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ABSTRACT

Purpose: The purpose of this study was to investigate the experiences and expectations of people with stroke, during their transition from hospital to home, after participating in a novel inpatient outreach program, entitled STRENGTH.

Method: A qualitative study was conducted using semi-structured interviews, which were undertaken at discharge and four to six weeks post discharge. Thematic analysis was used to code the interview transcripts.

Results: The study incorporated data from seven people with stroke, who had a mean age of 61 years. Thematic analysis derived two themes, each with two sub-themes. The first theme was 'Hospital and Home' and described clients' experiences of therapy and the hospital environment. The second theme was 'Life will never be what it was before' and elaborated on the adaptations and changing expectations that clients had before and after discharge.

Conclusions: People with stroke described the therapy they received in both the hospital and home as beneficial. The results support the addition of the home-based inpatient program, STRENGTH, to the current rehabilitation system, as it appeared to realign the expectations of people with stroke and better prepare them for their discharge home.

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INTRODUCTION

Each year, approximately fifteen million people worldwide experience a stroke and five million are left with long-term disabilities [1]. In Australia alone, two-thirds of people living with stroke in 2012 were left with disabilities that impacted upon their ability to complete daily activities [2]. The substantial number of people being discharged into the community after experiencing a stroke places a high level of demand upon the community support services, families and carers who support them. Although this demand exists, recent consumer forums of current stroke services have highlighted that services are lacking in the areas of discharge planning, rehabilitation coordination and family involvement [3]. For this reason, difficulties have been identified around the return to home experience and it has been acknowledged that this area of stroke recovery requires further attention.

A transition can be defined as “the process of changing from one state or condition to another” [4] and for people with stroke this can be in the form of returning home from hospital. This transition presents a significant life event for this group, as it marks a time where re-engagement begins to occur with their former lives [5]. Before returning home people with stroke report feeling a sense of joy and positive anticipation, with excitement overshadowing thoughts relating to the practicalities of life without twenty-four hour care [6-8]. Once returning home, however, they begin to understand the full impact of their stroke and report a range of negative emotions including; isolation, abandonment, uncertainty, and confusion [5,9-10]. As negative emotions emerge, they start to question their self-identity, self-concept, self-esteem, sense of role capability, independence and autonomy [5,11-12]. Factors reported to contribute toward the development of these feelings include; a lack of preparation, needs being unfulfilled, and a loss of valued roles and relationships [8-9,12-14].

The Australian National Stroke Foundation’s current recommended care pathway for stroke recovery involves four major stages including; an admission to a stroke unit, ongoing

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inpatient rehabilitation in a stroke rehabilitation unit, an assessment for ongoing outpatient rehabilitation, and discharge or ongoing outpatient rehabilitation [15]. Within this pathway, the focus of rehabilitation historically has centred on improving physical abilities and basic activities of daily living to allow for a safe and quick discharge [9,16]. This focus, however, has been accompanied by some noted downfalls. Firstly, concentration on the person's physical abilities neglects the fundamental elements of client-centred care where emphasis should be placed upon personally meaningful goals [9]. Secondly, rehabilitation is predominantly undertaken within the unfamiliar hospital environment, limiting the person's ability to engage in meaningful activities and daily tasks needed for real-life functioning [6,16]. In order to address this, research has started to focus on the use of the home environment for rehabilitation purposes. From these investigations, it has been reported that the home environment provides; more stimulation, more opportunities for people with stroke to participate in decision-making processes, the potential for identifying factors that support continuity, and reassurance of the person's functional safety in their home [17-18].

A number of programs have developed to capitalize on the positive links between the home environment and rehabilitation outcomes. One such program is Early Supported Discharge (ESD), which involves an interdisciplinary team entering and completing rehabilitation in the person's home once they are medically fit for discharge [9,19]. A recent review of ESD studies concluded that it is a beneficial intervention for selected stroke survivors as it enables them to experience reduced hospital length of stay and increased independence [20]. This research, however, has primarily been conducted in the United Kingdom and Scandinavia, with results indicating that the program is mainly effective for stroke survivors with minor to moderate disability [9,20]. Similarly, results have suggested that success relies heavily upon discharge planning procedures, continuity of care and co-ordination of outreach teams, which may not be available in all healthcare settings [9,20].

