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The 2014 Canadian Stroke Congress Nursing Pre-Conference Workshop

“Building a Stroke Nursing Toolkit”

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Kristy Smaggus, Coordinator for Champlain EMS, rounded out the opening plenary, presenting on “Evaluation of the Implementation of the Revised Paramedic Prompt Card for Acute Stroke Protocol”, which demonstrated the utility of the protocol in the Champlain region.

The concurrent session following the opening plenary included talks on tools to measure stroke severity, presented by Nancy Newcommon, Stroke NP in the Calgary Stroke Program, and Luchie Swinton, Rehabilitation Practice Lead Stroke Action Plan (Alberta Health Services), and a discussion of hyperacute risk stratification by Melanie Penn, ANP and Dr. Kristine Votova from Victoria BC’s Stroke Rapid Assessment Unit (SRAU).

Sunday morning began with a plenary on patient outcome measures. Dr. Lindsay again opened the session by talking about how patient and nursing outcomes are two sides of the same coin and reminded us that nurses need to track outcomes to inform practice.

Andrew Dawson, Fraser Health’s Rehabilitation Program Medical Director, spoke on patient outcome measures used in rehab, while Holly Reimer, a Post-doctoral Fellow in Aging at McMaster University, brought us “Measuring outcomes in community for persons living with stroke.” Ms. Reimer spoke about shifting our focus to the client’s goal-oriented outcomes through strength based practice.

The mid-morning concurrent sessions included Audrey Brown’s presentation on available mobile and on-line applications supporting best practices for stroke, and a vocational rehab presentation by Dr. Vaughan Marshall and Tiffany Chan. Audrey Brown is a Speech-Language Pathologist in Providence Care, Kingston, ON, who’s passion for her role in assisting stroke patients to recovery their speech fuels her search for innovative technology. Dr. Marshall is an Instructor and Coordinator in Vocational Rehabilitation Counseling UBC. Tiffany Chan works as a Vocational Rehab Counselor in GF Strong Rehab Centre. They spoke about supporting the stroke survivor in their efforts to return to work, and directed listeners to the website Brainstreams.ca. Here the survivor of brain injury can find practical advice for recovery.

The final plenary of the workshop brought together speakers from Alberta and Ontario to talk about their experiences implementing tools and programs to support and enhance practice in acute, rehab and long-term care. Cheryl King, Clinical Practice Lead Cardiovascular Health and Stroke Strategic Clinical Network, Alberta Health Services, presented on her experiences in facilitating “stroke unit equivalent care” in Alberta sites with low stroke volumes and Dawn Tymianski, ANP CV Surgery and Practice Leader, Krembil Neurosciences Program, Toronto encouraged participants to consider Advanced Practice Nursing in Stroke. Sarah Munce and Gwen Brown were invited to speak to the abstracts they had submitted, outlining their experiences in delivering staff education.

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Some Highlights of the 2014 Canadian Stroke Congress

Stroke Survivors Remain at Risk: Patients who survive the initial 90-day period after stroke or TIA remain at high risk of negative outcomes. Few clinics follow patients for years, but even stable patients may be at high risk. Negative outcomes include a repeat TIA or stroke, a heart attack, admission to long-term care, or death. Within one year, approximately 10% of patients studied had one of these negative outcomes. The rate increases by 5% with each additional year, up to 5 years. The study involved 24,000 patients who did not have an event within the first 90 days. This new research was presented by Dr. Rick Swartz, Director of the University of Toronto Stroke Program and leader of the study.

Rural Hospitals replicate experiences of Big City stroke care: A new model of stroke care is being studied in rural Alberta with the goal of reducing inequities across communities. This model, Stroke Unit Equivalent Care (SUEC), shows how smaller hospitals can mimic the kind of care usually only available in larger centres. “There are challenges in these smaller centres, mainly because of lack of sub-specialists, dedicated beds or early exposure to therapists,” says Dr. Thomas Jeerakathil, stroke neurologist and co-chair of the Stroke Action Plan project. “What we are trying to do is replicate the experience of stroke unit care for rural and smaller urban areas.” The study received the CSC Co-chairs Award for Impact.

Code Stroke on the Ward: A new study, presented by investigators for the U of T Faculty of Medicine, Institute for Clinical Evaluative Studies and the University Health Networks, analyzed data from Ontario acute care facilities over the last 9 years. Stroke care delivery and outcomes were examined for 2 groups: patients who had a stroke in community (~32,000) and those who had a stroke while already hospitalized for other reasons (~1000), and the results were surprising. Compared to patients from community, patients with in-hospital strokes had longer symptom recognition to CT times, waited longer after confirmation of stroke to receive tPA and were less likely to receive tPA than their counterparts admitted from community, even if eligible. “Hospitals already have sound protocols on handling strokes coming in from the community,” Dr. Patrice Lindsay says. “We need the same awareness and services within the hospital for patients who are already admitted, to ensure their rapid access to stroke care.

