Implementing the evidence-based ‘Safe Recovery’ falls prevention programme into Burwood wards

A JOINT CDHB & BAIL PROJECT EVALUATING THE EFFECTIVENESS OF THE ‘SAFE RECOVERY PROGRAMME’

BURWOOD ACADEMY
OF INDEPENDENT LIVING
Hā-i-mano

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

Project contributors

SRP EVALUATION

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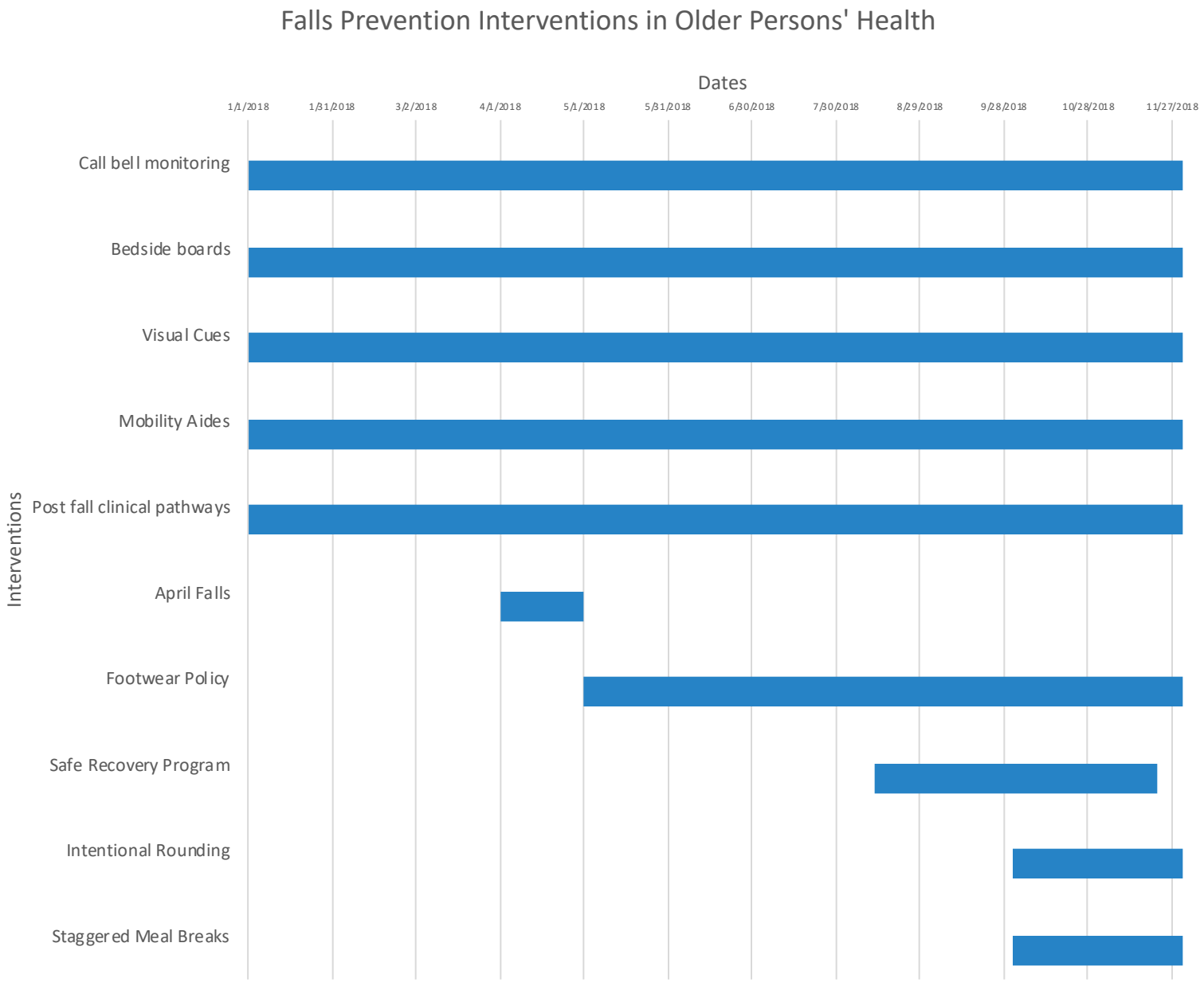
SRP DELIVERY

What is SRP and why was it introduced to Burwood?

Why the need to focus on falls prevention & reduction?

	Rates of falls	Rates of injuries as a result of falls
International geriatric & rehabilitation wards	Between 10 and 17 per 1000 patient bed days	About 30% of falls result in injuries
OPHSS (2012- 2014 references)	Medical OPH wards: 17.3-18.0 / 1000 bed days BG: 25.7-34 / 1000 bed days	Approx. 20%



What has been done already?

Why was the SRP chosen?

Reduced the fall rates, in wards similar to OPH wards, from 13.8 /1000 bed days to 7.8/1000 bed days (40% reduction)

HQSC supported a visit from Dr Anne-Marie Hill in 2016 to discuss the Safe Recovery Program original research.

Later her presentation and research would be used in applying for funding to address high falls rates in Older Persons' Health Rehabilitation.

"We believe this programme can reduce falls and injuries in our older in-patients. It can reduce fall related injury costs and needs to be implemented as soon as possible. "

The Safe Recovery Program is one of few evidence-based interventions that have been shown to reduce the rate of inpatient falls on rehabilitation wards.

Overview of key components of SRP programme

EDUCATING PATIENTS ABOUT THEIR:

RISK OF FALLING AND PERSONALISING THIS RISK

MOTIVATING THEM TO MITIGATE THIS RISK.

STAFF TRAINING ABOUT THE SRP INTERVENTION AND FALLS PREVENTION, AND HOW THEY CAN POSITIVELY REINFORCE THE MESSAGES WITH PATIENTS.

FEEDBACK FROM PATIENTS TO STAFF ABOUT PERCEIVED BARRIERS TO PATIENTS ENACTING FALLS PREVENTION STRATEGIES.

PATIENTS ALSO ARE ENCOURAGED TO SPEAK UP AND PROACTIVELY SEEK HELP FROM STAFF AND ENCOURAGE STAFF TO CARRY OUT THE PREVENTION STRATEGIES.

How is SRP thought to work?