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Some alternative home-based rehabilitation programs to ESD include; the Extended Stroke Unit Service (ESUS), hospital supported discharge, and the Stroke Transition After Inpatient Rehabilitation (STAIR) program [9,12,21]. ESUS involves an early assessment of the client partnered with a home visit, discharge family meetings, follow-up rehabilitation services, an outpatient review, and an educational meeting at three months post discharge [9]. On the other hand, hospital supported discharge patients are assigned an interdisciplinary stroke team consisting of an occupational therapist, a physiotherapist and a physician who, take over their training and complete home visits in the last 7 days of their hospital stay [21]. The team also complete a rehabilitation program after discharge that lasts up to 30 days, with a maximum of 10 visits [21]. STAIR was developed to improve the post-discharge care of people with stroke and involves weekly phone calls, monthly home visits and home-based therapy in the early stages post-discharge [12]. Research into these programs' effectiveness is currently limited and it appears that most of the rehabilitative therapy given in the programs is conducted after the client has left hospital [9,12,21]. As a consequence of the limited evidence surrounding current home-based rehabilitation programs the most effective means for preparing stroke survivors for discharge is still to be determined.

STRENGTH (Stroke Rehabilitation Enhancing and Guiding Transition Home)

With the high prevalence of stroke in society and reports of people with stroke experiencing difficulties upon discharge, there is a need for the development of services that support the transition home. A preliminary study by the research team [16] has identified that the transition to, and first month at home are marked by unexpected difficulties that may be pre-empted if rehabilitation is conducted within the home environment before discharge.

Participants reported that rehabilitation had not adequately prepared them for completing essential activities within their own environment, leading to frustration at unexpected difficulties and limited confidence in their ability to access the community. This finding

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supports the assertion that the incorporation of the home environment into rehabilitation may be able to improve the transition experience.

Currently recommended models of rehabilitation within the home environment, such as ESD, are not always applicable or possible within all healthcare settings, and alternate models are needed. For this reason, the STRENGTH program was developed within the Queensland metropolitan hospital that was the site for the previous study [16]. STRENGTH differs from models such as ESD, STAIR and ESUS which all incorporate a community based healthcare team offering support and intervention after the person with stroke has returned to their home, or in the final week before discharge. In contrast, STRENGTH incorporates the treating inpatient healthcare team, and involves the occupational therapist, physiotherapist and speech pathologist, accompanying clients home and conducting therapy at home with them once a week, in the weeks leading up to discharge. The purpose of STRENGTH was to provide opportunities for the therapists, clients and carers to experience the challenges of everyday activities within the home and immediate community environment during inpatient rehabilitation. In doing so, it was hoped that they would be able to identify problems, collaboratively set goals and work to overcome their difficulties prior to discharge. Therapy was therefore conducted within the home for one day a week and within the hospital environment for the remaining days of every week. The purpose of this paper is to identify whether STRENGTH was able to succeed in improving the transition experiences of people with stroke and used the specific research question of, “What are clients’ expectations and experiences of the transition home after participating in the STRENGTH program?”

METHODS

A descriptive qualitative design incorporating semi-structured interviews was utilised to identify the expectations and experiences of clients who participated in STRENGTH. This design was part of a larger study performed at the metropolitan hospital over a six-month

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period, which aimed at implementing and determining the impact of STRENGTH through acquiring information from therapists, clients and carers. Ethical approval for the study was obtained from the ethical committees of the university and the metropolitan hospital involved in the study. The metropolitan hospital provides health services to residents living in the northern suburbs of the metropolitan centre, and specialist services to the broader state in which it is located and to the northern part of an adjacent state [22]. The research team were not members of the healthcare team in this setting.

Participants

All clients who entered the rehabilitation ward after experiencing a stroke were considered for inclusion into the study. Further inclusion criteria included; (1) the experience of a first-time stroke, (2) a planned discharge destination of home, (3) adequate language and cognition to be able to participate in interviews and self-report questionnaires, and (4) a discharge destination within a 20km radius of the treatment centre.