The Heart and Stroke Foundation (HSF) announces the development of a new and enhanced “Signs of Stroke” campaign, which encourages Canadians to recognize the signs of stroke and act FAST.

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Sarah participated in the SCORE-IT project, the aim of which was to evaluate whether using an implementation intervention promotes use of best practices by rehabilitation professionals and leads to improvements in patient outcomes for individuals with stroke. Gwen’s experience involved evaluating optimal methods of delivering education to long-term care staff. The team developed a series of educational posters accessible to staff, residents and visitors. Gwen’s posters were in great demand by the end of the session.

It was an informative weekend, and we are grateful to all participants. Send in your ideas for next year, so we can keep these workshops relevant.

The new campaign includes social media, new information on the HSF website, and an educational TV spot which began airing in December (in Ontario only at first). The new campaign has also been integrated into the Canadian Stroke Best Practice Recommendations and related resources. For more information about FAST and FAST resources please visit www.heartandstroke.ca/FAST

Read these and other stories at www.strokecongress.ca/news/. Stories reproduced with permission.
**Province of Prince Edward Island:** In Prince Edward Island we continue to work towards building a comprehensive organized stroke care program. Accomplishments since 2010 include the establishment of a provincial acute stroke unit and enhanced inpatient and ambulatory provincial stroke rehabilitation services. A secondary stroke prevention clinic located at Prince County Hospital has also been established, servicing 40% of the provincial population. Current priorities include provincial expansion of stroke prevention services and plans to support community re-integration.

In 2013, a needs-assessment for community re-integration was completed and a business case was submitted with recommendations to address gaps in the transition from hospital to home and to community participation. This includes building on the work that has been completed to date for Telestroke rehabilitation services. Funding is being sought through the government process, and Health PEI is currently awaiting a decision.

The proposal submitted to government included: the creation of a Stroke Navigator position to assist stroke survivors and caregivers with supports and services that they need; creating a respite and rehab program to provide respite while also providing the opportunity to practice activities and skills; implementation of a provincial telestroke system to further enhance provincial stroke rehabilitation services. As well, hyperacute management is a current priority.

One area we have identified requiring further focus is the percentage of ischemic stroke patients who receive alteplase therapy (tPA). The Accreditation Canada Stroke Distinction Program threshold target is 7%. In PEI, we range between 6% and 10% over the years examined. A current challenge is we do not have the critical mass to offer 24/7 access to neurology services to support emergency physicians in the decision to administer tPA. Through the support of the Canadian Stroke Network, we are exploring the potential to become part of another province’s Telestroke program as a possible solution. We are holding a Physican Engagement session on using a Telestroke Service for providing tPA support in Hyperacute Stroke Care this Fall in PEI.

**Nova Scotia:** The 8th Atlantic Canada Stroke Conference, held September 12th and 13th, was hosted by Moncton NB for the first time. There was a very successful turnout (totals and evaluations pending). Provincial and district level planning have identified secondary prevention, rapid access TIA intervention and stroke rehabilitation as key areas for further reorganization.

Cardiovascular Health Nova Scotia (CVHNS) is continuing to work with districts to improve care for stroke patients across the province and across the continuum. The CVHNS is leading activities in 2014/15 to gain a better understanding of further enhancements and investments required to meet best practice recommendations for remaining areas of the continuum of care: secondary prevention, rehabilitation and community re-integration. Activities include: follow-up calls with a selected number of stroke patients throughout the province to better understand the patient experience and potential areas for improvement, creation of inventories of stroke rehabilitation and TIA rapid assessment/secondary prevention services throughout the province, the exploration of models of TIA rapid assessment and stroke rehabilitation from other provinces, including the use of tele-technologies to improve access to services.

As a result of enhancements, Nova Scotia has made substantial improvements in care and outcomes as shown in comparisons of data from 2004/05 and 2012: a 61.4% increase in patients cared for on a stroke unit and an increase in all team members (physiotherapy, occupational therapy, speech language pathology, social work, and dietitian) involved in stroke patient care. In 2012, 65.2% of in-patients were being discharged home, increased by 4.5% since 2004. In 2012, 8.1% of in patients were being discharged to long term care, a 4.7% decrease since 2004. In 2012, 97% of in patients received a brain scan during their admission, an 11.6% increase since 2004 and Nova Scotia has demonstrated a 10.6% increase in the proportion of ischemic stroke patients receiving thrombolytic therapy.

**Alberta:** The Calgary Stroke Program once again attained Stroke Distinction and was recognized in October at the 5th Canadian Stroke Congress. The Co-chairs Award for Impact was awarded to the Cardiovascular Health and Stroke Strategic Clinical Network for their work in implementing the Stroke Action Plan in small urban and rural centres in Alberta, a project designed to bring Stroke Unit Equivalent Care and Early Supported Discharge to sites with low stroke volumes.

