Risky Behaviours Post Stroke: How Can We Support?

The Northwestern Ontario Stroke Network

presents:

Provincial Stroke Rounds

Wednesday December 1st, 2021

0800-0900

NORTHWESTERN ONTARIO Regional Stroke Network

OREG ONTARIO REGIONAL EDUCATION GROUP

Stroke Knowledge Translation Specialists

Evaluation

Please take 2 minutes to fill out the evaluation form, either online or in the room. Thank you!

Link:
https://www.surveymonkey.com/r/7SXYYCF

For the Provincial Stroke Rounds Planning Committee:

- To plan future programs
- For quality assurance and improvement

For You:

Reflecting on what you've learned and how you plan to apply it can help you enact change as you return to your professional duties

For Speakers:

The responses help understand participant learning needs, teaching outcomes and opportunities for improvement.

Mitigating Potential Bias

The Provincial Stroke Rounds Committee mitigated bias by ensuring there was no Industry involvement in planning or education content.

Provincial Stroke Rounds Committee

Learning Objectives

Upon completion, participants will be able to:

1. Identify stroke best practices that relate to substance abuse post-stroke
2. Describe ethical principles when engaging with stroke patients regarding risky behaviours
3. Apply harm reduction and health teaching principles to stroke patients in the acute and secondary prevention stroke environment

Speakers

NWORSN is pleased to introduce:

Martina Nuttall

Clinical Nurse Specialist,
Mental Health Services,
Thunder Bay Regional Health Sciences Centre

Christina Johnson

Nurse Practitioner,
Regional Stroke Unit,
Thunder Bay Regional Health Sciences Centre

Michelle Allain

Bioethicist,
Thunder Bay Regional Health Sciences Centre

Disclosure

Martina Nuttall

Clinical Nurse Specialist,
Mental Health Services,

Thunder Bay Regional
Health Sciences Centre

Disclosure of Affiliations, Financial Support, & Mitigating Bias

Affiliations:

I have no relationships with for-profit or not-for-profit organizations

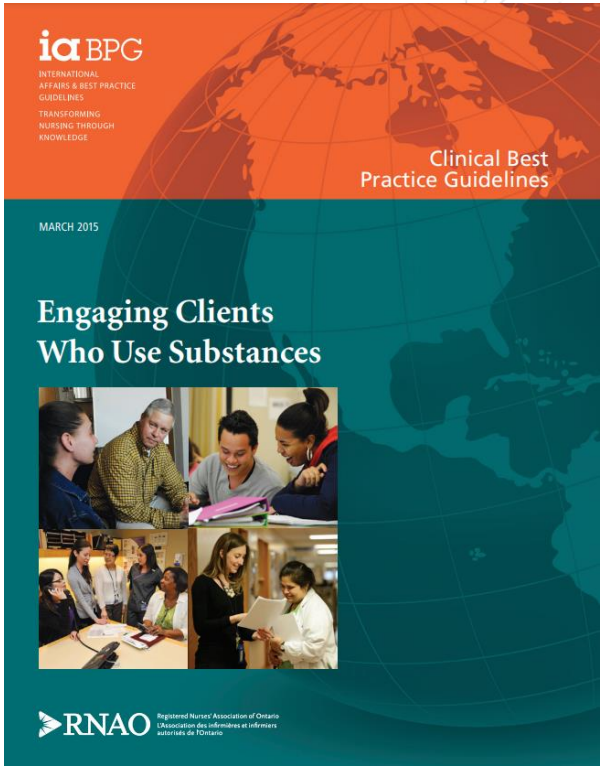
Engaging Patients Who Use Substances

Building collaborative relationships is essential when working with clients at risk for or experiencing a substance use disorder. Collaborative relationships between the health-care provider and the client allow for the creation of a therapeutic environment that fosters client well-being and autonomy throughout the process of recovery.

RNAO Best Practices

RNAO has a great document on Engaging Patients Who Use Substances that talks about implementation across different healthcare settings.

Recommendations include utilizing standardized screening or assessment tools. (ex. CAGE-AID, GAIN-SS)



Motivational Interviewing (MI)

Motivational interviewing (MI) is an evidence-based counselling approach that is client-centered, non-directive, and non-judgmental, and which nurses can use in order to develop collaborative and empathic relationships with all clients in all practice settings. This approach honours personal stages of change and it involves the use of open ended questions, affirmations, reflections and summarizing information.

