Navigating The Integrated Stroke Care Journey: Patient and Caregiver Perspectives

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DR. SUE BOOKEY-BASSETT; DR. SHERRY ESPIN; DR. KRIS ERICKSON; SALLY GOLBERG POWELL; DAVID ARROMBA; DANIELLE MOED; SUKHANJIT KAUR; AND SANTIAGO SANZ

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INTRODUCTION

DR. SUE BOOKEY-BASSETT; DR. SHERRY ESPIN; AND SUKHANJIT KAUR

Introduction

This project takes a step towards educating future health-care professionals about providing equitable, integrated, and interprofessional care for people with stroke who are transitioning out of the hospital and into the community.

This experiential learning activity contains an interactive journey map that depicts the experiences of people living with stroke, caregivers, and healthcare staff through three phases of the healthcare continuum:

1. Acute Inpatient Hospital Care
2. Community Rehabilitation
3. Transition and Community Reintegration

Video narratives of patients and caregivers illustrate their experiences across each phase of care, helping learners understand and reflect on the nuanced, complex, and diverse realities within the current healthcare system. The narratives that are shared highlight the value of an equitable, integrated, interprofessional approach to community-based stroke care. The activity also incorporates valuable insights gained through focus groups with interprofessional stroke team members, and integrates case studies into each phase to support students in critically analyzing the evolving needs of the characters throughout the care continuum.

Learning Outcomes

DR. SUE BOOKEY-BASSETT AND DR. SHERRY ESPIN

By the end of this session, students will be able to:

1. Define and apply the concept and models of interprofessional integrated stroke care in Ontario.
2. Critically analyze the facilitators and challenges in accessing equitable, diverse and inclusive stroke care related to several vulnerable populations.
3. Describe the impact of the social determinants of health on individuals living with stroke and access to care.
4. Identify how this experiential learning opportunity impacts students' perspectives and understanding of patient and family experiences of stroke and how it will influence their future practice.

Student Preparation

DR. SUE BOOKEY-BASSETT; DR. SHERRY ESPIN; AND SUKHANJIT KAUR

Students will be provided with the required readings, learning objectives and case studies prior to class to familiarize them with the core concepts that will be explored through this activity. The experiential learning activity will be facilitated by faculty members in class.

Pre-class Preparatory Readings

To prepare students prior to the in-class portion, the students will be expected to complete the following pre-readings and reflect on the learning objectives provided in the previous section:

Required Readings:

Camicia, M., Lutz, B., Summers, D., Klassman, L. & Vaughan, S. (2021). Nursing's Role in Successful Stroke Care Transitions Across the Continuum: From Acute Care into the Community. *Stroke*, *52*(12), e794-e805.https://doi.org/10.1161/STROKEAHA.121.033938

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University of Central Lancashire. (2022, February 22). Stroke Specific Education Framework: 16 Elements of Care. National Health Services in England. https://stroke-education.org.uk/framework/

Recommended Readings:

Heart and Stroke Foundation of Canada. (2019). *Following Stroke Canadian Stroke Best Practice Recommendations Rehabilitation, Recovery and Community Participation Following Stroke Part Two: Transitions and Community Participation Following Stroke*. https://www.strokebestpractices.ca/recommendations/managing-stroke-transitions-of-care

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Theoretical Perspectives and Competencies

DR. SUE BOOKEY-BASSETT; DR. SHERRY ESPIN; AND SUKHANJIT KAUR

Theoretical Perspectives and Competencies

This work is influenced by several theoretical perspectives and frameworks that support the need for education about integrated interprofessional stroke care in a community setting. Please refer to Appendix A for detailed information on the theoretical perspectives and competencies that were considered. These include:

Integrated Stroke Care

Integrated care brings together components of design and delivery of care that are fragmented, and integrates those parts together to form a whole that optimizes care provision (Goodwin, 2016). Services, providers, and organizations from across care settings and sectors come together to work jointly, complement each other, and act in coordination with each other to ensure a seamless, unified system with continuity (Markle-Reid et al., 2020). During the acute phase of stroke care, patients are admitted to a stroke unit where an interprofessional stroke team assists with initiating early rehabilitation for patients (Toronto Stroke Networks, 2023). This team may consist of physicians, nurses, occupational therapists, pharmacists, clinical nutritionists, social workers, physiotherapists, and speech-language pathologists (Toronto Stroke Networks, 2023).

Once patients are ready to transition out of acute care hospital settings, evidence supports the need for ongoing integrated interprofessional stroke-specific care in the community. A 2023 randomized controlled trial conducted by Markle-Reid et al. in Canada found that patients who received integrated interprofessional care in the community setting for 6 months had significantly greater gains in self-reported physical functioning, stroke self-management, and patient experience.

Stroke Care Transitions

When transitioning patients out of the acute care phase of their journey, there is a need for safe transfer of patient information and care needs to prevent a breakdown in care processes (Registered Nurses Association of Ontario, 2023). This is essential to ensure a seamless integration of care across facilities (acute and community care facilities) and interprofessional teams, as it facilitates coordination within teams (Markle-Reid et al., 2020).

