Reviewer's report

Title: Evidence-based practice in stroke rehabilitation: Knowledge translation and implementation

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Reviewer: Teresa Damush

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This is an observational study of what appears to be a usual care uptake of a rehabilitation clinical intervention after the research trial had ended. Thus the authors recognized the opportunity to query rehabilitation clinicians on factors related to the intervention implementation into usual practice.

Major comments:

1. The research question is appropriate and the authors are applauded for applying two frameworks to their analyses. However, it appears that the frameworks were used to analyze the data post hoc but were not used to inform the interview guide apriori? It’s unclear whether the authors chose the CFIR constructs apriori. Thus, respondents may not have been prompted to consider other influential implementation factors.

2. To be to understand the data, it would be helpful to know the reach of the sample into all clinics in the region etc that were exposed to the GRASP intervention. From the total clinics, how many participated? Do you have any way of declaring nonrespondent clinics as implementing GRASP vs Not Implementing? From the clinics that responded, what percentage of personnel responded?

3. Of the clinics interviewed, how many were not implementing GRASP and how many were? What factors from the two frameworks were related to implementation vs no implementation? This would give more insight into how clinics were able to implement GRASP into usual care.

4. For the influence of leadership that is being reported, what level of leadership influenced the implementation after the intervention ended? That is, was it the hospital chief of staff, rehabilitation service chief? Individual clinician? How did leadership make the decision? Did you interview any leadership? If the program is free, why would the clinician not use it? Is it best practice or just as good as usual practice? What exactly was leadership engagement?

5. For networks, how exactly did the sites outside of the research trial decide to adopt GRASP?

6. Briefly present NPT and CFIR – why the need for two frameworks? Were each inadequate, in what ways?

7. Results: Did any factors emerge that were unrelated to two frameworks?

8. A major limitation of the data is the variation in length of time from event to
interviews (page 18 –few months to years). What is the average length of time since event?
9. It’s unclear what is in Tables 3, 4, 5, 6, 7?
10. What is Figure 1 based upon? What do the arrows indicate?

Minor comments:
Abstract: Results: What does it suggest when therapists evaluated their own implementation rather than the department?
Abstract: Conclusions: Would delete first sentence as this is not a conclusion. What about “network” finding? Would delete “are modifiable” in last sentence.
Data Collection: What was length of time since GRASP trial ended and interviews were completed? Was it same for all in sample?
Results: Is GRASP replacing another practice or augmenting?
Page 9, is the concern by the therapist that the quality of the exercise movement outside of therapy have to do with the quality of the GRASP materials or the general thought that patient exercises done outside of therapy is of lesser quality in general?
Page 9, So the primary implementers were rehabilitation assistants but only 2 participants were assistants? What was the rationale for not including more? Was it the therapist who set the prescription?
Page 10 Again it would be helpful to distinguish implementation vs not implementation on professional judgment.

Level of interest: An article of importance in its field
Quality of written English: Acceptable
Statistical review: No, the manuscript does not need to be seen by a statistician.
Declaration of competing interests:
I declare I have no competing interests.