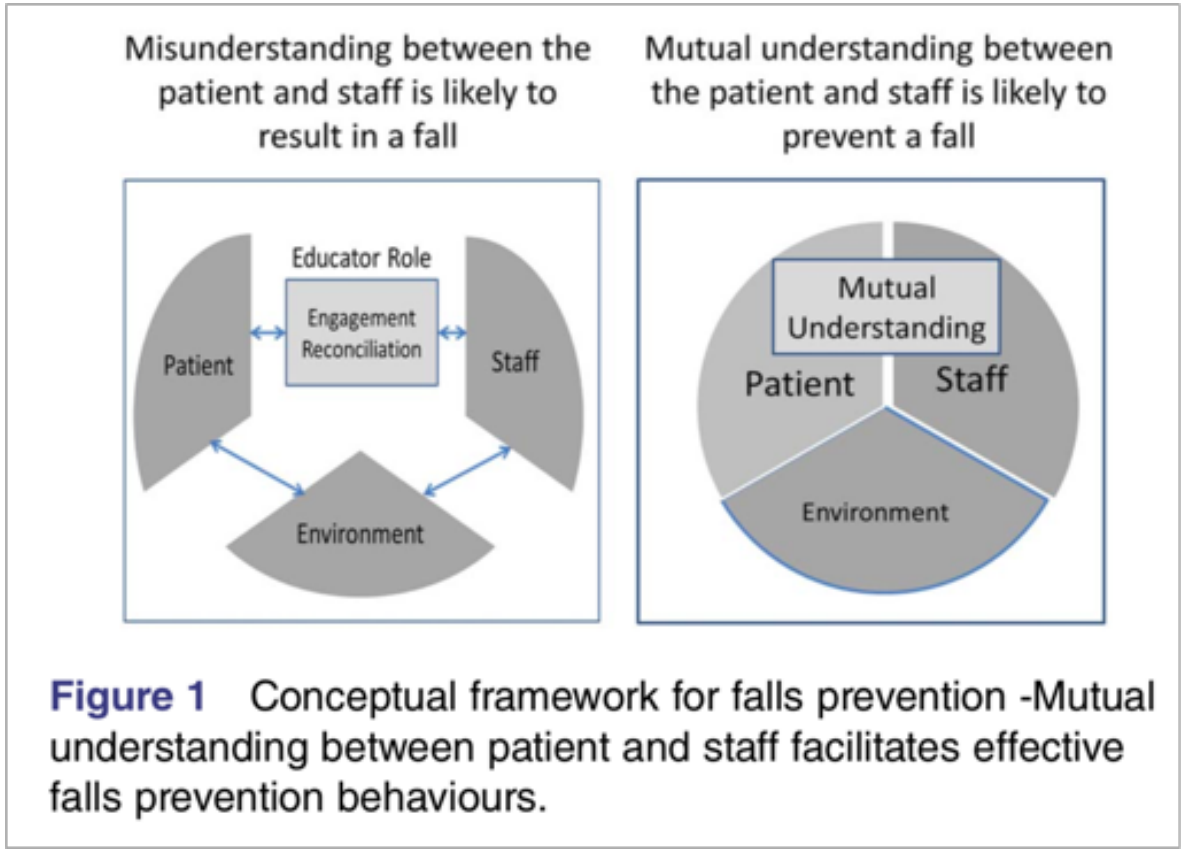


Figure 1 Conceptual framework for falls prevention -Mutual understanding between patient and staff facilitates effective falls prevention behaviours.

How was SRP adapted to suit the Burwood context?

- Volunteers
- Posters
- Environmental Education
  - Patient Status at a glance boards
  - Red/Yellow/Green mobility tags on frames
- Time

Why did we undertake a formal evaluation?

How has collaboration helped this?

Why is it important to evaluate new interventions or programmes?

- Most evaluations assume that interventions directly cause outcomes
- A realist stance argues that intervention resources are responded to differently by different people, resulting in different behaviours
- Therefore, realist evaluation expects that **different outcomes will be apparent for different people, and in different contexts**

C + M = O

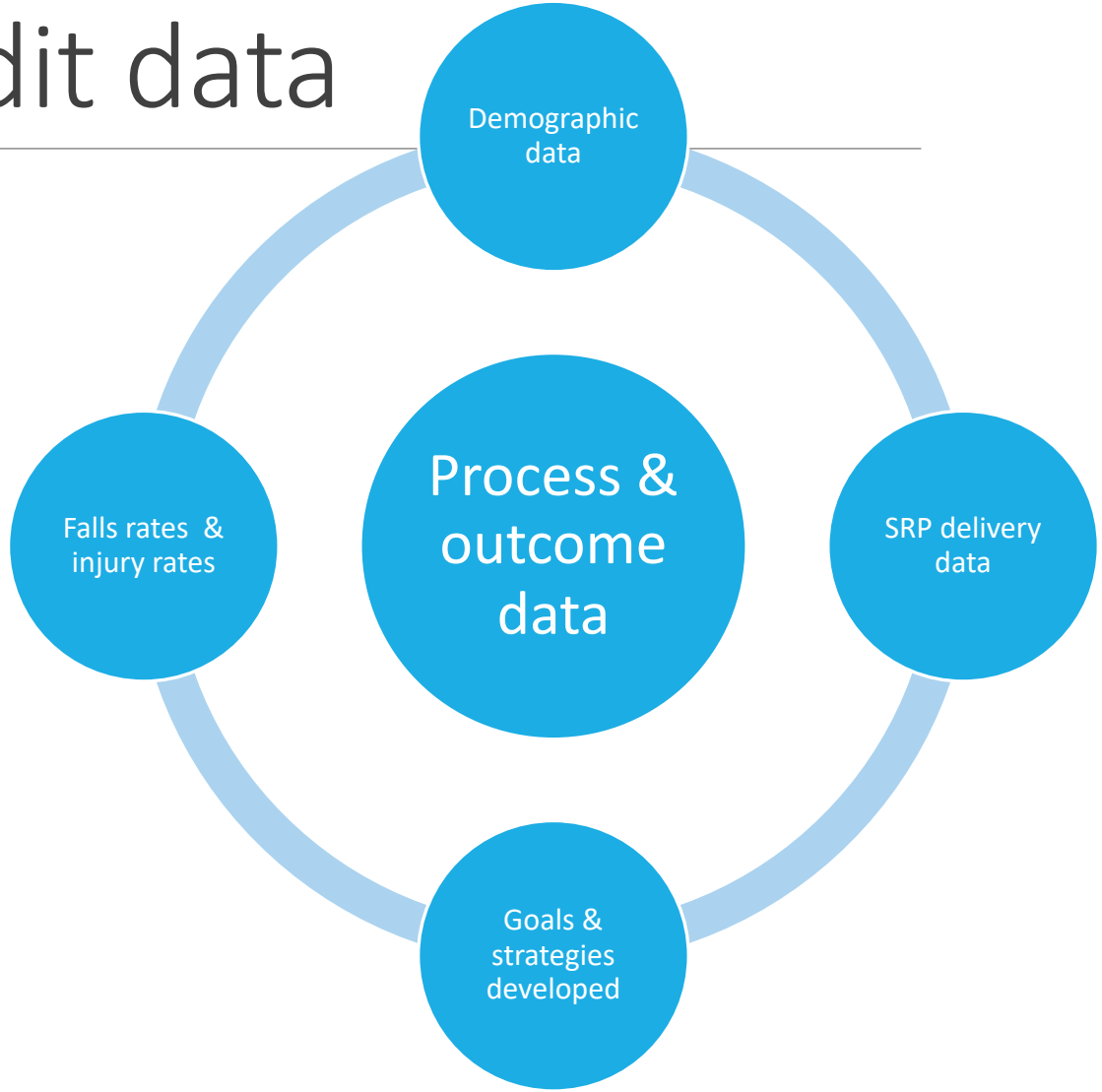
Aims of evaluation

- Determine **to what extent** has the SRP reduced the rate of falls, injuries as a result of falling and the number of fallers
- Evaluate whether the SRP works, **for whom it works (or not), and what the key mechanisms of action are in leading to its effects,** by exploring the views of patients, staff and volunteers on the experience of the falls programme.
- Make **recommendations** about the ongoing provision of a SRP or similar service within the OPHSS
- Contribute to the **ongoing development of SRP internationally** – theory development and contextual influences