The Heart and Stroke Foundation's 2019 Canadian Stroke Best Practice Recommendations for Rehabilitation, Recovery and Community Participation

The Canadian stroke best practice recommendations for rehabilitation, recovery, and community participation, provided by the Heart and Stroke Foundation (2019), support the need for and stress the importance of integrated and coordinated care across the healthcare system. This guideline was published with the goal of optimizing stroke care

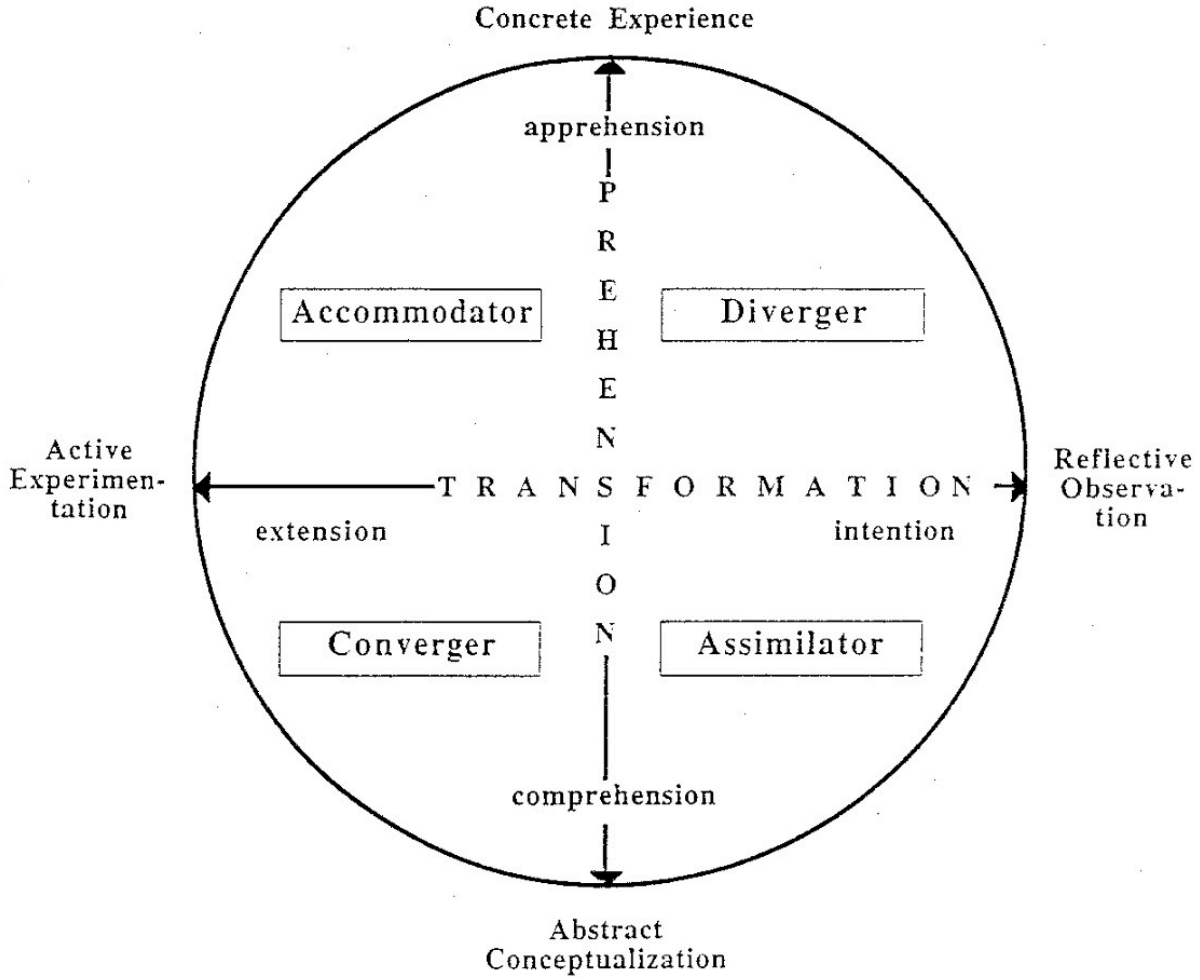
across Canada, reducing variations in how care is received by stroke patients, and closing the gap between research and practice (Heart and Stroke Foundation, 2019).

Kolb's Experiential Learning

Kolb's (1984) theory of experiential learning guided the design and delivery of this learning activity. The theory posits that education is experiential and that learning occurs through the reconstruction and critical reflection of experiences (Kreber, 2001). Learners begin by engaging with a concrete experience through direct, sensory, and intuitive interaction (Kreber, 2001). Then, they thoughtfully observe and reflect on their experience, leading to the creation of an abstract conceptualization of it through analytical or symbolic understanding (Kreber, 2001). And finally, they actively experiment with the new information through practical application (Kreber, 2001). These four processes form the four stages of the learning cycle (Kreber, 2001).