Quick Tips for MI

Table 3. OARS: The basic skills of motivational interviewing	
Ask Open-ended questions* • The patient does most of the talking • Gives the practitioner the opportunity to learn more about what the patient cares about (eg. their values and goals)	**Example** I understand you have some concerns about your drinking. Can you tell me about them? **Versus** Are you concerned about your drinking?
Make Affirmations • Can take the form of compliments or statements of appreciation and understanding • Helps build rapport and validate and support the patient during the process of change • Most effective when the patient's strengths and efforts for change are noticed and affirmed	**Example** I appreciate that it took a lot of courage for you to discuss your drinking with me today You appear to have a lot of resourcefulness to have coped with these difficulties for the past few years Thank you for hanging in there with me. I appreciate this is not easy for you to hear
Use Reflections* • Involves rephrasing a statement to capture the implicit meaning and feeling of a patient's statement • Encourages continual personal exploration and helps people understand their motivations more fully • Can be used to amplify or reinforce desire for change	**Example** You enjoy the effects of alcohol in terms of how it helps you unwind after a stressful day at work and helps you interact with friends without being too self-conscious. But you are beginning to worry about the impact drinking is having on your health. In fact, until recently you weren't too worried about how much you drank because you thought you had it under control. Then you found out your health has been affected and your partner said a few things that have made you doubt that alcohol is helping you at all
Use Summarising • Links discussions and 'checks in' with the patient • Ensure mutual understanding of the discussion so far • Point out discrepancies between the person's current situation and future goals • Demonstrates listening and understand the patient's perspective	**Example** If it is okay with you, just let me check that I understand everything that we've been discussing so far. You have been worrying about how much you've been drinking in recent months because you recognise that you have experienced some health issues associated with your alcohol intake, and you've had some feedback from your partner that she isn't happy with how much you're drinking. But the few times you've tried to stop drinking have not been easy, and you are worried that you can't stop. How am I doing?
* A general rule-of-thumb in MI practice is to ask an open-ended question, followed by 2–3 reflections	

(Hall, Gibbie & Lubman, 2012)

Harm Reduction

What is a harm reduction approach?

A harm reduction approach aims to reduce the negative consequences of using psychoactive substances, without necessarily reducing substance use itself.

Through policies, programs, and practices, a harm reduction approach:

- Accepts that abstinence may not be a realistic or desirable goal for a person
- Emphasizes that stopping substance use is not required to access health or social services

Psychoactive substances are commonly known as drugs. These are legal and illegal substances that affect mental processes. Examples include:

- Caffeine
- Alcohol
- Tobacco
- Prescription drugs
- Cannabis
- Cocaine
- Ecstasy
- Opioids

(Alberta Health Services, 2019)

Harm Reduction Principles

Principle	Definition
1. Humanism	• Providers value, care for, respect, and dignify patients as individuals. • It is important to recognize that people do things for a reason; harmful health behaviors provide some benefit to the individual and those benefits must be assessed and acknowledged to understand the balance between harms and benefits. • Understanding why patients make decisions is empowering for providers.
2. Pragmatism	• None of us will ever achieve perfect health behaviors. • Health behaviors and the ability to change them are influenced by social and community norms; behaviors do not occur within a vacuum.
3. Individualism	• Every person presents with his/her own needs and strengths. • People present with spectrums of harm and receptivity and therefore require a spectrum of intervention options.
4. Autonomy	• Though providers offer suggestions and education regarding patients' medications and treatment options, individuals ultimately make their own choices about medications, treatment, and health behaviors to the best of their abilities, beliefs, and priorities.
5. Incrementalism	• Any positive change is a step toward improved health, and positive change can take years. • It is important to understand and plan for backward movements.
6. Accountability without termination	• Patients are responsible for their choices and health behaviors. • Patients are not "fired" for not achieving goals. • Individuals have the right to make harmful health decisions, and providers can still help them to understand that the consequences are their own.

(Hawk et al. 2017)

Examples of Harm Reduction

What does harm reduction look like?

Interventions may be targeted at the person, family, community, or society. They can target the health, social, or economic consequences of substance use.