Evaluation methods

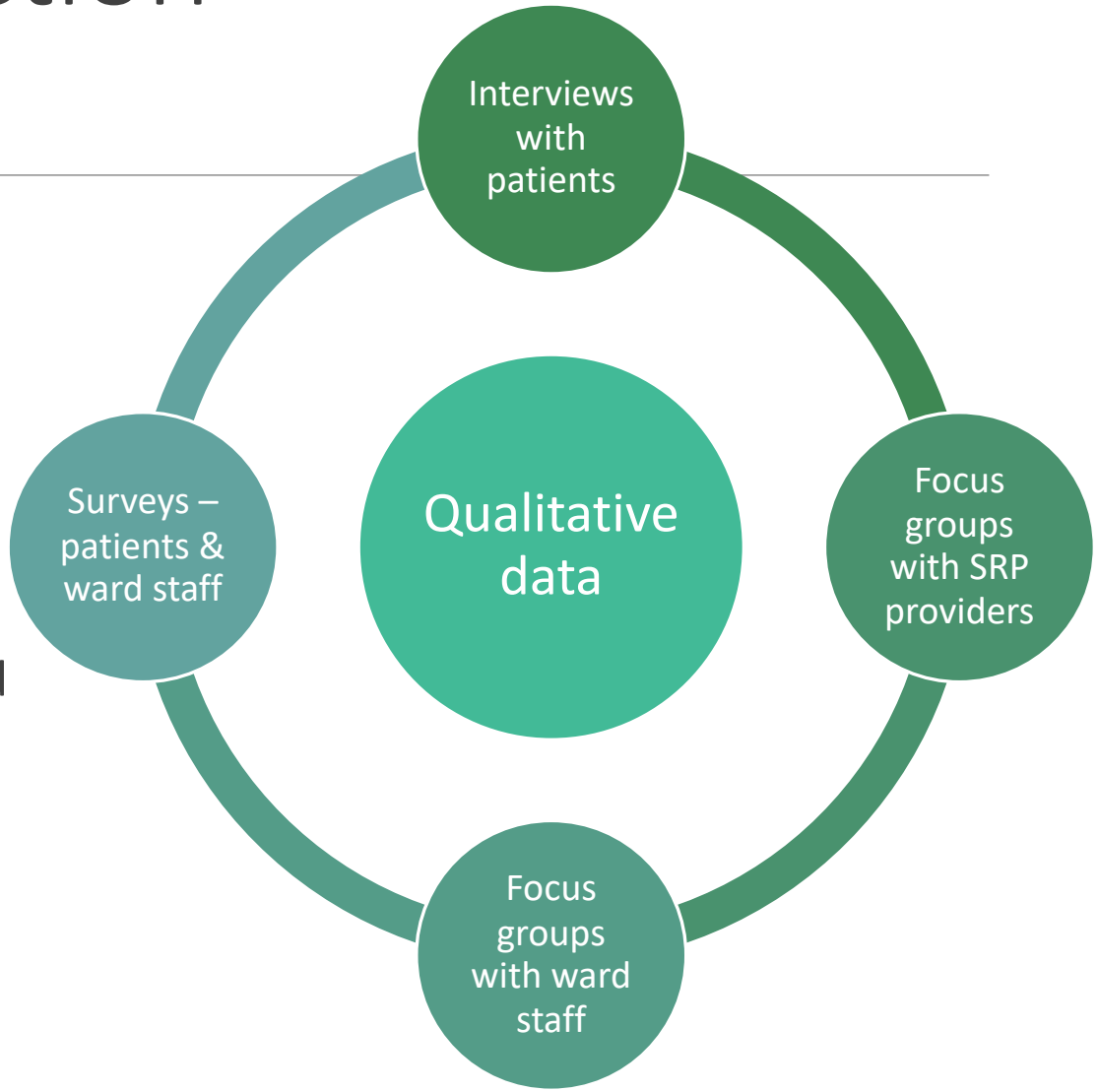
Analysis of CDHB-collected process & outcome audit data

- baseline demographic data
- data on the process of care related to the SRP - a cognitive functioning score (the 4-AT); number of SRP intervention sessions delivered to each patient
- ‘Safe Recovery goals developed by patients
- data on falls related outcomes - number of falls, severity of falls and time of falls



Qualitative data collection & analysis

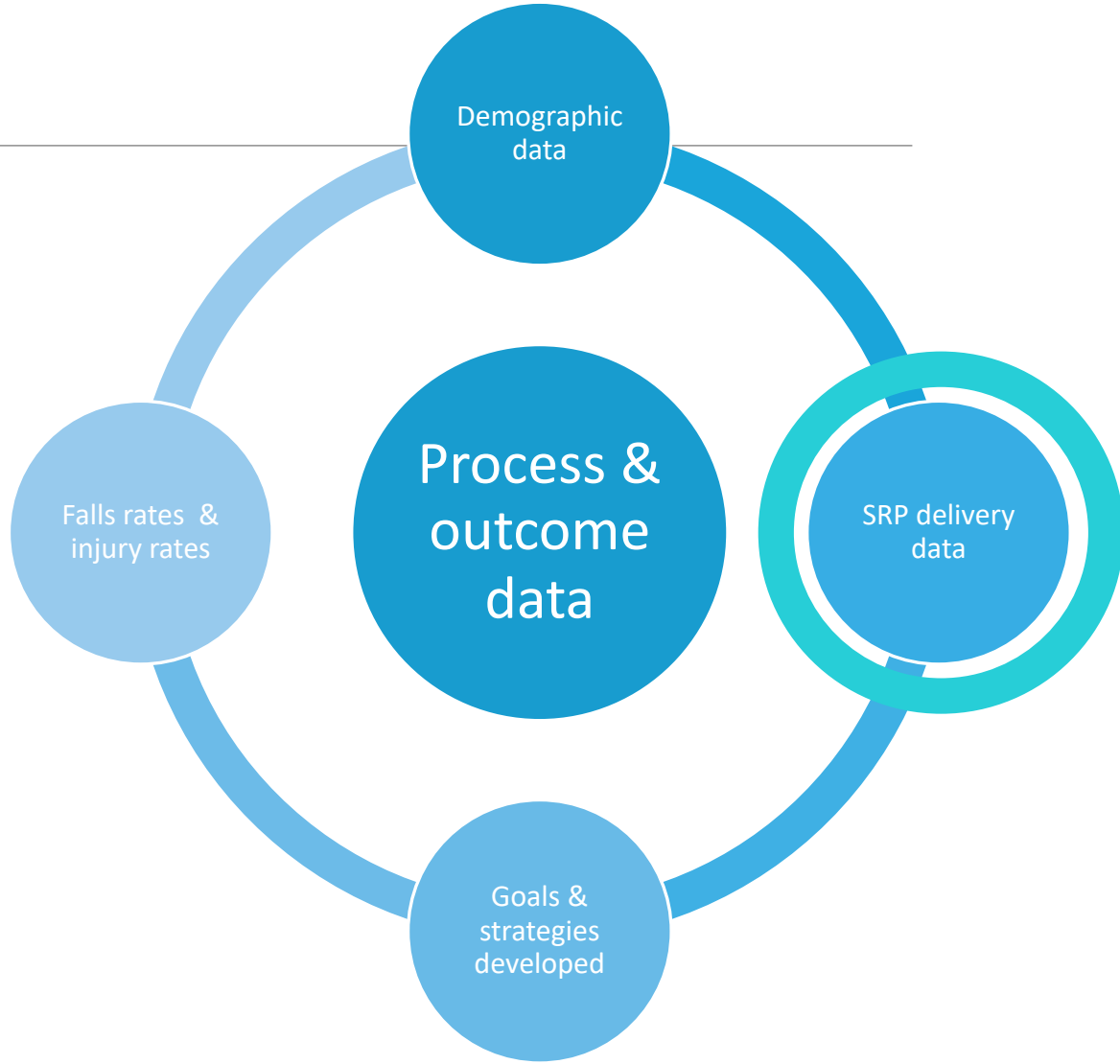
- Using realist interviewing and the development of context-mechanism-outcome (CMO) configurations
- Explore how different contexts in which a programme is delivered may impact on outcomes.
- Explicitly ask about:
  - contextual factors (e.g., staff attitudes, ward culture, availability of equipment),
  - possible mechanisms of action (e.g., improved knowledge, increased awareness, improvements in self-efficacy)
  - outcomes (e.g. how patient and staff behaviours may have changed)



What are the results and recommendations?

