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ORIGINAL ARTICLE

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The ReWork-Stroke rehabilitation programme described by use of the TIDieR checklist

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ABSTRACT

Background: About half of those that have had stroke in working age return to work (RTW). Few rehabilitation programmes exist focussing RTW after stroke.

Aim: To produce a clear replicable description of the ReWork-Stroke rehabilitation programme targeting RTW for people of working age who have had stroke.

Materials and methods: The Template for Intervention Description and Replication 12 item checklist was used to describe the ReWork-Stroke programme developed 2013–2014. This paper presents the development, rationale and processes in the programme to enable replication and provide evidence for implementation.

Results: Occupational therapists (OTs) skilled in stroke rehabilitation contribute knowledge about consequences of stroke and coordinate stakeholders involved. The ReWork-Stroke is person-centred, includes individual plans and generic components, consists of a preparation and a work trial phase. During the preparation phase, resources and hindrances for RTW are mapped and a plan for work trial is elaborated. During the work trial phase, the intervention is located at the workplace. The OT conducts recurrent follow-ups and collaborates with employers/co-workers.

Conclusions: A person-centred programme has advantages in its flexibility to meet different needs between people and by this thorough description of ReWork-Stroke, others can replicate the programme and its fidelity and evidence can be strengthened.

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Introduction

The prevalence of stroke in people of working age is increasing, both in Sweden [1] and internationally [2,3]. Stroke often impacts functioning in everyday life due to impairments, activity limitations and participation restrictions. In Sweden, more than one-third of those who have had a stroke below the age of 65 do not return to work (RTW) [1,4,5] which leaves about 3000 people outside the workforce every year. Return to work can be challenging as it is impacted by both personal and societal factors [6].

It has been found that predictors for not managing to RTW are: having a severe stroke, being cognitively impaired, depressed, dependent in activities of daily living, having post-stroke fatigue, other illnesses, and being on sick leave prior to stroke [7].

One societal factor obstructing RTW is the complex system for support in the RTW process after illness/injury. Loisel et al. [8] displayed this complexity in the Sherbrooke model. The stakeholders involved, i.e. the person with the work disability dealing with the consequences of illness/injury, the workplace, the healthcare system and the compensation system have their different roles and responsibilities, which entail challenges in the RTW process, were evident in the study of Hellman et al. [9]. Furthermore, the actual societal and political context can affect to what extent the various stakeholders fulfil their roles.

The ReWork-Stroke programme was developed as there are few evidence-based rehabilitation programmes for RTW for people with stroke [10] and no existing guidelines in the Swedish National guidelines for stroke care [11]. The development of the ReWork-

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Stroke programme was performed in several steps. In line with the Medical Research Council (MRC) guidance for developing and evaluating complex interventions [12], the ReWork-Stroke was developed based on an overview of existing knowledge. Furthermore, a focus group study targeting the various stakeholders involved in the RTW process was conducted, during which participants were interviewed about their experiences of the RTW process after stroke [9], and their opinions about what a rehabilitation programme targeting RTW should contain. Group interviews were held with the stakeholders: people who had had a stroke, employers, rehabilitation professionals, officers from the Swedish Social Insurance Agency (SSIA), and from the Swedish Public Employment Services. During the analysis process, representatives from each stakeholder group that had participated in a focus group interview were invited to a workshop where a preliminary analysis of the interviews was presented. Furthermore, group discussions on specific subjects were held; these included: (1) when each stakeholder should enter in the RTW process, (2) how to create continuity in the process and (3) how support could be designed and provided to family members as well as to employers. The discussions in this reference group were used to verify and add to the results of the focus group study. This study, combined with existing knowledge about RTW after stroke [6,13–15] established the base for the development of the rehabilitation programme ReWork-Stroke. The final programme was thereafter presented and discussed with rehabilitation professionals working with people of working age who had had a stroke, who agreed on the presented programme.

The ReWork-Stroke programme is developed to target people with stroke in general. However, as a first step in the evaluation of the programme it has been tested in praxis on people with stroke who were employed at time for stroke [16]. Experiences of participation in the programme have been explored [17,18] and documentation of the delivered components and a process evaluation of implementing the ReWork-Stroke programme will be presented elsewhere.

A detailed description of an intervention is desired to enable replicability in further studies but also constitutes a requirement for implementation of evidence-based rehabilitation programmes into healthcare practice [19,20].

