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Developing a Capstone Project

As a vestibular-competency trained clinician in the acute setting, I am often consulted by hospitalists, cardiologists and neurologists and referred to by other therapists to evaluate patients complaining of dizziness. Patients present with various types of dizziness including post-concussion, cervicogenic, neurologic, orthostatic hypotension and vestibular dizziness. Most of my patients are geriatric and I treat BPPV on a weekly basis.

For my EBPII assignment, I read the practice guideline for BPPV by Bhattacharyya et al (2008) and then reviewed several studies to determine if there are any (and if so, what) evidence-based interventions to prescribe patients after they are treated with the canalith repositioning maneuver for posterior canal BPPV. Prior to this year, I had been giving patients postural restriction and Brandt-Daroff exercises after treatment with the canalith repositioning maneuver. After reviewing the studies, I learned that these interventions are not evidence-based and so I have changed my practice and am no longer issuing these to patients. Further, the clinical guideline recommends that patients follow-up with clinicians one month after treatment (Bhattacharyya et al 2008) and I have started to pursue outpatient referral sources in order to refer patients for follow-up one month after treatment. I also provide patients with my work contact information.

Since my vestibular training in 2008, I have given several inservices to therapist peers and physicians as well as created a vestibular evaluation form that my company, Novant, has approved for use. I have also created a vestibular teaching module which I have presented at Winston-Salem State's physical therapy program for the past two years. These experiences have pushed me clinically, help me network and spur my interest in my specialty. My clinical practice, however, continues to be my passion and what I notice is that my geriatric patients have a hard time grasping what is causing their dizziness given multiple healthcare provider interactions, including my own education during vestibular assessment.

Given that we are in the stroke belt and the hospital in which I work, Forsyth Medical Center, is a stroke hub, educating patients about the risk factors for and signs and symptoms of stroke is important. When I educate vestibular patients about BPPV, I also include education about signs and symptoms of cardiac and stroke dizziness. The number one thing is that patients come back to the ER if they are experiencing stroke symptoms and so my vestibular recommendations include stroke education.

The American Physical Therapy Association's vestibular special interest group created a series of handouts for patients about dizziness, including BPPV. The handouts, however, have not been modeled after patient education guidelines that describe conditions in layman terms.

Novant has adopted the Ask Me 3 Teachback model as the appropriate way to educate patients. The model ensures that education is delivered at a sixth grade reading level and is organized by three questions: (1) What is my main problem? (2) What do I need to do? (3) Why is it important? (Ask Me 3).

I spoke with one of the Novant corporate education coordinators and he suggested that I develop BPPV and orthostatic hypotension handouts using the Ask Me 3 Teachback model to educate patients about this topic. The handouts will be added to a developing toolkit that includes education about stroke. The stroke handout has already been created by our neurology team.

References

Ask Me 3. (No date). Retrieved on 19 November 2011, http://www.npsf.org/askme3/

Bhattacharyya, N., Baugh, R.F., Orvidas, L., et al. (2008). Clinical practice guideline: Benign paroxysmal positional vertigo. *Otolaryngology-Head and Neck Surgery, 139*, S47-S81.

The Teach-back Method. (No date). Retrieved on 19 November 2011, http://www.nchealthliteracy.org/toolkit/tool5.pdf