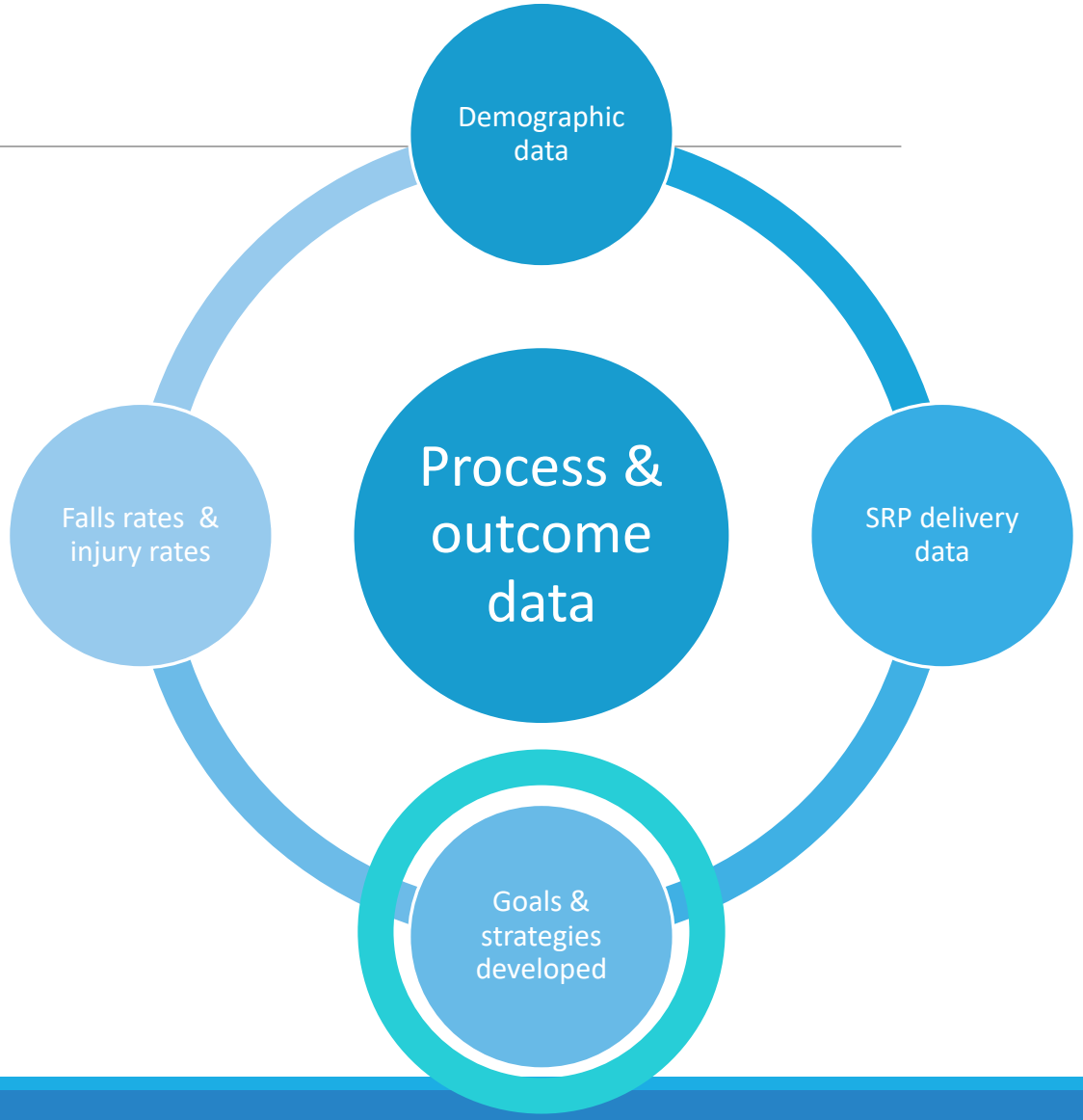
SRP implementation

- 201 patients had education delivered at least once, out of 260 patients who were screened by an educator.
- 113 were seen by educators and 80 seen by volunteers.
- Patients received on average 27 minutes from an educator or volunteer



SRP goals

- A wide range of goals were set - main focus was on the themes already in the video and booklet
- These were mainly set around:
  - using their call bell,
  - having their frame within reach and
  - patients' own risk-taking behavior
- Examples of this are; "taking my time", "planning out what I am doing" or "Calling for help early".