The aim of this study is to produce a clear replicable description of the ReWork-Stroke rehabilitation programme targeting RTW for people of working age who have had a stroke.

Materials and methods

This article presents an intervention developed 2013 and 2014, the ReWork-Stroke programme, which is coordinated by an OT and used in a project consisting of several studies evaluating the process and effect of the programme. The project contains two studies exploring the experiences of being involved in the programme [17,18] and two studies in progress focussing on the provision of the programme and the changes made in work potential and work performance. This study and the project were approved by the Regional Ethics Committee in Stockholm, Sweden (Reg. No. 2012/101-31/1).

In this project, the structure of the Template for Intervention Description and Replication (TIDieR) checklist 12 items [21] was suitable for describing the ReWork-Stroke programme. The TIDieR checklist is a tool that has been developed [21] as recommended in The Consolidated Standards of Reporting Trials (CONSORT) 2010 statement [22] and Standard Protocol Items: Recommendation for Interventional Trials (SPIRIT) 2013 [23]. This tool was produced to improve and make possible a sufficiently detailed reporting of interventions, and also intended to facilitate for authors.

Results

In the following section, the ReWork-Stroke programme is explored and described by the TIDieR checklist [21] in order to give an in-depth description of the programme that is evaluated in both qualitatively and quantitatively in published [17,18] and forthcoming publications.

Item 1. Brief name: ReWork-Stroke

Item 2. Why: Describe any rationale, Theory, or Goal of the Elements Essential to the Intervention

Physical impairment and cognitive impairment such as lack of insight, has been described as risk factors for poor work re-entry after stroke [14,24]. How these impairments impact the individual's work ability is dependent on remaining activity limitation as well as the demands of their work tasks. Therefore, the ReWork-Stroke rehabilitation programme needs to be person-centred [25,26] and tailored to preconditions at the specific workplace. Graded RTW and adaptations made at the workplace, if needed, have been

reported both by people who have had a stroke and by rehabilitation teams to be supportive for RTW [9] and that was a main feature in ReWork-Stroke. In the process of trying out suitable work tasks during ReWork-Stroke, the interaction between the demands of the work tasks, the ability of the employee, and the consequences of their stroke needs to be considered in relation to the specific work environment [27]. If the time allotted for the work re-entry process is too short it will constitute an additional risk factor for not returning to work [9].

It has also been recognized that employers express a lack of knowledge about the rehabilitation process, and a need to better understand the consequences of stroke [9,28] in order to meet the specific support needs at the workplace during the RTW process for a person who has had a stroke. Insufficient knowledge can lead to expectations being too high in the planned work re-entry [28]. A systematic overview of the literature by Franche et al. [15], confirmed by Culler et al. [6], found strong evidence that support at the workplace could reduce work inability.

Limitations in the collaboration between healthcare and other stakeholders in work-related rehabilitation leading to insufficient continuity in follow-up in the RTW process has been reported, which in many cases delayed or hindered RTW [29]. This prolonged process in RTW after stroke has been described as increasing insecurity about who has the responsibility in different phases [9].

It has been proposed that a professional, skilled in rehabilitation after stroke and with collaboration experience, should be a coordinator throughout the RTW process, offering support to the person who has had a stroke as well as to the employer [9]. The advantage of coordinators in the RTW process has also been emphasized in earlier research [4,30] and occupational therapists (OTs) have been found suitable for this role [16].

Item 3. What (materials): Describe any physical or informational materials used in the intervention, including those provided to participants or used in intervention delivery or in training of intervention providers.

Information sheets on the consequences of stroke: fatigue, memory impairment, etc. were given to employers, co-workers and relatives. Available at: http://www.lul.se/sv/Kampanjwebbar/Infoteket/Funktionsnedsattningar/Forvarvade-hjarnskador-hos-vuxna1/Minne-och-hjarnskada/

Item 4. What (procedures): Describe each of the procedures, activities, and/or processes used in the intervention, including any enabling or support activities.

The ReWork-Stroke consists of two phases: a preparation phase, including planning for RTW, and a work trial phase, including training at the workplace. As the intervention is person-centred, these phases can vary regarding length of time, especially the preparation phase. The main assignment for the OT is to make the client aware of the consequences of stroke in work situations, testing/finding strategies to handle the consequences of stroke and giving support to the client in the process of returning to work. The OT contributes with knowledge about stroke and rehabilitation to work after stroke through all steps and phases of the process, to all involved stakeholders. The OT acts as an organizer initiating meetings during the RTW where relevant stakeholders participate, and is also responsible for distributing information between stakeholders (SSIA, employers, etc.) and the client and his/her relatives during the work trial. Informed consent from the client is an important consideration during these contacts and sharing of information.