Data Collection

Background Data

Demographic information was obtained from all clients including; age, existence of a carer, days since stroke, days in rehabilitation, and number of visits home with STRENGTH. Data relating to the stroke were also recorded using standardized measures. Stroke severity was determined using the National Institute of Health Stroke Scale (NIHSS), a 15-item clinical deficit scale with high inter-rater and intra-rater reliability [23]. This scale covers a wide range of neurological functions and indicates the person's stroke severity according to their total score, with <6 indicating a mild stroke, 7-15 indicating a moderate stroke and 16-42 indicating a severe stroke [23-24]. Type and location of stroke was recorded using the Oxford Stroke Classification System. This system places the stroke into one of four categories, these being: Total Anterior Circulation Syndrome (TACS), Partial Anterior Circulation Syndrome

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(PACS), Lacunar Circulation Syndrome (LACS), and Posterior Circulation Syndrome (POCS) [25]. The 18-item Functional Independence Measure (FIM) was used to establish functional independence [26-27]. This measure has been reported to be a valid and useful tool for measuring motor and cognitive ability, and uses a 7-point scale to determine level of independence, from 1 equaling total assist to 7 equaling complete independence [26-28]. The presence of depressive symptoms was measured using the short form of the Geriatric Depression Scale (GDS), a 15-item questionnaire, where scores of 5-15 indicate depression [29-30]. The GDS has been identified as being a reliable and valid screening tool in people with physical and cognitive difficulties, making it appropriate for use with people who have had a stroke [30].

Semi-Structured Interview

Semi-structured interviews developed for a prior study investigating the transitional experiences of people with stroke and their carers, under the current rehabilitation and discharge framework, were adapted and used for this study [16]. Semi-structured interviews were deemed to be the most appropriate form of data collection for the study as they enabled the interviewer to have control over the interview whilst allowing for a variety of responses [31]. Specific areas that were targeted within the interviews included; the person with stroke's expectations in regards to returning home, whether these expectations had been met upon return, the person with stroke's opinions in relation to what they found beneficial and their suggestions for improvement.

Procedures

Before clients were able to participate in the program, medical and risk assessments were performed by hospital staff in order to give clearance for them to spend one day a week in their home environment. Once these assessments were completed and clearance was given, consent was obtained from clients and they were included in the program. During these

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recruitment procedures, basic demographic information and data related to the stroke were also collected. Clients then commenced the STRENGTH program where they performed personal, domestic, and community access activities, in and around their home with an occupational therapist, physiotherapist and speech pathologist, one day a week in the weeks leading up to discharge. In addition, clients were also given an opportunity to spend time alone or with their carers in their homes in order to identify problematic areas that could be discussed upon their return to hospital.

At discharge, clients were administered the semi-structured interviews to identify their expectations regarding their return home after participating in STRENGTH. At this stage, the data relating to their days spent in rehabilitation, visits home during STRENGTH, functional independence, and presence of depressive symptoms were collected. Four to six weeks after clients had returned home, the semi-structured interviews were again administered to determine whether their expectations had been fulfilled or if they had changed since returning home. The length of interviews varied, with the discharge interviews lasting up to 25 minutes and the follow-up interviews lasting up to 35 minutes. Member checking was completed at the end of each interview to improve the validity and rigour of the study. This involved the researcher checking their interpretation of the interview with each of the clients to ensure that the main themes identified were consistent with the client's thoughts. All semi-structured interviews were conducted by the same member of the research team, tape-recorded and transcribed by verbatim.

Data Analysis

Thematic analysis, a type of data analysis that employs a systematic approach to coding and classifying data in order to produce overarching themes, was used to examine qualitative data [32]. Two members of the research team independently read and coded qualitative data, with one researcher concentrating on discharge data and the other focusing on follow-up data.

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From this, three preliminary themes were developed from the discharge interviews and two for the follow-up interviews. Consensus coding was then completed by the two members of the research team individually matching data to the themes generated in discharge and follow-up data analysis. It was then identified that the preliminary themes for the discharge and follow-up interviews had many commonalities and the decision was made to combine themes. As a result, two final themes were produced from the preliminary themes, with each of these having two sub-themes.