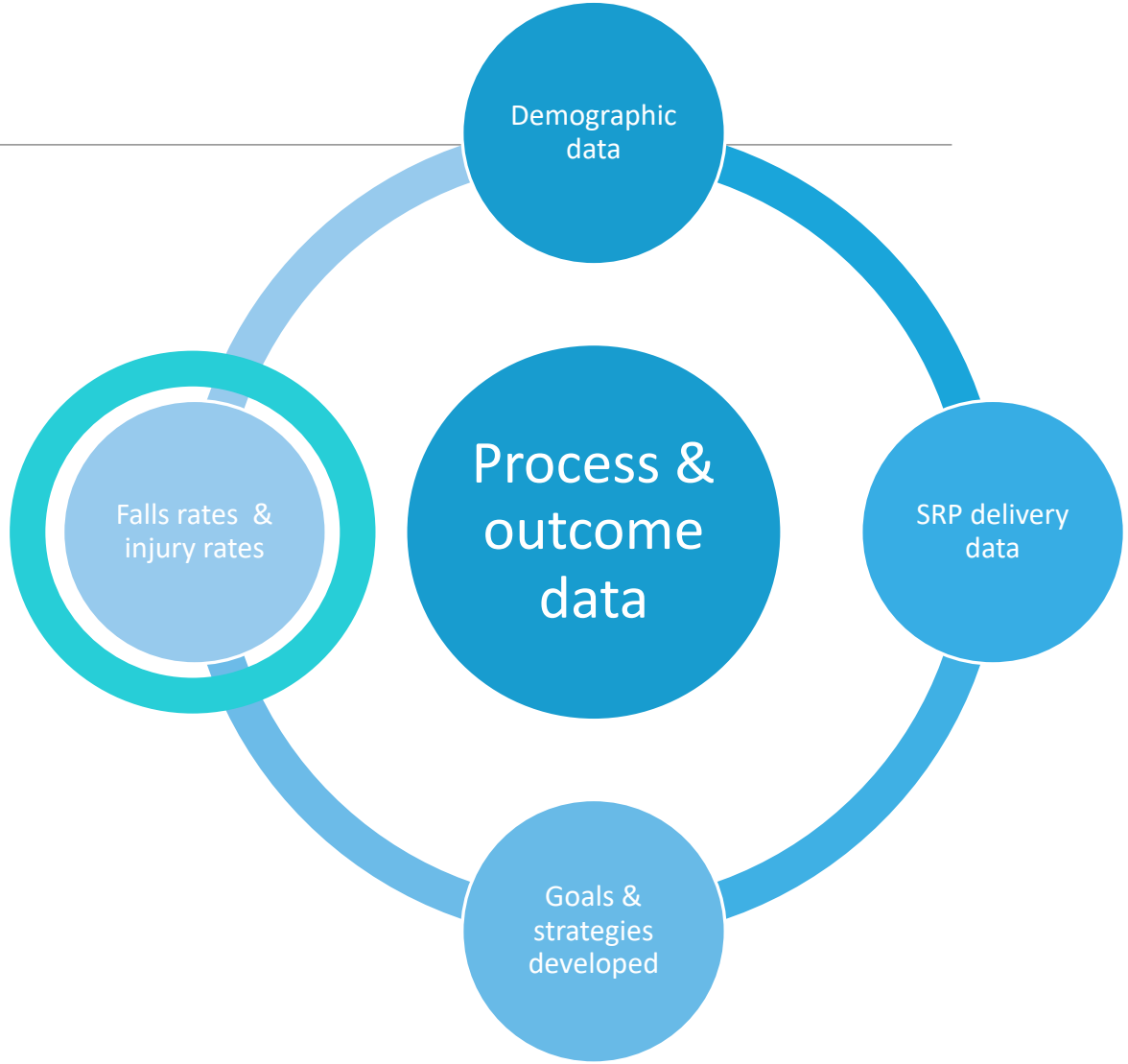


Reduction in falls

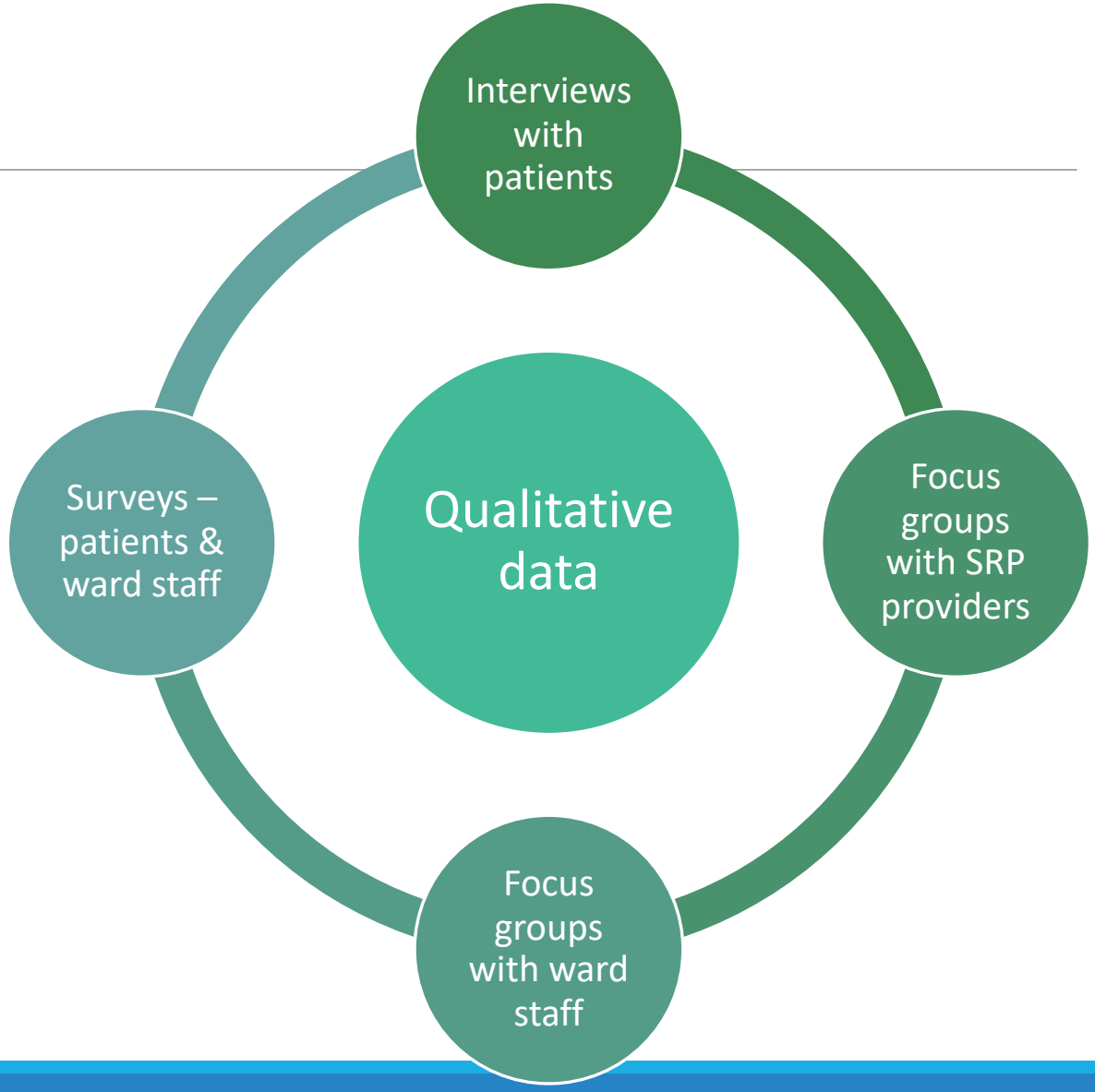
The analysis of falls data is ongoing with Decision Support and Quality.

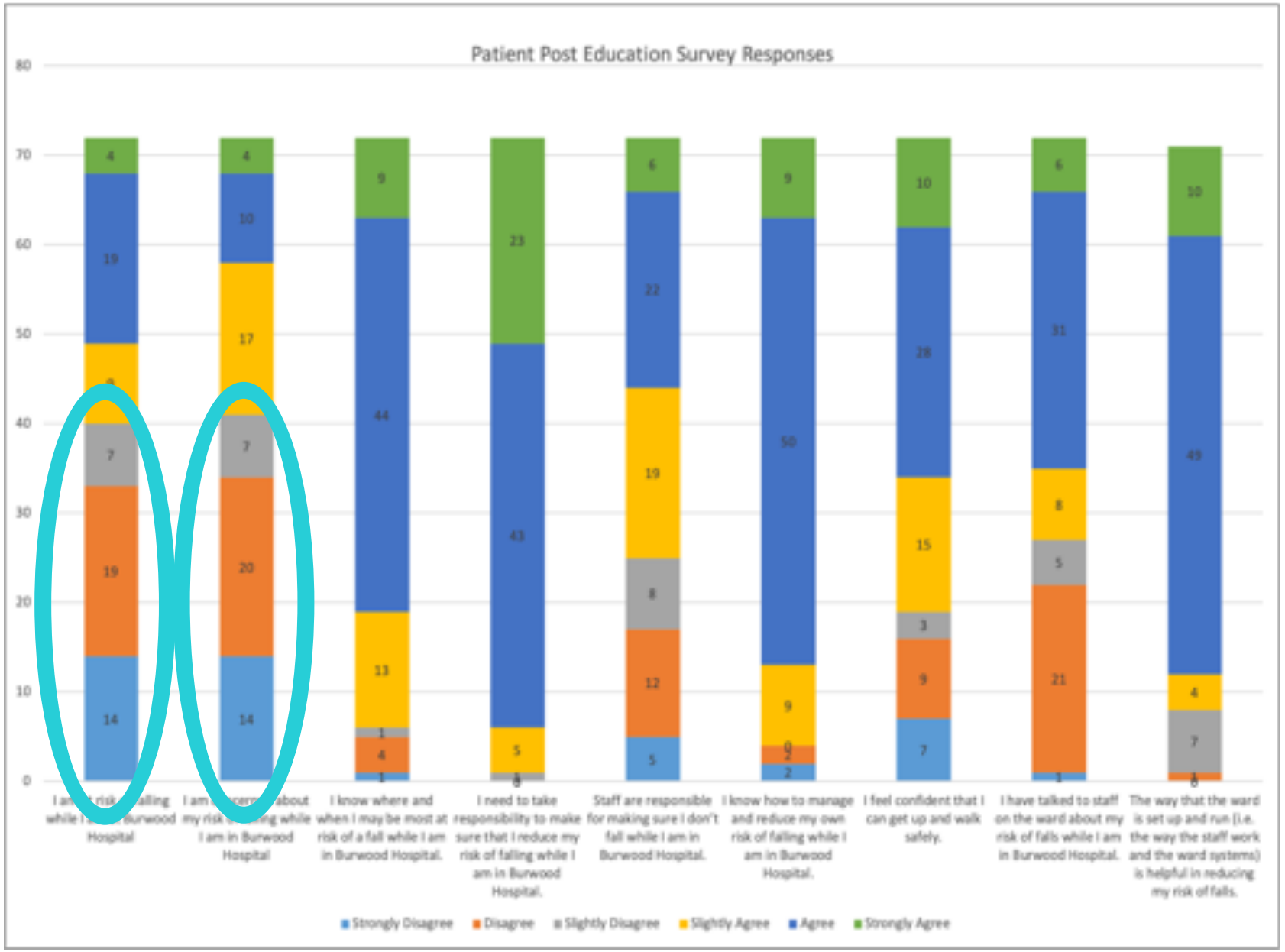
Whilst initial reports show a decrease in the falls rates per 1000 patient days, it appears the capture of ‘falls’ has not been consistent between our own source and the data warehouse. This could have implications in terms of clinical significance.

Therefore statements about the effectiveness at a falls level is difficult to provide at this stage.