Figure 1

Kolb's (1984) Model of Experiential Learning



Note. *From "Experiential Learning: Experience as the Source of Learning and Development," by D. A. Kolb, 1984, Prentice-Hall. © 1984 by Prentice-Hall. Used under fair dealing for the purpose of education.*

The World Health Organization Rehabilitation Competency Framework (2021)

The World Health Organization's (2021) rehabilitation competency framework provides competencies for all rehabilitation workers in the domains of practice, professionalism, learning and development, management and leadership, and research. This competency framework guides both rehabilitation workers' approach to practice and their daily practice activities. It addresses important concepts such as patient-centered care, collaboration, effective communication, and working effectively within a team approach to service delivery (World Health Organization, 2021).

Figure 2

Description of the Five Domains of the RCF

Note. *From "Rehabilitation Competency Framework" (p. 4), by World Health Organization, 2020. © 2020 by World Health Organization. Used under fair dealing for the purpose of education.*

Competency Framework for High-Quality Workforce Development in Integrated Care (2024)

This competency framework for high-quality workforce Development in Integrated Care, developed by Barraclough et al. in 2024, guides the development of this project. This framework provides the necessary competencies for the provision of training in integrated care in the following areas:

1. Person-centered care
2. Interprofessional teamwork and collaborative practice
3. Care coordination
4. Digital skill and technology
5. Health promotion and disease prevention
6. Population health approach to care

7. Leadership
8. Professional and ethical attributes

The Stroke Specific Education Framework by the University of Central Lancashire and the National Health Service in England (2022).

The framework for stroke specific education created by the University of Central Lancashire and the National Health Service of England (2022) outlines the knowledge and skills required of healthcare professionals working with patients with stroke. This framework comprises of 16 elements of care and 4 elements of professional practice. For the purposes of this learning experience, please refer to:

- Element 10: Specialist Rehabilitation
- Element 12: Seamless transfer of care
- Element 13: Long-term care
- Element 14: Review
- Element 15: Participation in community
- Element 16: Return to work
- Element 17: Professional behaviour and values
- Element 19: Education, training, and personal development

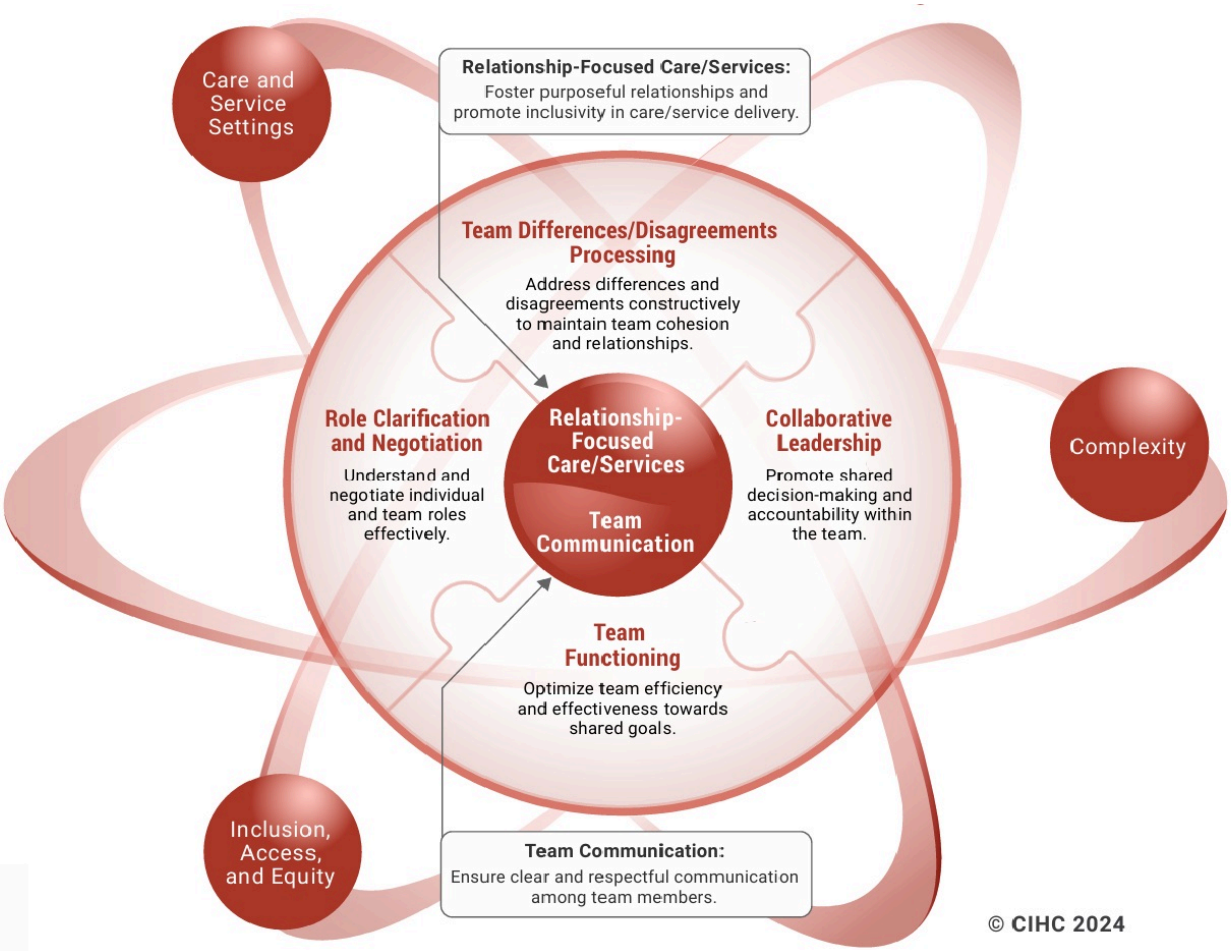
The Canadian Interprofessional Health Collaborative Competency Framework for Advancing Collaboration (2024)