Harm reduction interventions may include:

- Community-based naloxone programs
- Peer support programs
- Supply distribution and recovery programs
- Supervised consumption services
- Opioid dependency treatments

Healthcare providers

interact with a person who uses substances without judgment, or stigmatizing language or actions, regardless of personal beliefs.

People who use substances

have a right to a patient-centered care approach that includes informed choice, and to be an active, full partner in care.

(Alberta Health Services, 2019)

Disclosure

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Christina Johnson

Nurse Practitioner,

Thunder Bay Regional Health Sciences Centre

Affiliations:

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Canadian Stroke Best Practices

Secondary Prevention of Stroke

2.7 Recreational Drug Use

i. Individuals with stroke and known recreational drug use that may increase the risk of stroke (such as cocaine, amphetamines) should be counseled to discontinue use [Evidence Level C]; and should be provided with appropriate support and referrals to services and resources for drug addiction and rehabilitation.

ii. For cannabis, that may be prescribed for medical indications, counsel patients regarding any potential increased risk of stroke to support informed decision-making regarding the use of these agents [Evidence Level B

Substance use in Stroke

Potential contributing factors for substance use in stroke patients:

- loss of independence, unmanaged chronic pain, accessibility, legalization, pandemic effect, age

In Ontario, approximately 10% of the population uses substances problematically.

- the increasing use of some illicit drugs amoung people living in Northern Ontario regions represents a public health issue (ex: up to 10 times more patients per 100,000 people are in methadone maintenance treatment in North West region compared to central regions in Ontario

Long-term repeated use of cocaine can also cause CV disease over time, significantly increasing the risk of stroke, even in otherwise healthy young people who do not have other risk factors of stroke.

Substance Use

Cocaine

- 3rd most common substance of abuse
- Exact mechanism of cocaine-induced stroke remains unclear, likely a number of factors involved: vasospasm, cerebral vasculitis, enhanced platelet aggregation, cardioembolism, hypertensive surges associated with altered cerebral autoregulation
- Risk of stroke is 6 times higher in drug users than non drug users
- In many cases, when stroke does occur, it happens within hours of drug use

Treadwell & Robinson (2007); Desai et al (2017)

Substance Use

Cannabis

- 2nd most common substance of abuse
- potent synthetic cannabinoid products associated with an array of severe adverse side
- Frequency and intensity of cannabis use has an association with various adverse health outcomes
- Mechanisms most frequently assumed in cannabis related stroke are vasospasm and postural hypotension with abnormal regulation of the brain blood flow
- Studies have also shown an increased incidence of paroxysmal atrial fibrillation in patients with stroke of idiopathic etiology with cannabis use

Fischer et al (2017)

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Michelle Allain

Bioethicist,

Thunder Bay Regional Health Sciences Centre

Affiliations:

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Relevant Ethical Principles

- Autonomy
- Right to live at risk
- Justice
- Informed consent

Consent

When is consent required?

- Consent is required for all treatments/admissions to LTC unless emergency & no reason to believe pt would not want intervention

What is valid consent?

- Relate to treatment
- Informed
- Voluntary
- Not obtained through misrepresentation or fraud

Capacity

What is capacity?

- Ability to understand (factual knowledge + problem solving ability)
- Ability to appreciate (realistic appraisal of outcome + justification of choice)

Who assesses capacity?

- Treatment: health practitioner proposing tx
- LTC admission: HCCSS coordinator

Does capacity change?

- Capacity is decision & time specific

Substitute Decision Making

What is the hierarchy of SDMs?