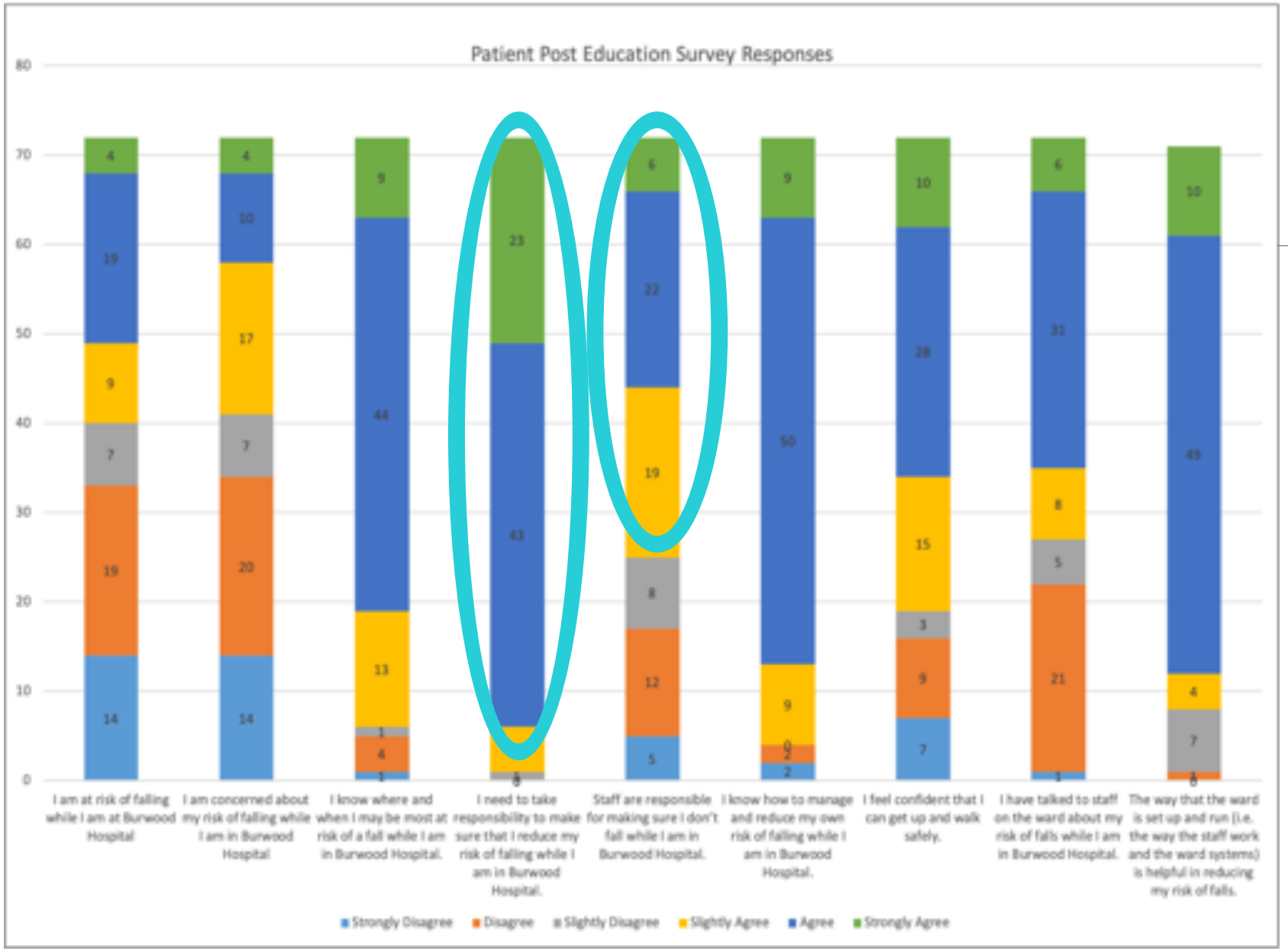
Qualitative data





Patient survey data

(*n* = 72)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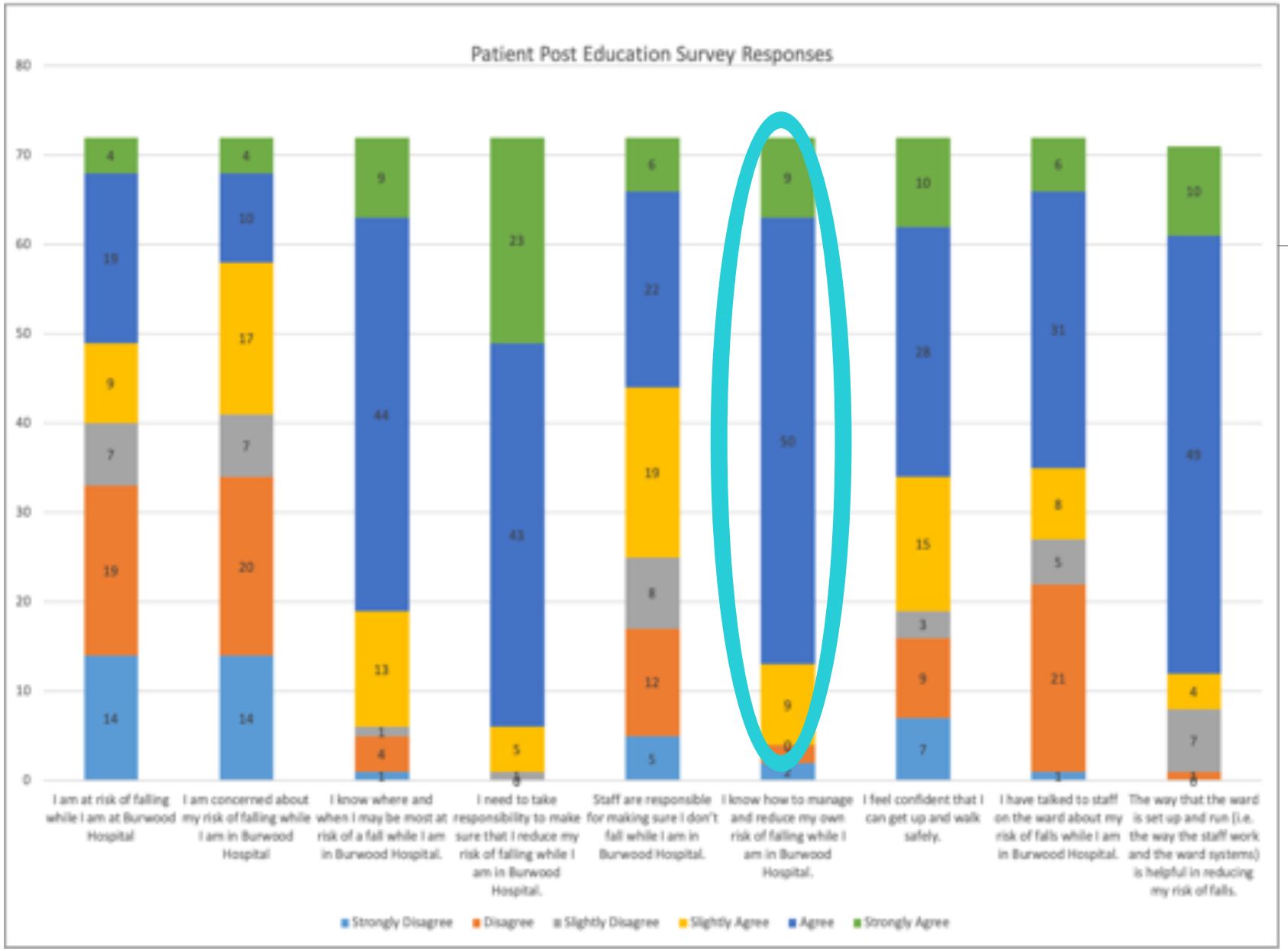
I am at risk of falling while I am at Burwood Hospital
I am concerned about my risk of falling while I am in Burwood Hospital
I know where and when I may be most at risk of a fall while I am in Burwood Hospital.
I need to take responsibility to make sure that I reduce my risk of falling while I am in Burwood Hospital.
Staff are responsible for making sure I don't fall while I am in Burwood Hospital.
I know how to manage and reduce my own risk of falling while I am in Burwood Hospital.
I feel confident that I can get up and walk safely.
I have talked to staff on the ward about my risk of falls while I am in Burwood Hospital.
The way that the ward is set up and run (i.e. the way the staff work and the ward systems) is helpful in reducing my risk of falls.
Strongly Disagree
Disagree
Slightly Disagree
Slightly Agree
Agree
Strongly Agree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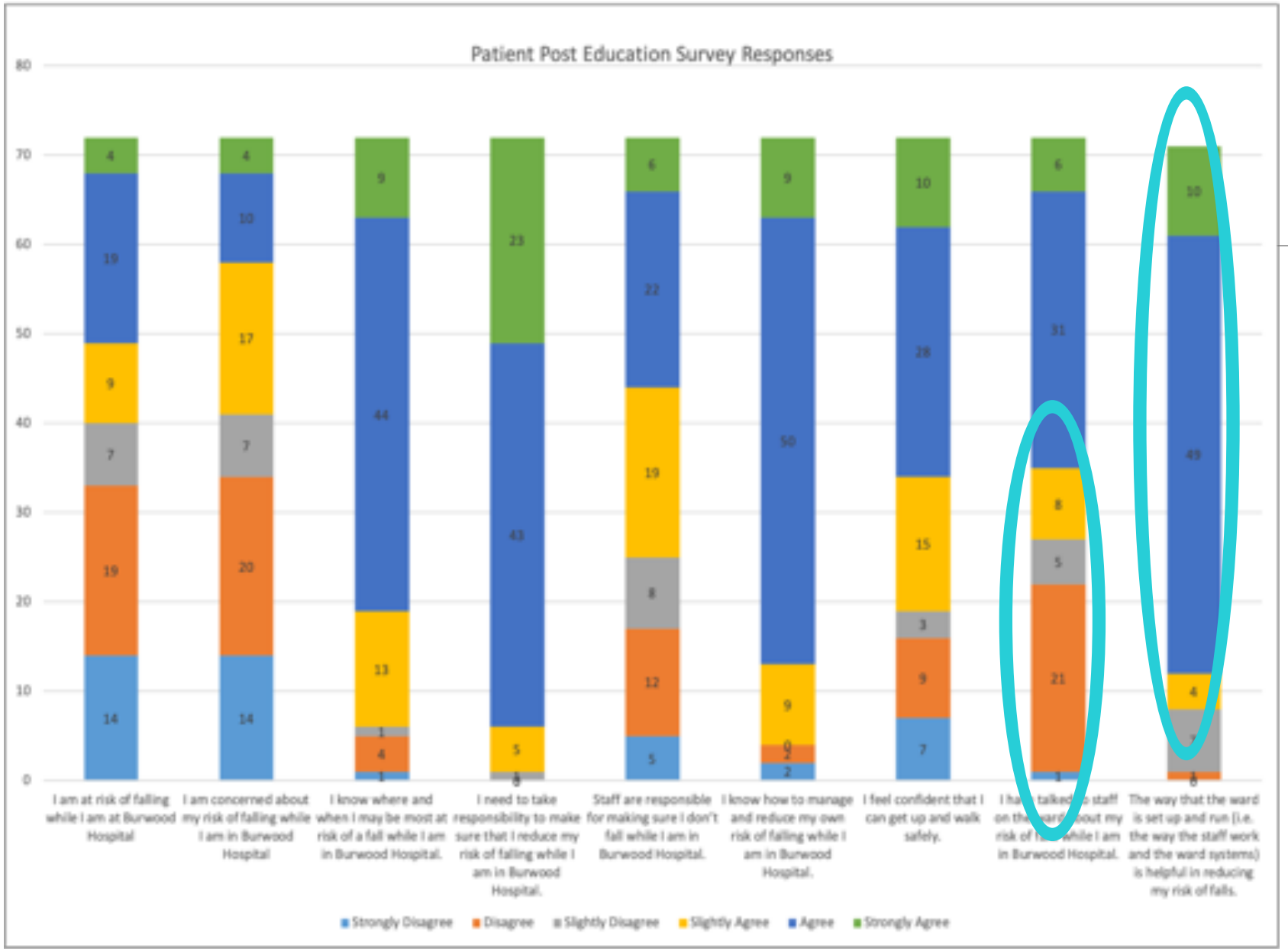
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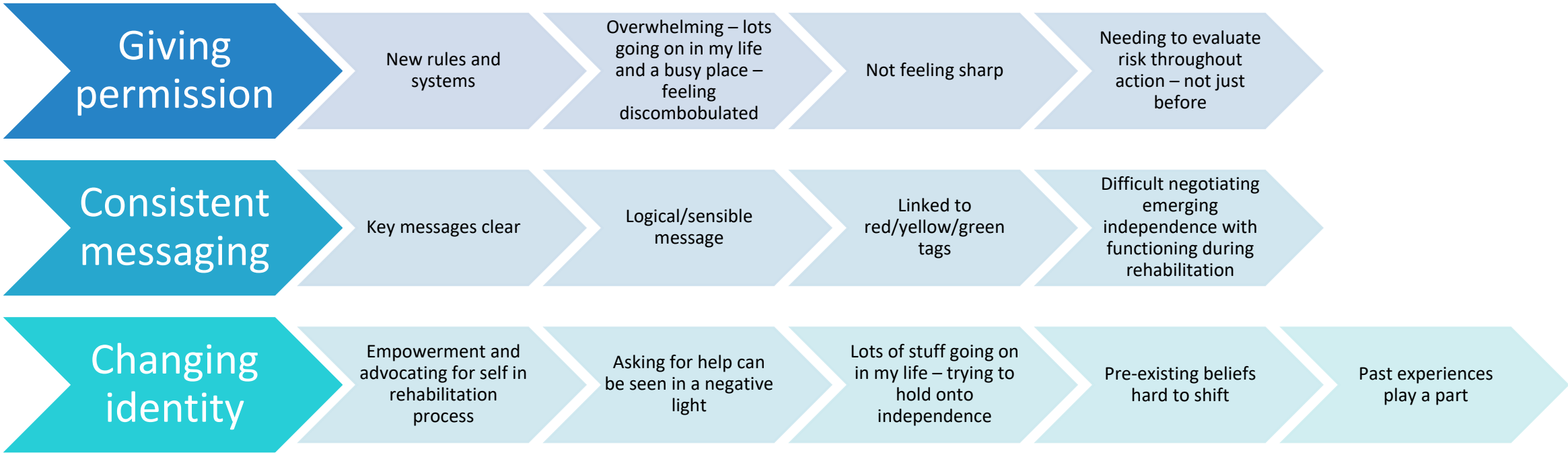
Patient interviews (*n* =11)



Staff surveys
(pre-pilot *n* = 49; post-pilot *n* = 44)

- In contrast to the perspectives of patients (in the SRP patient survey**), staff feel that they talk to patients about their risk of falling** (79% agree or strongly agree) and **discuss falls prevention strategies with patients** (71% agree or strongly agree).
- Overall there is agreement (90%) that the ward culture, processes and systems are supportive of minimising the number and severity of falls.
- There is strong agreement that patients should have goals and specific strategies to prevent falls (90% of staff agree or strongly agree with 41% strongly agreeing).
- However there is a **mix of responses as to who holds overall responsibility for preventing falls** with 51% of staff agreeing to some extent with the statement that staff are fully responsibly for preventing patients from falling and 59% to some extent disagreeing that patients are responsible for preventing falling.

… the use of language …

…we shouldn't be using language which places individual blame for system errors

Staff are not entirely responsible for this. Strategies are only as good as compliance from the patient which sometimes is not evident. Therefore there is a joint responsibility.