RESULTS

In total, 11 clients were recruited, however, discharge and follow-up data were only available for 7 clients. Exclusion of 4 clients from the final results occurred as a result of the following reasons; unable to be contacted (n=1), declining to participate at follow-up (n=1), discharged before they could participate (n=1), and not returning to community living (n=1). There was a relatively equal male (n=3) to female (n=4) ratio in the remaining sample, and the clients ranged between 36 and 80 years of age, with a mean age of 61 years. The mean days since stroke at the time of recruitment was 28.86 days, the mean days spent in rehabilitation was 77.29 days, the mean FIM score at discharge was 64.43 and all participants had mild to moderate stroke. Descriptive demographic details for each participant are reported in table 1.

Insert table 1 about here

Analysis of the discharge and follow-up interview data identified two main themes in regards to how clients experienced STRENGTH, their time in hospital, and their return home. The first theme is entitled 'Hospital and Home' and relates to clients' views on therapy and their thoughts on the hospital environment, with sub-themes relating to each of these. The second theme 'Life will never be what it was before', also has sub-themes, which reflect the change in clients' expectations between discharge and follow-up interviews. Pseudonyms for

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each of the clients have been used to ensure privacy is kept whilst enabling the same client data to be identified each time it is referred to.

Hospital and Home

This theme is comprised of two sub-themes that relate to therapy and the hospital environment. The first part of the theme is called 'It's All Helpful' and discusses clients' experiences of therapy in hospital and at home. The second sub-theme is entitled 'Life in Hospital is a False Existence' and represents the views clients held of the hospital environment.

'It's All Helpful'

Both before and after discharge, clients discussed the benefits and differences of the therapy they received in the hospital and home. Clients highlighted the value that both of these therapy environments had on their recovery, with statements such as, "*...it's all been beneficial. I wouldn't sort of just say one particular area has been more helpful than another*" (Amanda). They also, however, elaborated on the limitations of therapy within both environments, specifying areas in need of change.

The therapy received in the hospital environment was viewed by clients as important for improving their functional abilities to a level at which they could confidently return home. Clients spoke positively of 'Physio', 'OT' and 'Speech' and described the activities and outcomes that they found beneficial from each of these therapies. Limitations of the hospital environment were highlighted, with clients expressing that they did not always understand the reasoning behind completing particular activities, for instance Bill said, "*Yeah. Some things we did, What the hell do I want to do this for?*". Some clients also seemed to have difficulty comprehending why therapists chose certain equipment for them to use or why they were not provided opportunities to use equipment such as the exercise bike. Similarly, the

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repetitive nature and intensity of therapy was not always understood or appreciated, with Amanda stating in relation to her therapy sessions,

“...Unfortunately they are very much the same, just repeat, you know very repetitive because that’s obviously how you achieve success. By doing the same thing over and over. So there is not a lot of variety.” (Amanda)

Although they sometimes did not understand the reasoning behind the therapy they were completing, clients admitted to it being advantageous to their overall recovery, with Bill summarizing this by stating, *“...Everything in here has been wonderful as far as I am concerned. I wouldn’t have survived without it.”*

Similar to therapy in the hospital, STRENGTH was viewed positively by clients due to the beneficial outcomes they perceived it brought to their preparation for discharge. Clients indicated that the program was able to help them in their transition home and was completed at an appropriate time within their rehabilitation. They also felt that the program gave them an opportunity to practise activities and tasks that were important to them within the meaningful location of their home. As a result of these factors, clients appeared to become more confident in returning home, with statements such as,

“...I do say that an invaluable part was coming home for the day and the weekends and the therapy in home was very much worthwhile because it gives you the confidence to do things in your own home that you don’t in the hospital.” (Amanda)

This increase in confidence coincided with a development of realistic expectations for returning home. Clients indicated that the initial visits home had been quite confronting and difficult; however, this experience seemed to allow them to adjust to certain changes in their lives and realize that life may be more challenging than initially expected. Juliette highlighted this in her discharge interview,

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“It will be a bit of an unknown but I think I have a much better idea from going home on the program. The first day I went home I was amazed of all the things I thought I could do and I couldn’t.”

The home visits also appeared to give clients insight into the differences that exist between the physical environments of the hospital, the home and community,

“At home it is trickier because of our shower situation. In here the floor is made to be non-slip even though it is still slippery. At home you are a bit more dubious about stepping out on the tiles and that.” (Juliette)

From this experience, clients were then able to anticipate challenges they may have upon return home and prepare for these with the help of the therapists.