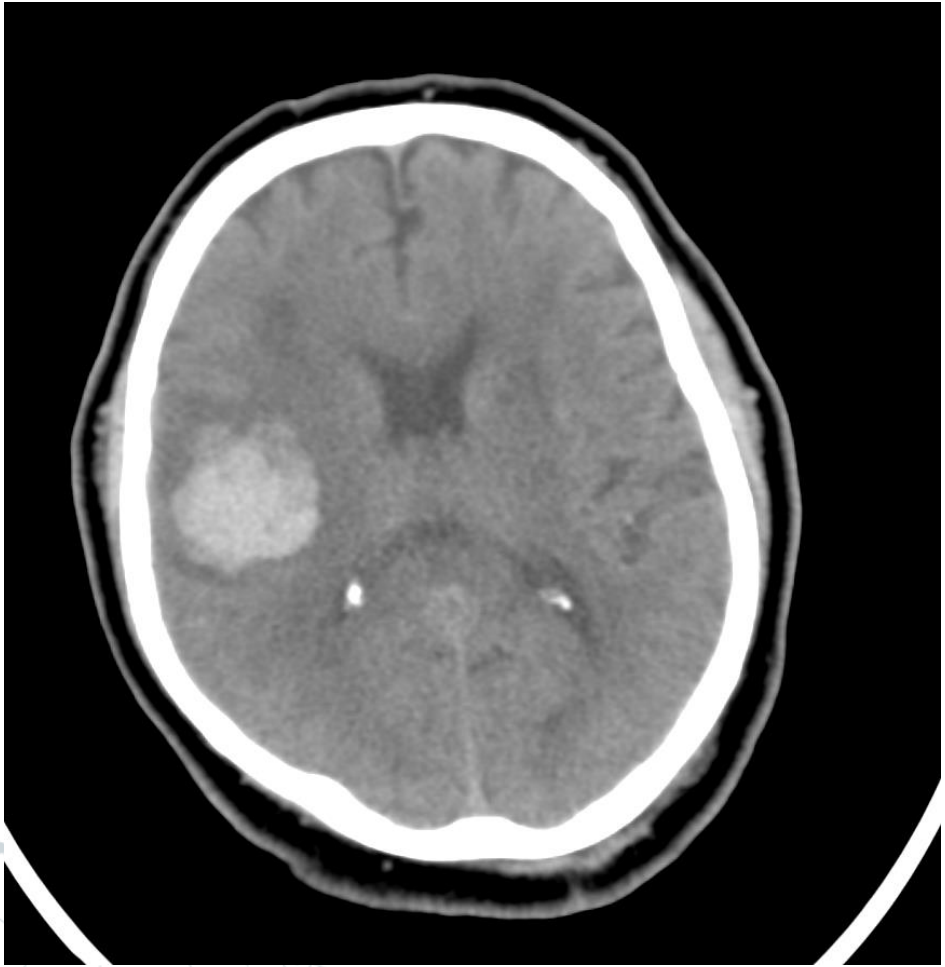
1. Guardian of the person
2. POA – personal care
3. Representative appointed by the CCB
4. Spouse or Partner
5. Child or parent or Children's Aid authority
6. Parent with right of access only
7. Brother or sister
8. Any other relative
9. PGT

- If CONFLICT between persons in same category and cannot agree PGT shall act as SDM
- Role of SDM is to make decisions in line with pt's previously expressed capable wishes or if not known best interests

Case Study

James Fish, a 46 years of old male, presented to the Emergency Department from the Northwest region, on Friday morning.

- He was found to be drowsy, but rousing to verbal stimuli and obeying commands.
- His speech is significantly slurred and difficult to understand.
- He is not oriented to place, but can state his name and age.
- On physical exam he has moderate left sided weakness and left-sided facial asymmetry.
- Past medical history includes a previous hemorrhagic stroke in 2011, hypertension, and coronary artery disease with a triple bypass in 2014. He is a non smoker and his current occupation is a full time truck driver.
- A Code Stroke is activated and on CT the neurologist sees a right frontal parietal acute hemorrhage. He is then flown to the Regional Stroke Unit in Thunder Bay for further stroke workup.



Right frontal parietal acute hemorrhage

Case Study Continued

The next day, he continues to say he needs to go home.

The inter-disciplinary team is in to assess.

- The Speech and Language therapist reports that he failed his initial swallowing screen and is at high risk for aspiration.
- The Physiotherapist reports that he is unsafe to ambulate and at this point requires a mechanical lift to get out of bed and into the wheelchair.
- The Occupational Therapist reports that his cognition has been impacted by the stroke, showing signs of impulsivity and poor judgement.

Case Study Continued

His wife has come in to Thunder Bay this morning. She informs his nurse that the patient has been smoking 1-2 joints of marijuana daily for the last 3 years. She also reports that he has used cocaine 2-3 times this past year.

There is concern about the patient's capacity. After 7 days in hospital, he has made some mild improvements and is now a two-person assist to wheelchair. The stroke team recommends transfer to the rehabilitation facility in Thunder Bay for further inpatient care.