**Ontario:** The 17th annual Stroke Collaborative 2014 was held on October 27th in Toronto. There were 550 registrants with a waiting list of 40. Attendance has grown exponentially from the original conference of 30 participants.

The focus of the conference was “Connecting Experiences: Achieving Best Practices”.

The program started with Mr. Ken McCaw, an IT professional and musician, who experienced a significant stroke in 2011. Mr. McCaw described his experience and stroke recovery,
emphasizing that simple words and statements from healthcare providers who said the “right thing at the right time” made a significant difference. Mr. McCaw’s optimism and determination was evident throughout his presentation: he shared how a clinician helped him achieve his goal, which was to play the guitar again, a seemingly daunting task when his right hand had no movement. He concluded his speech with an amazing guitar performance, which was truly inspirational.

Dr. Andrew Samis, General Surgeon and Critical Care Physician, Assistant Professor. Department of Surgery, Assistant Professor, Queen’s University, gave a thought provoking Plenary Session “Dietary Fat and Cardiovascular Disease. Have we got it all wrong?”

Since the 1960’s and 70’s, advice aimed at reducing the risk of atherosclerotic disease has included dietary recommendations to reduce total fat and saturated fat. It was observed at the time that this “vast nutritional experiment” was embarked upon with little scientific evidence. Forty years later, the results of this experiment have started to come in, and many are asking whether we have it all wrong.

Following the Stroke Collaborative, a full day meeting was held with team members of the eleven Regional Stroke Networks. The groups are comprised of members from the Rehabilitation Coordinators, Community and Long Term Care Coordinators, Ontario Regional Education Coordinators, Regional Program Directors and District Stroke Coordinators. Provincial Integrated Task Groups are working collaboratively on targeted projects: Early Supported Discharge and a Navigation Model to Support Patient Transitions. New projects include: Stroke Core Competencies, Stroke Unit - Acute and Rehab and Rehab Intensity.

Concurrent sessions on topics throughout the continuum were also held. Presentations and posters describing the innovative initiatives that teams throughout Ontario have undertaken to meet the Canadian Stroke Best Practice Recommendations were shared.

Handouts from selected presentations will soon be available at http://www.heartandstroke.on.ca/site/c.pvi3leNWJwE/b.5338853/k.6785/HCP_Continuing_Educatio n.htm

New Brunswick: By December 8th, the entire province of NB will be wired for telestroke. All 10 provincial facilities with CT scans and 24 hour ERs have been equipped with clinical carts. A 24/7 roster of neurologists are equipped with laptops and available for any calls. Telestroke launched Sept 15 with 4 sites. Phase 2 commenced October 27th with 2 sites and the remaining sites are set for Dec 8th. This has been a wonderful collaborative between the Dept. of Health, HSFNB, Ambulance NB, the NB Medical Society, Horizon Health Network and Vitalité Health Network. There were many individuals who worked tirelessly to make this happen. We are thankful for a $100,000 implementation grant from the Canadian Stroke Network. Support from the HSFNB and individual donors, totalling $250,000, allowed for the purchase of clinical carts, which were instrumental to the success of the program.

Manitoba: Telehealth appointments have progressed well over the last year and we are now seeing 15 - 20 patients a month via Telehealth through the Stroke Prevention Clinic. The response from patients who are no longer required to travel long distances to Winnipeg has been very positive. A study looking at the cost savings of reduced patient travel is underway. We anticipate interesting results.

Manitoba is pleased to announce that Telestroke Acute Stroke treatment via Thompson General Hospital in Thompson, Manitoba commenced November 18, 2014. Thompson General Hospital services many of the rural communities in the northern one third of the province. A total of 5 neurologists from the University of Manitoba Department of Neurology will rotate weekly call for this acute stroke service. Many people and departments in the Winnipeg Health Sciences Centre, Thompson General Hospital and Brandon General Hospital have worked hard over the past few months in order to organize and implement this very important treatment option for the northern population of our province. This will complement the Telehealth service also available at present to these same northern communities that is offered through the Stroke Prevention Clinic at Health Sciences Centre, allowing for many of these patients to stay in their home communities and receive best practice stroke care.
About the Canadian Stroke Nursing Council

The Canadian Stroke Nursing Council was established in late 2005 with the support of the Canadian Stroke Network to promote leadership, communication, advocacy, education and nursing research in the field of stroke.

The Council works to build understanding of the critical role of Canadian stroke nurses, to give a voice to experiences on the frontline and to support the vision of the Canadian Stroke Strategy.

To promote leadership, communication, advocacy, education and nursing research in the field of stroke.

**Objectives**

- Build a nationally and internationally recognized accessible stroke nursing network
- Disseminate information and best practice standards to stroke nurses
- Facilitate implementation of stroke best practices across the continuum of care
- Promote the value and understanding of the various nursing roles in stroke care

**Goals**

1. To build an understanding of the critical role of stroke nurses in Canada.
2. To give voice to experiences of stroke nurses on the front line.
3. To support the vision of the Canadian Stroke Strategy.

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