Although many positive outcomes of STRENGTH were noted by clients, similar to therapy completed in the hospital, some expressed a lack of understanding towards the reasoning behind activities. Bill portrayed this when he said, *“Well we just sit at home and talk”* and Ivy during her follow-up interview, *“It was just a trip away from the hospital.”*

Life in Hospital is a False Existence

Clients identified that the hospital environment presented a false way of living in comparison to life at home. There appeared to be multiple reasons for this, with the most predominant being; the structure of days, the loss of independence, the lack of opportunities for socialization, and the meaning connected to home.

Clients viewed the hospital environment as restrictive as they felt it limited the way they occupied their days. Therapy appeared to be the central focus of days and it seemed that a substantial amount of time was spent waiting around for it. Amanda highlighted this when discussing the aspects of home that she was most looking forward to at discharge,

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“Probably just getting back to some normalcy I suppose this is a very false existence. I have been thinking the last couple of weeks, what on earth did I do with my life before I did physio?”

Similarly, clients also spoke of how much of their time was spent waiting for hospital staff and expressed a dislike for the regimented nature of the hospital environment, with Ivy stating,

“...you get up in the morning and it was breakfast, pills, a shower – and you go to physio for an hour, OT for an hour and speech for an hour. Then you’d come back and that was lunch, then 1 o’clock, start again. And I hated that but that was good for you.”

Not only did the structured routine of the hospital environment affect how clients spent their days but it also appeared to have a carryover effect on the number of opportunities that were present for them to participate in daily activities, with Harry stating, *“...I mean I can’t make my own sandwiches here because everything is provided and they make your bed for you...”*

Safety requirements and the way in which clients were informed of these also appeared to contribute to the level of restriction placed upon their opportunities for participating in daily activities. Jack highlighted this when stating, *“I mean they put the fear of God in you. Nurses telling you [that] you are going to fall....”*

The restrictions placed upon clients on a daily basis within the hospital seemed to also impact upon their sense of self. Clients expressed that they had been ‘treated like a child’ or ‘treated like an old person’ whilst in hospital and described a loss of independence,

“...we were like little kids playing around [laughs]. No, that was only in my own mind. Kindergarten [laughs]. Well it’s reducing, you’ve been reduced, haven’t you?... your independence is taken away from you and you’re not in charge...” (Harry)

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Affecting clients' emotions and the way they viewed themselves further was the social environment of the hospital. Younger clients seemed to be impacted by this the most and disliked the fact that there were minimal people their own age to socialize with,

"...being in the rehab ward you are with a lot of elderly people. Which is not always, you know it doesn't really lift your spirits much. I find it quite depressing to be down there." (Amanda)

The meaning that clients attached to their home appeared to be a final element that contributed towards the way they experienced the hospital. Over half of the clients expressed a longing to be back in their homes during discharge interviews and at follow-up discussed the positives of therapy in the home,

"...Just to get out of the ward, get out of the hospital. Not that they didn't do the good things, they done everything marvelous for me. No, it's just a lot of a relief 'cause there's nothing like your home." (Bill)

'Life will never be what it was before'

This theme has two sub-themes that relate to the different views held by clients in the two stages of data collection. The first sub-theme is entitled 'Life is Going to be Different', which refers to clients' expectations regarding their return home. 'Finding New Ways' is the second sub-theme and it represents how, upon return home, clients were finding different ways to complete activities.

'Life is Going to be Different'

During discharge interviews, over half of the clients reported being aware that life would be different upon return home. The way clients seemed to process these differences varied, with some focusing on how they would re-enter their lives with statements such as "*As long as I think about what I am doing before I tackle it, it is normally OK*" (Juliette), and others expressing a sense of loss and frustration related to a perceived reduction in meaningful roles

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and independence, as Amanda indicated when she said “...*in the short term I will need a great deal of help. This is very difficult to accept when I have been a strong, capable and independent person.*” Clients’ interpretations of how their life would change upon return home were affected further by the impact they believed their presence would have on their family and family dynamics, with Bill stating,

“I just don’t know whether we are going to be able to cope with it first up. Because I’ve just got to stand back and let my wife do it. Can you get that in there...you can get up and walk to it...yeah but I just need you to come with me love just in case I fall. Little things like that would start to get on my nerves after a couple of weeks at home...she will be getting sick of it too...”