The patient is noticeably irritated of this plan and reports that he wants to go home. The wife however is in agreement that the patient needs to listen to the recommendations for further inpatient rehabilitation.

Panel Discussion

How do we assess capacity of Mr. Fish?

Who is responsible, when, how often?

How do we support Mr. Fish with a safe transition to the next level of care?

How to we address the substance use with the patient and family?

Case Study Continued

The patient is now agreeable to attend the rehabilitation facility.

5 weeks later, he arrives for his follow up appointment at the Stroke Prevention Clinic with his wife. He is now ambulating with a cane and his speech is clear. He does report that it has been a long 5 weeks and he feels that every day is sometimes a struggle. The patient discloses that he has continued to smoke marijuana and divulges that he has used cocaine previously.

He reports that he does not want to stop his substance use at this time, as it is helping him cope.

Panel Discussion

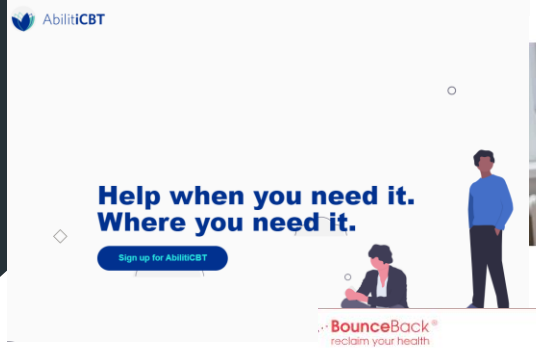
How do you engage with the patient in a bias free environment?

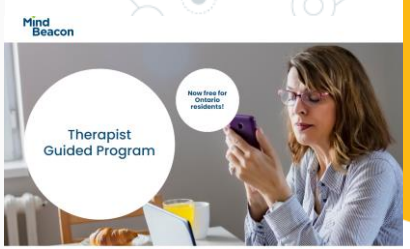
What are the health teaching and harm reduction strategies can you use with this patient?

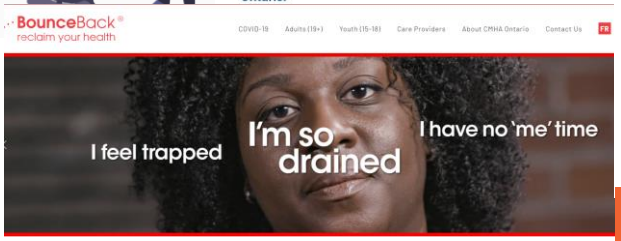
How do best practices in stroke prevention apply to this patient?

What is our ethical responsibility as health care professionals?

Resources







NICE
National Initiative for the Care of the Elderly
We care together
Ensemble pour le bien-être des aînés

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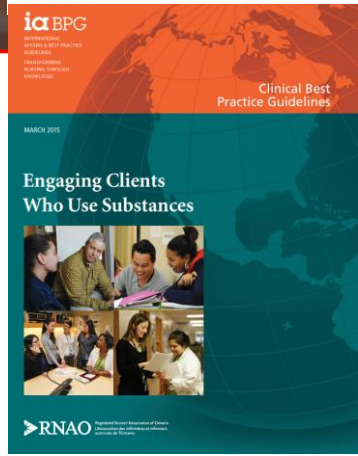

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- https://static.wixstatic.com/ugd/d1d295_f6daf8526ec248dd9bb88b2a6d3b06fa.pdf
- https://rnao.ca/sites/rnao-ca/files/Engaging_Clients_Who_Use_Substances_13_WEB.pdf

Thank you!

Questions?

Please utlize the chat box

For more information contact

Michelle Allain
Bioethicist

Thunder Bay Regional
Health Sciences Centre

AllainM@tbh.net

807-684-6538

Martina Nuttall
Clinical Nurse Specialist

Thunder Bay Regional
Health Sciences Centre

nuttallm@tbh.net

807-684-6962

NORTHWESTERN ONTARIO
Regional Stroke Network

nwostroke@tbh.net

807-684-6706

http://

www.nwostroke.ca

Medical Centre, 201
984 Oliver Road,
Thunder Bay, ON P7B 7C7

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References

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