become available, such as the MDS-Home Care, as well as hospital discharge summaries and information provided by family members, how important is the TIP Tool to you work? (relative importance)

   7.1 Considering all these other sources of information, are there any added benefits of also having the TIP Tool?

9. What do you think would happen if the TIP Tool was no longer available? What are the implications, or impacts, for your work and for residents if the tool was discontinued?

For those who had not used the TIP Tool, questions were modified to determine what information they find useful to have at admission, whether they get sufficient information to meet their care planning needs, and their perceptions of the TIP Tool in terms of potential usefulness and benefits.

Communication Strategies

10. Do you have any suggestions for how the TIP Tool could be improved?

11. Is there any information that is not currently available to you that you think would be useful to have at the time at a resident with stroke is admitted to long-term care?

12. Do you have any suggestions for improving information sharing or communication at the time that residents with stroke are transferred from hospital to long-term care?

13. Do you have any suggestions or comments to make about how care to residents with stroke, in general, could be improved?

Additional Comments

We are now at the end of the interview, do you have any additional or final comments that you'd like to make about the TIP Tool, or about information sharing with hospital.

Appendix C

Long-Term Care Home TIP Tool Survey

Use of the TIP Tool

1. How often do you use the TIP tool when residents with stroke are admitted to your long-term care home?

   - ☐ With all or almost all residents with stroke
   - ☐ With most residents with stroke
   - ☐ With some residents with stroke
   - ☐ With hardly any residents with stroke
   - ☐ With none of the residents with stroke

2. Overall, how would you rate the usefulness of the information contained in the TIP Tool to your immediate care of residents with stroke?

1 Not at all useful	2	3	4	5 Extremely useful

3. How would you rate the importance of each of the following components/ sections of the TIP Tool to your immediate care of residents with stroke?

	1 Not at all important	**2**	**3**	**4**	**5 Extremely important**
A. Medical Care Plan and Secondary Stroke Prevention: Current status	1	2	3	4	5
Care strategies/ devices	1	2	3	4	5
Risks and safety	1	2	3	4	5
B. Cognition/ Perception: Current status	1	2	3	4	5
Care strategies/ devices	1	2	3	4	5
Devices					
Risks and safety	1	2	3	4	5
C. Communication: Current status	1	2	3	4	5
Care strategies/ devices	1	2	3	4	5
Devices					
Risks and safety	1	2	3	4	5
	1	2	3	4	5

	1 Not at all important	2	3	4	5 Extremely important
D. Nutrition and Feeding: Current status					
Care strategies/ devices	1	2	3	4	5
Risks and safety	1	2	3	4	5
E. Mobility: Current status	1	2	3	4	5
Care strategies/ devices	1	2	3	4	5
Risks and safety	1	2	3	4	5
F. Pain: Current status	1	2	3	4	5
Care strategies/ devices	1	2	3	4	5
Risks and safety	1	2	3	4	5
G. Continence: Current status	1	2	3	4	5
Care strategies/ devices	1	2	3	4	5
Risks and safety	1	2	3	4	5
H. Behaviour: Current status	1	2	3	4	5
Care strategies/ devices	1	2	3	4	5
Risks and safety	1	2	3	4	5

4. Overall, how would you rate the TIP Tool in terms of how it helps you to care for residents with stroke when they are first admitted to your home?

Poor   Fair   Good   Very Good   Excellent

Tell us about yourself:

Which of the following best describes your discipline?

- ☐ Registered Nurse
- ☐ Registered Practical Nurse
- ☐ Personal Support Worker (PSW)
- ☐ Director of Care
- ☐ Physiotherapist
- ☐ Other, please specify: ______________________________

How many years have you worked with individuals with stroke? ________years

Appendix D

Guide for Interviews with Directors of Care[4]

Interview participants will be sent the interview questions in advance, along with a copy of the TIP Tool.

Preamble: The purpose of this interview is to learn more about the usefulness of the TIP Tool in providing care to residents with stroke upon admission to long-term care. To ensure the privacy and confidentiality of the resident we do not need to identify him/her by name and can refer simply to the "the resident". You do not need to provide any personal information about the resident. **We recommend that you have a copy of the TIP tool available to you during the interview.**

<u>Use of the TIP Tool</u>

I'd like to start this interview by talking about the use of the TIP Tool in your long-term care home with the resident that was recently admitted to your home from Parkwood Hospital. In particular, I am interested in the process by which the TIP Tool information is shared with staff.

4. Which staff members reviewed the TIP Tool developed for this resident?

5. How was the tool shared with staff – directly (they reviewed the tool itself) or indirectly (they received the information from someone else or in a different format)?

    2.1 If staff receive the information indirectly: Why have you chosen to share the information this way? What the issues associated with having frontline staff review the information directly?

6. When did they have access to the information? (Prompts: prior to admission, upon admission, or several days later)

<u>Usefulness of the TIP Tool</u>

7. On a scale from 1 to 5, how would you rate the usefulness of the TIP Tool information for staff as they prepared to care for this resident, with 1 being not at all useful and 5 being extremely useful?