The Canadian Interprofessional Health Collaborative (CIHC) Framework (2024) guides educators, researchers, health administrators, service providers, and persons receiving care in fostering effective collaborative practice. The framework focuses on supporting the application of knowledge, skills, attitudes, and values in real-world environments to guide behaviours that enhance collaboration. The framework has six competency domains which are interdependent.

The overarching goal of this framework is to improve healthcare and human services by promoting collaborative, relationship-focused partnerships for shared decision-making.

Figure 3

Description of the Five Domains of the RCF



Note. *From "Canadian Interprofessional Health Collaborative Competency Framework for Advancing Collaboration" (p. 5), by Canadian Interprofessional Health Collaborative, 2024. © 2024 by Canadian Interprofessional Health Collaborative. Used under fair dealing for the purpose of education.*

Facilitator guide

DR. SUE BOOKEY-BASSETT; DR. SHERRY ESPIN; DR. KRIS ERICKSON; DAVID ARROMBA; SALLY GOLBERG POWELL; SUKHANJIT KAUR; AND SANTIAGO SANZ

This experiential learning activity is intended to be facilitator-led. Facilitators will be provided with a detailed guide in advance that contains the following information to assist them in leading the activity:

- Theoretical underpinnings and competency frameworks
- Required and recommended readings for instructors
- Required and recommended readings for students
- Step-by-step instructions on how to lead learners through the interactive stroke journey map in a synchronous class format
- Key points to highlight through each phase of the journey map
- Questions and prompts to spark critical reflections and discussions.
- A sample lesson plan that can be adapted for the format of each class.
- A sample feedback form, which can also be adapted as needed. A formal assessment will also take place in relation to this activity, as appropriate, in consultation with instructors.

Access the facilitator guide here: Facilitator Guide – October 23rd, 2025

EXPERIENTIAL LEARNING ACTIVITY: THE INTERACTIVE STROKE JOURNEY MAP

Prebrief

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Following the International Nursing Association of Clinical Simulation and Learning (INACSL) best practices for pre-briefing (McDermott et al., 2021), facilitators should:

- Orient learners to the experiential learning activity and introduce technology and processes
- Establish a psychologically safe learning environment
- Review the learning objectives to be addressed through the activity and the expectations of learners

Briefing

This experiential learning activity is intended for synchronous delivery in-class or online and is faculty-facilitated. The facilitator can refer to the sample learning plan provided in the facilitator guide and adapt the lesson plan according to the format of their class. For a 100-minute session, it is recommended that facilitators allocate:

- 5-10 minutes to grab the learner's attention and introduce the lesson and its importance
- 3-5 minutes to outline the learning outcomes
- 5-10 minutes for a pre-assessment of learners' baseline knowledge of integrated interprofessional stroke care
- 45-50 minutes for the guided walkthrough of the interactive journey map with pauses to discuss key points
- 5-10 minutes for a follow-up post-assessment
- 10-15 minutes for a recap and summary, as well as completion of a student feedback form.

Interactive Stroke Journey Map

DR. SUE BOOKEY-BASSETT; DR. SHERRY ESPIN; DR. KRIS ERICKSON; SALLY GOLBERG POWELL; SANTIAGO SANZ; AND SUKHANJIT KAUR

Please refer to the facilitator guide on step-by-step instructions on how to interact with the hotspots in this activity.

An interactive H5P element has been excluded from this version of the text. You can view it online here: https://pressbooks.library.torontomu.ca/integratedstrokejourney/?p=66#h5p-1

Debrief

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Debrief for Students with Different backgrounds

New Students

- What do you notice as key similarities and differences between the communities you have been learning about and those represented in these examples?

Current Practitioners

- Consider the communities within which you currently work. What do you notice as key similarities and differences from the examples and cases represented here?
- What do you notice as key similarities and differences between the three phases represented here and your clinical experience?
- What similarities and differences do you notice during transitions?

For All Learners

- The categories of "patient," "caregiver," and "staff" clearly represent a wide variety of community members and professionals, as well as a range of lived experiences. Identify one experience or moment from each of their stories that, if you were to encounter it, you feel well-equipped, personally and professionally, to address, and briefly describe how you would do so.