Although negative feelings were associated with the expected loss of roles and changes in clients’ lives, many had started to think of alternative ways of completing activities in order to allow them to continue to participate actively in their lives, suggesting that they would employ services and use adaptive strategies.

‘Finding New Ways’

In this subtheme clients expanded on their experiences of home life, four to six weeks post-discharge from hospital. It highlights how clients experienced the anticipated changes and the unexpected differences in their life upon return home. Two groups emerged during analysis in relation to this. The first of these groups contained four clients who had an optimistic outlook on their lives and the second was comprised of three clients who were less engaged with their lives.

Those who remained positive described how they were trying new things, participating in outpatient therapy and were discovering ways of completing meaningful activities. These clients were also taking control of services in order to ensure they were being provided in a way that suited them, with Amanda stating,

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“...They said they came from 7 in morning until 1 or 2 in afternoon. I said I’m not sitting around until lunch time waiting for my shower...So I arranged. I asked them if I could be earlier in the day so they pretty much come 7.30/8.00 at the latest.”

Clients in this group also indicated that even though they were appreciative of services they were looking forward to not receiving them, with Harry stating *“No, it’s something you’ve got to go through, it’s part of the deal...I just want to be left alone..”*

While clients demonstrated increased confidence through their desire to cease services, some unexpected problems did arise upon their return. Within the home, these difficulties seemed to occur in small indiscriminate activities such as jar opening and hair tying. In the community, clients expressed that poorly designed community facilities and limited transportation options were barriers to their participation. A more unanticipated difficulty; however, was the emotional challenges that clients experienced as a result of others’ behaviours. This was particularly evident within Juliette’s interview,

“That’s the thing. Like we went to [son’s] soccer game the other week and you walk through and it’s like walking through the red sea. They are just like get out of the way of the lady with the walking stick [upset and crying].”

This change in the behaviour of others towards clients was reported to be mostly from strangers; however, there were instances of families and friends acting differently. Clients reported that their families sometimes restricted their movements and activities within the home, with Penny referring to this behaviour as *‘point duty’*, expressing a feeling of being watched all the time. Bill described a comparable feeling in regards to his wife’s behaviour towards him, stating, *“[Wife’s name] don’t let me do much. I’m limited because of me [sic] walking; she doesn’t want to see me fall down again.”* Clients also described that close friends generally treated them the same, although some friends had become overly helpful in social situations, with Jack

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stating, “...*They couldn't do enough for me. They were running around. How do they treat me? They treat me as if I need help.*”

Whilst four clients demonstrated an eagerness for re-engaging with their lives and taking control, there were three clients who expressed a sense of grief in regards to their new lives. Bill portrayed this when he discussed how he occupied his time since returning home,

“Sitting here, or sitting out there on the veranda, or going for a ride in the car over to [shopping centre]; something like that. I just sit there, fairly quiet, very quiet. Very sad, very sad.”

Ivy, who was now living with her daughter, also insinuated a sense of sorrow throughout her discharge interviews where she described limited engagement and seemed to mourn not being in her own home. These clients were less likely to describe the benefits of STRENGTH and reported experiencing a much more sedentary lifestyle, reduced socialization, increased dependence on others for basic self-cares, and reduced participation in meaningful activities.

DISCUSSION

The purpose of this study was to determine the impact of STRENGTH on the transition home from stroke rehabilitation. Interview transcripts from seven clients were analysed producing two key findings. The first of these was that therapy in both environments was beneficial and the second was that STRENGTH helped to give realistic expectations and appeared to improve the transition from hospital to home experience for people with stroke. This discussion will explore in detail the major points that were highlighted from these findings.

One of the pertinent outcomes of this study was that clients valued therapy equally in both the hospital and home environments, with each holding a distinct role in their recovery. Clients considered the therapy in the hospital to be beneficial as it allowed them to see positive outcomes in relation to their physical, cognitive and communication abilities. This

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confirms findings from previous studies, which have identified the significance that clients associate with physical training in their recovery [16,33]. On the other hand, in contrast from previous studies that have identified the experiences of people with stroke that did not receive therapy in the home [16,33], clients expressed that the therapy in the home allowed them to; become aware of their bodily limitations, improve their self-awareness, adapt to their changed life and have increased confidence [34]. Compared with the findings from the preliminary study [16], this study suggests that STRENGTH may have promoted adaptation, which can be inhibited when clients have limited opportunities to practise meaningful activities and to test their abilities before returning home. Within both of these environments, however, clients indicated that they did not always understand the reasoning behind certain interventions, indicating that therapists should pay close attention to their explanations of therapeutic activities.