An overview of the different components in the ReWork-Stroke programme is presented in Table 1.

ReWork-Stroke preparation phase

Mapping the client's situation

The mapping started with obtaining a clear picture of the client's everyday life situation including the client's resources and hindrances for work re-entry, such as consequences of stroke, social situation, education, previous work situation and family support. In the mapping interviews with the client, both informal and formal mapping, using Canadian Occupational Performance Measure (COPM) [31], of the client's goals for his/her rehabilitation was conducted. When all information was compiled the clients trained with the OT, to present themselves and their consequences of stroke to others. In this process, it was also necessary to reach an agreement with the client about what they approved informing the employer and co-workers about.

Mapping the work and the workplace

The OT visited the workplace with the client to meet the employer and to learn about the client's employment situation, the actual work tasks, demands in the work situation, and at the workplace. Visiting the workplace also presented an opportunity to find out about the client's personal resources, such as being a

Table 1. The ReWork-Stroke programme.

Phases	Components	Content/stakeholder interactions			
Preparation phase	Mapping client's situation	Resources and hindrances after stroke	Social and everyday life situation	Education	Support from family
	Mapping the work and workplace	Work tasks	Employment	Resources for rehabilitation	
	Providing information about RTW after stroke	To client	To employer	To SSIA	To relatives
	Collaboration with stakeholders about work trial	With client	With employer	With SSIA	
Work trial phase	Plan for work trial	Start date	Working hours	Work tasks, workplace adaptations	Need of support
	Evaluation of work performance	Visits at workplace	Tools for follow-up to employer		
	Follow-up of work situation during work trial	Visits at workplace	Phone calls		
	Evaluation of work trial with stakeholders	Meeting with all involved			
	Conclusion/finalization of ReWork-Stroke	With client	With employer		

valued colleague to whom co-workers have a positive attitude. Resources for rehabilitation available at the workplace, such as occupational health services, were discussed.

Providing information about RTW after stroke

The OT provided information about work-related rehabilitation to the client and his/her relatives. The OT also learned about the family situation and their support for RTW for the client. At the workplace, the OT provided information about work-related rehabilitation to the employer and information about different aids, transport options and economic support.

Collaboration with stakeholders about work trial

The OT contacted the SSIA officer for future collaboration, met the client and employer at the workplace, and provided information on the stroke consequences to the employer and the SSIA officer.

ReWork-Stroke work trial phase

Plan for work trial

A plan was created for work trial and follow-ups in collaboration with the client, the employer and the SSIA officer. This plan included a start date, working hours and their distribution over the week, appropriate work tasks, and how support should be provided. The plan was adapted to the rules from SSIA.

Evaluation of work performance

The OT contributed tools that the employer could use for evaluation of work performance. By using a questionnaire/check list based on Assessment of Work Characteristics (AWC) [32], the employer could evaluate how the client was performing in actual work tasks.

Follow-up of work situation during work trial

The OT conducted co-occurring visits at the workplace for follow-up of work trial every other week. During these visits, the OT discussed the work performance with the client and co-workers, and gave advice to the client, the employer and to the co-workers about appropriate adjustments of work tasks and/or time plan. Actual issues were discussed and joint problem-solving was utilized. Information about consequences of stroke and how this can affect work performance was repeated. The OT had regular contact with the SSIA officer and the client's GP to exchange information related to the ongoing RTW process, and the plan ahead was discussed. Contact with relatives/family was made to get information about how everyday life outside work was functioning, and to provide information on the consequences of stroke, if needed.

Evaluation of work trial together with stakeholders

The OT supported the employer to evaluate a possible RTW for the employee and discussed appropriate work tasks that can be accomplished to start with and set reasonable limits in time. All the involved stakeholders met to plan for returning to work/not returning to work.

Conclusions/finalization of ReWork-Stroke

The intervention concluded by summarizing the actions taken during the work rehabilitation phase in a concluding discussion with the client and with the employer.

Item 5. Who provided: For each category of intervention provider (for example, psychologist, nursing assistant), describe their expertise, background and any specific training given.