- Consider one experience from each that you currently feel poorly-equipped to address, and identify services or supports (either from within the community, across the region, or that are available elsewhere) that you feel would be most helpful.

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DR. SUE BOOKEY-BASSETT; DR. SHERRY ESPIN; AND SUKHANJIT KAUR

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Appendix

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Theoretical Underpinnings and Competency Frameworks

The Competency Framework for High-Quality Workforce Development in Integrated Care by Barraclough et al. (2024)

This framework presents competencies to guide education facilities, workplaces, and accreditation in creating a trained workforce in integrated care.

Table 1.

Competency Framework for High-Quality Workforce Development in Integrated Care (2024).

Competencies	Team members should be able to...
Person-centered care: teams place individuals and their support networks at the center of care planning and delivery.	• Promote shared identification of strengths and have a comprehensive understanding of the individuals' needs. • Increase individuals' and caregivers' knowledge, skills and confidence in navigating the health and social care system. • Empower individuals to participate in their own care. • Actively involve and support caregivers and respond to signs of caregiver distress.
Interprofessional teamwork and collaborative practice: *team members work effectively across multiple disciplines*, care settings, and services to provide high-quality, coordinated care.	• Work effectively in teams across disciplines and settings. • Collaborate with service providers within the acute, primary, and informal care sectors. • Share information and data across teams, service providers, and individuals and their families. • Demonstrate well-developed negotiation skills.
Care coordination: team members organize and integrate care across multiple services.	• Adopt a care coordinator role and emphasize effective communication. • Demonstrate the ability to effectively coordinate care within a complex system. • Demonstrate knowledge of local and national policies and programs, and communicate them to others. • Identify and collaborate with a range of professionals.
Digital skills and technology: team members should have digital literacy and technological proficiency.	• Engage patients and families through technology-based communication tools. • Use a range of technology. • Utilize linked datasets and population health management tools to analyze data and identify trends to inform and evaluate integrated care. • Using shared electronic patient records to enhance communication and collaboration.
Health promotion and disease prevention: team members empower individuals, families and communities to make informed decisions that support overall wellbeing.	• Facilitate behaviour change among individuals, families, and communities to promote health, resilience, wellbeing, and disease prevention. • Obtain an integrative and comprehensive history. • Have knowledge of community resources and preventative programs. • Provide education on self-care strategies and resources, and incorporate them into all care plans.
Population health approach to care: team members use a population health approach to improve community health.	• Identify and address community needs by understanding available resources, population data, and gaps in healthcare delivery. • Demonstrate knowledge of population health strategies and programs. • Understand how to navigate the system. • Identify and refer vulnerable populations and those experiencing health inequalities to appropriate support programs. • Understand the social determinants of health and their impact on population health.

***Leadership*:** team members guide change, promote collaboration, and create environments that support person-centered, system-wide improvements.	• Develop as leaders and role models to advocate for and support the implementation of integrated care. • Demonstrate leadership in person-centred and collaborative practice. • Implement shared governance across multiple stakeholders and sectors. • Work with service providers and people with lived experience and use research methods to drive change and improve services.
***Professional and ethical attributes*:** team members model integrity and ethical behaviour with a commitment to self-awareness, continuous growth, and inclusive, compassionate practice	• Demonstrate the following professional and ethical practitioner attributes: ◦ Practicing and integrating self-care strategies ◦ Engaging in continuous learning, supervision and maintaining evidence-informed practice ◦ Becoming mentors, teachers and peer learners ◦ Showing empathy and emotional intelligence ◦ Practicing reflective thinking and learning ◦ Demonstrating competencies in working with differences (cultural, social and neurodiversity).

The World Health Organization Rehabilitation Competency Framework (2021)

The World Health Organization (WHO) created a competency framework for rehabilitation in 2021 for all rehabilitation workers, comprised of five overarching domains. These domains include practice, professionalism, learning and development, management and leadership, and research. The framework also contains the associated activities for each competency. Please refer to the competency framework document for the different levels of mastery of each competency or activity, along with the core knowledge for each competency.

Table 2.

Key takeaways from the World Health Organization Rehabilitation Competency Framework (2021).

Domain	Competencies – The worker:	Activities – Activities include:
Practice	• Places the person and their family at the center of practice. • Establishes a collaborative relationship with the person and their family. • Communicates effectively with the person, their family, and their health-care team. • Adopts a rigorous approach to problem-solving and decision-making. • Works within their scope of practice and competence.	• Obtaining informed consent for rehabilitation • Documenting information • Conducting rehabilitation assessments • Developing and adapting rehabilitation plans • Referring to other providers • Implementing rehabilitation interventions • Evaluating progress towards desired outcomes • Discharging and ensuring appropriate continuity of care
Professionalism	• Demonstrates ethical conduct • Maintains professionalism • Works collaboratively • Manages professional responsibilities	• Managing risks and hazards • Undertaking quality improvement initiatives • Participating in team forums • Advising on rehabilitation
Learning and Development	• Continues to learn and develop • Supports the learning and development of others • Works to strengthen rehabilitation education and training	• Managing own professional development • Supervising and teaching others
Management and Leadership	• Works to enhance the performance of the rehabilitation team • Works to enhance the performance of rehabilitation service delivery • Acts as a rehabilitation advocate	• Managing a rehabilitation team • Managing rehabilitation service delivery • Monitoring and evaluating rehabilitation service delivery
Research	• Integrates evidence in practice • Works to strengthen evidence for rehabilitation	• Designing and implementing research • Disseminating evidence • Strengthening rehabilitation research capacity

The Stroke Specific Education Framework by the University of Central Lancashire and the National Health Service in England (2022).