While both therapy environments were highlighted as being important to clients' recoveries, a significant limitation was identified in relation to the therapy received in the hospital. This limitation was in relation to the impact that the routines and false environment of the hospital had on rehabilitation experiences. Clients discussed how therapy was the main focus of their day and hospital routines limited their capacity to participate in daily activities outside of therapy. This lack of flexibility in hospital daily routines has previously been described by people with stroke who have highlighted that a decrease in independence is experienced in this environment, with control often being given over to health professionals [8,16,35]. In order to combat this, it is suggested that hospital staff further develop opportunities to encourage clients to participate in activities of daily living outside the context of therapy [16]. Within this program, STRENGTH appeared to encourage engagement in these activities and enabled them to be conducted in a more realistic and meaningful environment.

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The expectations clients held prior to discharge were generally met, thereby supporting the concept that STRENGTH enables clients to develop realistic expectations. This contrasts with results of previous studies, which have identified that the transition to home is a time of major adjustments and unmet expectations [33]. With more realistic expectations, clients in this study were able to plan for their return home before leaving hospital, with many discussing the adaptive strategies and services they were going to incorporate into their lives. Following discharge, clients discussed the ways in which they were employing these adaptive techniques and taking control of services. This also appears to contradict the findings of earlier studies, where people with stroke have spoken minimally about their plans to participate in daily life, highlighted the challenges that they have experienced in completing simple domestic and personal activities upon return home, and discussed the demands associated with planning and completing tasks in the home environment [6,16].

Whilst clients' experiences of returning home were predominantly positive, there was one particular difficulty that was regularly discussed by clients. This difficulty was in relation to emotions that were conjured within clients when faced by the altered manner in which people treated them outside of their home. For this reason, the psychological impact of transition for stroke survivors should be taken into consideration in future versions of STRENGTH. The addition of a psychological component to the program could be a possible means to address this and should be explored further.

Similarly, although STRENGTH appeared to better prepare clients, there were some who seemed to have reduced participation levels after returning home. These were the same clients that had difficulty in grasping the concept of STRENGTH and two out of three of these clients appeared to have protective family members that restricted their participation in daily activities, decreasing their independence. Previous research has shown that protective

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family members have a tendency to limit the opportunities available for people with stroke to complete activities by themselves [14]. Due to this, it may be appropriate for further studies to provide better education to family members about the person's need for independence.

Limitations and Future Recommendations

There were two main limitations identified in regards to how this study was conducted. The first of these related to the small sample size and the second of the study's limitations derives from the fact that it was undertaken in one location, affecting the transferability of results to different hospitals or healthcare environments. Collection of data from a relatively heterogeneous population and the use of member checking and consensus coding by the research team were seen to be strengths of this study. Future studies should aim to implement STRENGTH on a wider scale, incorporating people with various stroke severities.

Furthermore, it would be beneficial to compare the program with alternate and existing interventions to solidify its value in preparing patients with stroke for discharge. Finally, it was identified that a psychological intervention should be incorporated into programs, such as STRENGTH, in order to better prepare people for the possible emotional adjustments that present themselves during the transition home.

Conclusion

The clients in this study highlighted the benefits of the therapy they received in both the hospital and home environments, and also detailed the limitations that exist in each of these environments. The ability of the STRENGTH program to be conducted in the meaningful location of the home was valued by clients, and this environment was identified as being more realistic than the artificial hospital environment. As a result of this, clients were able to gain insight into the practicalities of returning home, aiding them to formulate realistic expectations. In addition to these expectations, clients discussed the ways that they were able to prepare for their transition home. Overall, the findings suggest that an in-patient home-

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based rehabilitation program, such as STRENGTH, can be helpful in preparing people with stroke for discharge and improving their transition home.

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Declaration of Interest Statement

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