In the ReWork-Stroke programme OTs, having a position in a specialized brain injury rehabilitation team and skilled in rehabilitation after stroke, conducted the intervention and were able to secure support from other professionals if needed. The OTs received training in the theoretical base of the programme, the current evidence for RTW for people who had had a stroke, and the procedures in ReWork-Stroke in two workshops held by the researchers before the start of the project. During the delivery of the programme, telephone meetings were held between the OTs and the researchers every week for the first three months to support the delivery of the programme and provide advice to the OTs when something unexpected occurred. Furthermore, the procedures were continuously discussed in project meetings every other month throughout the delivery of the programme.

Item 6. How: Describe the modes of delivery (such as face to face or by some other mechanism, such as internet or telephone) of the intervention and whether it was provided individually or in a group.

The programme focussed on the person who had had a stroke and therefore much of the intervention was provided individually in face-to-face meetings or in contact over the telephone. As several stakeholders (employers, co-workers, GPs, officers from SSIA) were involved in the rehabilitation, meetings in groups were also conducted. Both formats were grounded in the specific support the individual required. Mapping of the person's resources and hindrances, as well as some of the follow-ups of the work trial, were made individually while planning for and follow-up of work trial plans were conducted together with the employer and co-workers.

Item 7. Where: Describe the type(s) of location(s) where the intervention occurred including any necessary infrastructure or relevant features.

As the focus of the programme is on work performance, it was important to locate the intervention at the workplace. The client was then exposed to a real work environment, real work tasks and collaboration with colleagues.

Item 8. When and how much: Describe the number of times the intervention was delivered and over what period of time including the number of sessions, their schedule, and their duration, intensity or dose.

This programme is person-centred, which provides an opportunity for variation, both in length of time the client can receive interventions, and the number of times the intervention was delivered. Often the sessions are more frequent in the preparation phase compared to the work trial phase. Regular visits at the workplace for follow-up of work performance are planned for every other week.

Item 9: Tailoring: If the intervention was planned to be personalised, titrated or adapted, then describe what, why, when, and how.

The programme has a common base, including steps for mapping, educating, planning and follow-up. The intervention is personalized according to differences in resources and hindrances for the client in returning to work and regarding what support the employer can offer. The differences can refer to frequency of meetings, information/education to co-workers, and number of visits at the workplace to give support to co-workers. The number of contacts with SSIA officers can also vary according to the way different officers work, and to the opportunities/difficulties that the client and the employer have in finding relevant work tasks.

Item 10. Modifications.

The programme has been complemented by adding tools to be used by the employer to evaluate/follow-up work performance.

Item 11. How well (planned): If intervention adherence or fidelity was assessed, describe how and by whom, and if any strategies were used to maintain or improve fidelity, describe them.

Holding telephone meetings every week during the first time period of the delivery of the intervention was a way to assess fidelity together with the records written by the OTs, which included information on everything they did regarding the client, such as phone calls, visits, emails, etc. to all involved stakeholders, and what these encounters contained.

Item 12. How well (actual): If intervention adherence or fidelity was assessed, describe the extent to which the programme was delivered as planned.

The information on adherence and fidelity is the OTs registrations in the logbooks concerning which elements in the programme they provide.

Discussion

This article describes the ReWork-Stroke rehabilitation programme targeting RTW for people of working age who have had a stroke. The TIDieR checklist was a valuable tool to make a clear description of the programme. Hopefully, this description will assist others

in replicating the study and/or implementing this new programme for people who have had a stroke in working age and wants to go back to work. A person-centred approach has been used as a framework for this programme [33,34], which also is emphasized in the Swedish Healthcare Act [35], as well as in documents [36] on coordination of RTW in Sweden. Several factors in the context of RTW after stroke provided motives for this choice; varying consequences after stroke, the different demands of work tasks, different resources for employers and other stakeholders' systems for work re-entry. Using a person-centred approach was also supported by the fact that the few evaluated evidence-based rehabilitation programmes for RTW after stroke [25] or other acquired brain injuries [26] that were effective in comparison to regular rehabilitation, both used a person-centred approach as well as an appointed coordinator. In ReWork-Stroke, the use of OTs as coordinators is emphasized [14]. The advantage of a person-centred programme and its flexibility in relation to those receiving the programme can, on the other hand, imply difficulties in producing a clear description of the programme and thereby replicating it. In this paper, the TIDieR checklist has been used as a tool to diminish that risk. However, even a reasonably detailed description of the procedures and actions in the programme cannot include all variations provided to the client or to other stakeholders. Therefore, a thorough knowledge on the principal meanings of person-centeredness [33] and the use of a person-centred approach is necessary to enable adherence to any described person-centred programme.