The framework for stroke-specific education, created by the University of Central Lancashire and the National Health Service of England (2022), outlines the knowledge and skills required by those caring for people with stroke or affected by stroke. This framework comprises 16 elements of care and 4 elements of professional practice.

For the purposes of this learning experience, please refer to “Element 10: Specialist rehabilitation”, “Element 12: Seamless transfer of care”, “Element 13: Long term care”, “Element 14: Review”, “Element 15: Participation in community”, “Element 16: Return to work”, “Element 17: Professional behaviour and values”, “Element 18: Leadership, management, and governance”, and “Element 19: Education, training, and personal development”. Please visit the website for the framework for more in-depth information under each element.

Table 3.

Key takeaways from the Stroke Specific Education Framework (2022).

Element	Required knowledge	Required skills
Element 10: Specialist Rehabilitation Stroke survivors access rehabilitation services, and survivors and their caregivers require high-quality, stroke-skilled services as soon as possible in all 3 phases, including within the hospital, immediately following transfer, and for as long as required thereafter.	• The range of potential impacts of stroke on individuals and their families, including psychological, social, physiological, sensory, neurological and neuropsychological effects • The cause of, interactions between, assessment of, management of, and treatment of the above impacts. • Principles and techniques of multidisciplinary stroke assessment and rehabilitation • Screening measures • Safe moving, handling and positioning • Ways to facilitate communication • Health promotion approaches • Ways to enable those affected by stroke to take an active role in recovery • Pharmacological and non-pharmacological interventions and secondary prevention • Full range of resources • Equipment and technology • Implications of stroke on lifestyle • Transfer/discharge process, long-term management and rehabilitation	• Collect and interpret a thorough me • Recognize the signs and symptoms r • Determine, plan and initiate the app interventions and treatments ◦ Use a range of communication r • Provide a psychologically-informed, and intervention • Use safe moving, handling and posit • Provide a range of stroke-specialist rationale for the chosen technique • Assist in the management and devel patient-centered. • Assist, encourage, and facilitate pos reintegration • Identify and refer to appropriate res • Identify the need and when to refer
Element 12: Seamless transfer of care A workable, clear, and patient- and caregiver-centered discharge plan is developed by the multidisciplinary team with other services such as transport and housing.	• Assessment and management of the effects of stroke to identify care and ongoing rehabilitation needs • Implications of stroke for lifestyle, driving, occupation, including voluntary work or education, and social participation • The range of local and national resources and services for stroke survivors, especially for: ◦ Transfer ◦ Short and long-term needs assessment ◦ Packages of care ◦ Continued rehabilitation and psychological care ◦ Finance and personal budgets ◦ Respite care • Principles of good discharge planning for transition between services, cessation of services, and for transfer of care to the community, including education for those impacted by stroke • Principles of multi-agency working	• Determine, plan, and initiate approp assessments, to determine care and risk • Assess, discuss, and review goals, ou • Identify the need for and when to re • Identify resources and services to o efficient discharge for those affecte

Element 13: Long-term care A range of services are in place and easily accessible to support the individual long-term needs of those affected by stroke.	• The assessment and management of the effects of stroke to inform long-term care • The impacts of stroke on survivors and their caregivers, and assessment methods • Implications of stroke on lifestyle, driving, occupation, and social participation • Risk factors for further vascular events • Pharmacological and non-pharmacological interventions for secondary stroke prevention and to promote recovery after stroke, and their potential adverse effects • Resources and services relating to long-term care, housing, transport, adjustments, and supporting independent living when possible • Communication methods • Assessments of medication adherence, factors that impact it and how to motivate and facilitate engagement	• Recognize stroke-related communic methods. • Discuss current events, risk of futur assessments, rationale for intervent possible side effects • provide timely information, advice a • Monitor progress and modify plan o • Assess, discuss and review goal-sett stroke • Identify resources and services to su services; work across agencies; shar arrangements. • Assess post-stroke apathy and readi change • Deliver and evaluate self-manageme
Element 14: Review The primary care service offers those affected by stroke a review of their health and social care status, as well as their secondary prevention needs.	• The assessment and management of the effects of stroke • Ways to assess and meet the needs of those affected by stroke • Available resources and services • Implications of stroke on lifestyle • Risk of further vascular events • Pharmacological and non-pharmacological interventions for secondary prevention and to promote recovery, and their potential adverse effects • The methods, resources, and approaches available to facilitate communication • Medication adherence, factors that impact it and how to motivate and facilitate engagement	• Take and interpret a thorough medi out decision-specific mental capacit • Recognize stroke-related communic methods. • Discuss the current event, risk of fu treatments, timeframes, and possibl • provide timely information, advice a • Monitor progress and modify plan o • Assess, discuss and review goal-sett stroke • Assess medication adherence and fa • Plan appropriate assessments and tr • Identify the need for additional/spe • Evaluate the review process and act