1 Not at all useful	2	3	4	5 Extremely useful

8. What information or parts of the TIP Tool did staff find most useful or relevant to providing immediate care to this resident?

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[4] Interviews with Directors of Care, or the person identified by the Directors of Care of being the best informants for this interview. This interview guide was never use as there were no opportunities to conduct the prospective interviews.

5.1 Do you get this same information from other sources of information? (Determine where)

5.2 Is this information available at admission?

9. What information or parts of the TIP Tool were least useful?
10. Considering all the other sources of information about this resident that were available such as the MDS-Home Care, hospital discharge summary and information provided by family members, on a scale from 1 to 5, how would you rate importance of the TIP Tool information, with 1 being not at all important and 5 being extremely important? (relative importance)

1	2	3	4	5
Not at all important				Extremely important

7.1 Do you have any comments you would like to make about this?
7.2 If relevant: What are the added benefits of also having the TIP Tool? In what ways is the information more important or beneficial in comparison to other sources of information?

11. What are the benefits of the information contained in the TIP tool to resident care?

12. What do you think would happen if the TIP Tool was no longer available? What are the implications, or impacts, for your work and for residents if the tool was discontinued?

13. Can you provide an example based on your experience to illustrate a key impact of the TIP tool? Can you share with me any cases (residents or staff-related) that stand out in your mind as being particularly illustrative of the benefits associated with the TIP tool? You do not need to provide any information that would identify the resident or staff member.

Suggestions for Improvements

14. Was there any information about this resident that you did not have access to but that would have be useful or relevant for you to have had upon admission?

15. Related to the care of this particular resident, do you have any suggestions for how the TIP Tool could be improved?

16. In general, do you have any suggestions for improving information sharing or communication at the time that residents with stroke are transferred from hospital to long-term care?

Additional Comments

We are now at the end of the interview, do you have any additional or final comments that you'd like to make about the TIP Tool, or about information sharing with hospital?

Appendix E

Results of the Long-Term Care Home TIP Tool Survey

N = 3

Use of the TIP Tool

How often do you use the TIP tool when residents with stroke are admitted to your long-term care home?

0	With all or almost all residents with stroke
0	With most residents with stroke
0	With some residents with stroke
66.7% (2)	With hardly any residents with stroke
0	With none of the residents with stroke

Note: Percentages do not sum to 100% due to missing responses.

Overall, how would you rate the usefulness of the information contained in the TIP Tool to your immediate care of residents with stroke? 5-point scale: 1 = not at all useful; 5 = extremely useful.

5.0 (0)	Average (+/-)
5	Range
3	N

How would you rate the importance of each of the following components/ sections of the TIP Tool to your immediate care of residents with stroke? 5-point scale: 1 = not at all important; 5 = extremely important.

	Average (+/-)	Range
I. Medical Care Plan and Secondary Stroke Prevention: Current status	5.0 (0)	5
Care strategies/ devices	5.0 (0)	5
Risks and safety	5.0 (0)	5
J. Cognition/ Perception: Current status	5.0 (0)	5
Care strategies/ devices	5.0 (0)	5
Risks and safety	4.67 (.58)	4 – 5
K. Communication: Current status	5.0 (0)	5
Care strategies/ devices	5.0 (0)	5
Risks and safety (N = 2)	4.50 (.71)	4 – 5
L. Nutrition and Feeding:	4.33 (1.2)	3 - 5

	Average (+/-)	Range
Current status		
Care strategies/ devices	4.33 (1.2)	3 - 5
Risks and safety	4.33 (1.2)	3 - 5
M. Mobility: Current status	5.0 (0)	5
Care strategies/ devices	5.0 (0)	5
Risks and safety	4.67 (.58)	4 – 5
N. Pain: Current status	5.0 (0)	5
Care strategies/ devices	5.0 (0)	5
Risks and safety	5.0 (0)	5
O. Continence: Current status	4.33 (1.2)	3 - 5
Care strategies/ devices	4.33 (1.2)	3 - 5
Risks and safety	5.0 (0)	5
P. Behaviour: Current status	4.67 (.58)	4 – 5
Care strategies/ devices	4.67 (.58)	4 – 5
Risks and safety	4.67 (.58)	4 – 5

Overall, how would you rate the TIP Tool in terms of how it helps you to care for residents with stroke when they are first admitted to your home?

Poor	Fair	Good	Very Good	Excellent
0	0	0	33.3% (1)	33.3% (1)

Note: Percentages do not sum to 100% due to missing responses.

Which of the following best describes your discipline?

0	Registered Nurse
0	Registered Practical Nurse
0	Personal Support Worker (PSW)
33.3% (1)	Director of Care
33.3% (1)	Physiotherapist
33.3% (1)	Other: *Restorative Care Manager*

How many years have you worked with individuals with stroke? (N = 3)

13.7 years (15.9)	Average (+/-)
4 - 32	Range