The target group for the ReWork-Stroke was people in general who had stroke but as the first step persons who had employment when they had stroke was included in the study. The reason for this choice was to reduce external factors that might have impacted on the person's ability to RTW during the first test of the programme. However, we believe that the programme can also be useful for those not employed. If used for unemployed people, the mapping phase might be longer as it can take time to find a place for work trial. Furthermore, another stakeholder, the Swedish Public Employment Service, with another set of rules, has to be involved. However, the overall content of the ReWork-Stroke programme would mainly be the same.

This programme has been developed and explored for people who have had a stroke [17] but can, ideally, also be used for people with other acquired brain injuries as work-directed interventions facilitate the RTW process regardless of the cause of the brain injury [10]. The person-centred structure of the programme, with the strong evidence for interventions at the workplace, coaching and collaboration with the employer [10], might also be seen as generic in relation to people with multiple symptoms after injury/illness, such as whiplash syndrome [37], stress related disorders [38] and others.

In the ReWork-Stroke programme, the coordinator is an OT skilled in brain injury/stroke rehabilitation, working in parallel at a rehabilitation clinic. Having this link to other expertise has been helpful in mapping the client's resources and hindrances after stroke, and is recommended in an implementation phase of this programme. This is in line with a meta-synthesis by Brannigan et al. [14] in which the link between the clinical and workplace competences is addressed.

An effective rehabilitation programme focussing on the phase of returning to work can best be built through collaboration between healthcare and stakeholders in working life. Since February 2020, healthcare services in Sweden is legally required to provide RTW coordination, i.e. offering individualized support and coordination [39] between stakeholders. In a collaboration such as this, the involved stakeholders share their specific knowledge with each other, building a reciprocal relationship. This relationship and knowledge sharing are fundamental to a successful RTW process.

The ReWork-Stroke programme was developed within the Swedish context and social insurance system. One might anticipate contextual hindrances if to implement the programme in its entirety in other countries with other social systems. However, several of the components that constitute the programme are based on research findings from several studies from various contexts [6,9,10,13–15,25,26,28]. Due to that we regard the programme as useful in countries with other social systems with some modelling of the programme components that are specific to the actual context.

The use of the TIDieR checklist [21] while describing the ReWork-Stroke programme has been valuable as it provides important guidance and clarity. Using the guidance, the items and the comprehensive examples in the TIDieR tool clarified to us as originators to a higher extent what the components in the programme intended to impact, details in the provision of the programme became obvious as well as the extensive coordination between stakeholders. The TIDieR structure provided a thorough guidance for reporting a comprehensive description of the

ReWork-Stroke with enough details. However, it was unclear in the tool where the development of the intervention should be added. Information on development of the specific would be of interest for those who are interested to use it and would therefore preferably be included in the TIDieR checklist [20].

As earlier papers have pointed out [20,21], comprehensive descriptions of intervention programmes have often been lacking. By adding a description of the programme that is studied, the interpretation of the scientific evidence might be easier and thus give solid material to use when deciding whether or not the programme should be used in practice. Such a thorough description by using the TIDieR tool also facilitates the replication of the programme and contributes to decrease the existing gap between research and practice.

Conclusions

Comprehensive descriptions of intervention programmes targeting RTW are lacking and this article aims to contribute to fill this gap. The ReWork-Stroke is developed for people with stroke who intend to go back to work. The person-centred structure of the programme includes work-directed interventions provided by an OT at the workplace and collaboration with the employer as well as coordination of other stakeholders. Knowledge in occupational therapy seems to be significant in the process of analysing demands in the work tasks in relation to the clients work ability and the contextual resources at the workplace. Even if the ReWork-Stroke is developed for people with stroke, the overall content would mainly be the same for other groups, as people with multiple symptoms after injury/illness. The programme could also be useful in countries with other social systems with some modelling of the programme components that are specific to the actual context.

Collaboration is crucial in the ReWork-Stroke where the involved stakeholders share their specific knowledge with each other, building a reciprocal relationship. This relationship and knowledge sharing are fundamental to a successful RTW process.

Disclosure statement

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