Element 15: Participation in community Those affected by stroke are enabled to live a full life in the community.	• The assessment and management of the effects of stroke and their impact on community participation • Local and national resources/services for those with stroke, especially those relating to community participation • The need for and method of assessment of those impacted by stroke • Implication of stroke for lifestyle • The methods, resources and approaches available to facilitate communication with those affected by stroke	• Assess, discuss and review goal-sett • Monitor progress on and modify the • Plan appropriate assessments and tr • Identify the need for and when to re treatments • Identify the full range of local and na and inclusion
Element 16: Return to work Those affected by stroke are enabled to participate in paid, supported, and voluntary employment.	• The effects of stroke and how they may affect return to work or education • How to assess and manage the impact of stroke • Legislation on employment, discrimination and health and safety at work • The role of healthcare professionals in vocational rehabilitation • The resources and services available to those affected by stroke • The meaning of "reasonable adjustment" in the workplace, how to adapt to the work environment, and the employer's responsibility • Available technology to assist with functional and activity limitations • Ergonomic principles • Accessibility issues and solutions • The relationship between meaningful engagement in occupation and health and well-being • Benefits in relation to occupation, including voluntary work and education • Workplace assessment, including risk, job analysis, return to work planning and job retention • Models of vocational rehabilitation and vocational case management • Vocational rehabilitation guidelines and standards	• Refer to a vocational rehabilitation s • Identify resources and services avail for those affected by stroke, liaise, a • Assess for, advise on, and review the technology and environmental adap limitations. • Create a personalized plan for retur • Advise employers, colleagues and ed negotiate a plan of return to work/e • Recognize the need for benefits, adv • Conduct or refer for a workplace ass • Set goals for return to or retention o • Case manage or refer for case mana • Implement vocational rehabilitation

Element 17: Professional Behaviour and Values Staff understand how to conduct themselves professionally at all times, in accordance with working guidelines, communicate effectively, and work collaboratively.	• Abilities and developmental needs to deliver evidence-based care • Barriers to effective professional communication and different communication strategies and tools to improve communication. • The code of professional conduct • Policies that guide professional practice, service improvement and research • Person-centered and values-based care • Methods of implementing behaviour change interventions • Evidence-based practice and the roles of applied health and social care • The roles of and interplay between multi-disciplinary team members and the wider team • working in partnership with individuals, families, caregivers, and stakeholders • factors contributing to workplace stress and ways to promote mental health and wellbeing, emotional intelligence, and improved resilience • the principles of time management and workload planning	• Demonstrate self-reflection and ide • Articulate opinions in a clear, eviden complex information effectively • Practice according to the code of co • Practice person-centered and value and care planning. • Exercise professional expertise and complexity management within the • Use evidence in practice. • Act as a role model • Demonstrate understanding of resp limitations of own competence and • Build professional working relations the multi-disciplinary team. • Identify when there is a requiremen advice is required, and when to esca • Demonstrate digital literacy
Element 19: Education, training, and personal development Staff understand the importance of lifelong learning for the individual, the team, and their patients, and continually take opportunities to engage in and encourage education.	• Importance of continued development • The role of critical self-reflection in personal development and regular assessments of learning needs • How to create an effective learning environment • Theories underpinning clinical education and mentorship • The theory of evidence-based practice and the role of research-informed teaching • Assessment and evaluation methods • Knowledge mobilization and capacity building	• Show a positive attitude to practice, • Undertake a personal learning need self-reflection, set goals and develo • Contribute to and promote the prof • Teach others • Devise and deliver research-informe • Promote learning and create a supp • Provide constructive, informative, a

Kolb's Theory of Experiential Learning

Kolb's (1984) theory of experiential learning builds on the ideas of John Dewey (1938), who posits that education is grounded in experience and that learning occurs through the reconstruction of and critical reflection on those

experiences (Kreber, 2001). Kolb's (1984) theory argues that knowledge is created through the transformation of experience and that learning is experiential only when an experience is transformed into knowledge (Kreber, 2001). For experiential learning to occur, students must be directly involved in it (Kolb, 1984; Kreber, 2001). This engagement can occur through action or reflection, which allows the transformation of knowledge to occur (Kreber, 2001). Figure 1 shows Kolb's 1984 (as represented in Kreber, 2001) model of experiential learning, which contains two dimensions:

- Prehension of experience – this dimension explains how students grasp experiences through either apprehension (felt qualities; includes intuitive, creative and tacit knowledge) or comprehension (conceptual interpretation and symbolic representation).
    - Concrete experience – this is a direct, sensory and intuitive engagement with the learning experience and is related to apprehension
    - Abstract conceptualization – this is the analytical or symbolic understanding of material related to comprehension
- Transformation of experience – this dimension explains how experiences are processed and how learning occurs. Learning occurs when an experience is transformed through internal reflection on the learning event or actively manipulating the outside world.
    - Reflective observation – related to internal reflection and is achieved through thoughtful review.
    - Active experimentation – related to active manipulation of the outside world or practical application.

These dimensions combine into a four-stage learning cycle

- Concrete experience – an encounter with the new experience or situation
- Reflective observation – thoughtful observation and reflection on the experience
- Abstract conceptualization – forming theories or models based on reflection
- Active experimentation – testing new theories through actions

Types of knowledge resulting from the intersection of the two dimensions:

- Divergent knowledge: a result of apprehension and reflective observation.
- Assimilative knowledge: a result of comprehension and reflective observation.
- Accommodative knowledge: a result of apprehension and active experimentation.
- Convergent knowledge: a result of comprehension and active experimentation.

Meaningful learning occurs when learners work through all four phases of the learning cycle.

In this activity, the journey map represents the abstract conceptualization and is meant to help contextualize the concrete experience students may not have had yet, as well as support reflective observation on experiences of patient and caregiver journeys they might have gained in other contexts of their studies or even lived experiences beyond school (Kreber, 2001). One important consideration the developers want to point out is that the linear abstraction of phases of care could be seen as both a valuable way of approaching designing and delivering services and supports, but also as potentially harmful in the ways they might permit lapses in service and support between transition points, that is, without intentional and supportive service integration considered from the outset. During this activity, students will be provided with information through narrative vignettes, written information from focus groups with experts, and case studies, which help provide context for the experiences that students will engage with in the future (Kreber, 2001). Students will process information on an emotional and intuitive level, and information will take hold based on how it feels to them (Kreber, 2001).

These narratives are organized into a journey map comprising three commonly experienced phases of the stroke

journey, and include points of transition between phases (Kreber, 2001). The instructors will facilitate the progression through this journey map. They will ask questions to help students distinguish key concepts within and between the narratives and phases. This enables symbolic and analytical comprehension of concepts, thereby facilitating abstract conceptualization (Kreber, 2001).

To help students transform knowledge and for learning to occur, facilitators will pose critical reflective questions throughout the different stages of the activity to promote reflective observation, internal reflection and thoughtful review (Kreber, 2001). These questions will ask students to think creatively about how to solve the problems posed. Students will then be asked to relate the knowledge they have gained to previous experiences and to hypothetical situations through the debriefing activities and the final evaluation activity. This will facilitate active experimentation with newly acquired knowledge (Kreber, 2001).

The Canadian Interprofessional Health Collaborative Competency Framework for Advancing Collaboration (2024)

The Canadian Interprofessional Health Collaborative (CIHC) Framework (2024) guides educators, researchers, health administrators, service providers, and persons receiving care in fostering effective collaborative practice by focusing on supporting the application of knowledge, skills, attitudes, and values in real-world environments to guide behaviours that enhance collaboration. The framework has six competency domains, which are interdependent.

The overarching goal of this framework is to improve healthcare and human services by promoting collaborative, relationship-focused partnerships for shared decision-making.

Domain	Description
Relationship-Focused Care/ Services	Team members collaborate and coordinate the building of purposeful, inclusive, culturally safe, respectful and trusting relationships in care and service delivery.
Team Communication	Team members promote clear, responsive, respectful, effective, and inclusive communication among team members through shared language, active listening, removing barriers to communication and documentation.
Role Clarification and Negotiation	Team members understand and negotiate roles to support collaborative, relationship-focused care using individual strengths and expertise and recognize the person receiving the care as the expert in their experiences.
Team Functioning	All team members work interdependently and collaboratively to coordinate efforts, make shared decisions, and achieve shared goals efficiently.
Team Differences/ Disagreements Processing	Team members address disagreements constructively to maintain team cohesion and respectful relationships.
Collaborative Leadership	All team members share leadership and accountability, value each other's knowledge, skills, expertise, strengths, and perspectives, and support one another in achieving shared goals.
Important considerations underpinning the framework	
Inclusion, Access, and Equity	Inclusion, Access, and Equity are essential considerations that guide the application of all competencies, ensuring effective collaborative practice within the team that is respectful of the diversity within the team members and the person receiving care. Considerations include differences in culture, ethnicity, race, gender, sexual orientation, ability, socio-economic positions, barriers to accessing care, and the accessibility of services.
Complexity	The complexity of each person's care needs can vary, requiring an individualized, person-centered approach that depends on multiple professions and sectors collaborating with each other.
Care and Service settings	The context in care and service settings is an important consideration when collaborating with team members. This includes the person's circumstances, such as food insecurity, home environment, work conditions, and available supports. This can also include the team's circumstances, for example, teams that communicate virtually or asynchronously. In these situations, it is essential to consider all available tools, share information amongst all openly, make decisions collaboratively, and respect each professional's expertise.