Safe recovery vs falls prevention

Rehabilitation vs risk reduction

Ward staff, SRP educators & volunteer focus groups

Overview of how SRP worked (or didn't work) in Burwood setting

- **Posters** very helpful for patients and staff
- **Peer educators** – appreciated by patients; increased discussion of continence related issues
- **Time** required to develop rapport and establish goals that are meaningful for the patient
- SRP providers became **more skilled** at delivering the intervention (especially personalised goal setting and strategy development)
- Need to more explicit **feedback mechanisms** to ward staff
- Reinforced Hills' qualitative findings > **shared understanding** > consistency and coherence of messaging and strategy reinforcement

SRP theory development

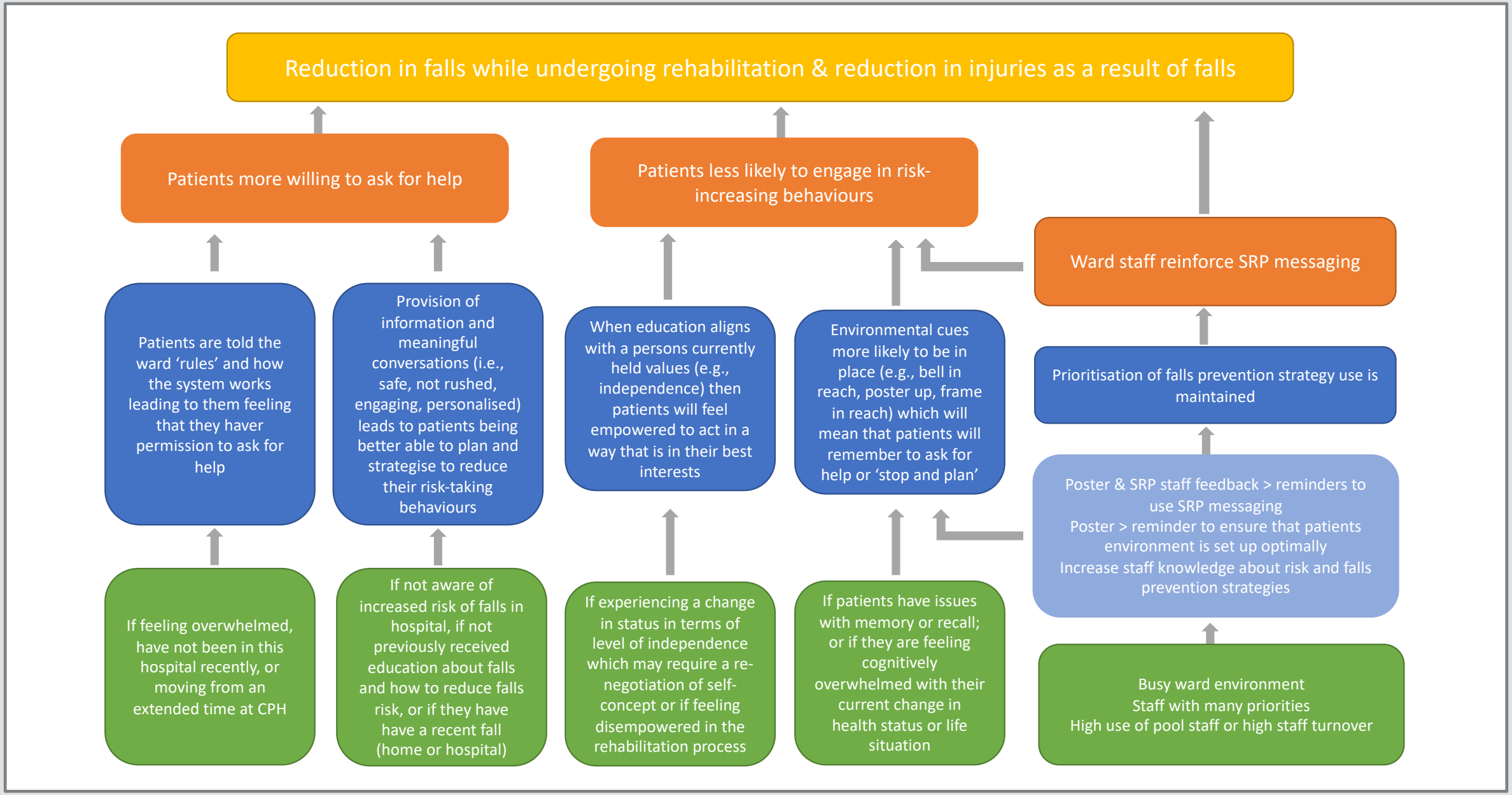
Patients are told the ward ‘rules’ and how the system works leading to them feeling that they have permission to ask for help

Provision of information and meaningful conversations (i.e., safe, not rushed, engaging, personalised) leads to patients being better able to plan and use strategies to reduce falls risk behaviours

When education aligns with a persons currently held values (e.g., independence) then patients will feel empowered to act in a way that is in their best interests

Environmental cues more likely to be in place (e.g., bell in reach, poster up, frame in reach) which will mean that patients will remember to ask for help or ‘stop and plan’

Prioritisation of falls prevention strategy use is maintained by staff


Reduction in falls while undergoing rehabilitation & reduction in injuries as a result of falls
Patients more willing to ask for help
Patients less likely to engage in risk-increasing behaviours
Ward staff reinforce SRP messaging
Patients are told the ward 'rules' and how the system works leading to them feeling that they haver permission to ask for help
Provision of information and meaningful conversations (i.e., safe, not rushed, engaging, personalised) leads to patients being better able to plan and strategise to reduce their risk-taking behaviours
When education aligns with a persons currently held values (e.g., independence) then patients will feel empowered to act in a way that is in their best interests
Environmental cues more likely to be in place (e.g., bell in reach, poster up, frame in reach) which will mean that patients will remember to ask for help or 'stop and plan'
Prioritisation of falls prevention strategy use is maintained
Poster & SRP staff feedback > reminders to use SRP messaging
Poster > reminder to ensure that patients environment is set up optimally
Increase staff knowledge about risk and falls prevention strategies
If feeling overwhelmed, have not been in this hospital recently, or moving from an extended time at CPH
If not aware of increased risk of falls in hospital, if not previously received education about falls and how to reduce falls risk, or if they have have a recent fall (home or hospital)
If experiencing a change in status in terms of level of independence which may require a re-negotiation of self-concept or if feeling disempowered in the rehabilitation process
If patients have issues with memory or recall; or if they are feeling cognitively overwhelmed with their current change in health status or life situation
Busy ward environment
Staff with many priorities
High use of pool staff or high staff turnover

Overall recommendations

Emphasise different types of learning depending on the patient characteristics

- If a recent fall > patient ‘primed’ for education. Higher risk & open to learning and integrating knowledge
- If relatively new to Burwood > emphasis on the rules of the system > will gain permission to call for help
- If the person is experiencing a change in independence status (i.e., requiring a lot more support than did prior to admission) > attention that education aligns with patients own values, and that goal setting discussion recognises this.

Poster is a key new intervention resource that has the ability to optimise:

- feedback loop to staff to maintain priority given to falls prevention behaviours by staff
- assist with patient recall

Overall recommendations

Use of volunteers contributed to effective delivery of intervention

- attention to skills and age of volunteers (i.e., peers)
- SRP requires ongoing coordination (i.e., still need CDHB SRP staff funding)

Video should ideally be adjusted to:

- take into account existing local falls prevention systems (e.g., red/yellow/green)
- linked to strategies that they might have heard about reducing falls risk at home (to improve explicit coherence)

Important to ensure **explicit and formalised processes to feedback to staff** are embedded prior to the start of SRP implementation > time to 'prime' ward staff about underlying concepts, how they can be part SRP, and how the SRP builds on other falls prevention strategies in use

What have we learnt about implementing evidence-based interventions in new settings?

Preparation

- Resources and training of intervention delivery
- Establishing systems for collaboration and coherent approach
- Preparing staff on wards
- Time to develop robust evaluation data collection methods
- Value of support from management

Delivery

- Integration with existing interventions and programmes
- Be clear about what is new/added, what is refined, and what has stopped – changes in resources
- Alternative forms of delivery can work as well, if not better – but are you changing key aspects of the intervention?
- Usually the published literature will not provide answers to tricky questions – talk to the primary researchers to clarify
- Multiple interventions starting at the same time

Evaluation

- Takes time, resources and planning
- Sustained reflective analysis of multiple forms of data contributes to better delivery of services
- Including the patients voices in evaluations of effectiveness
- Enacting recommendations will take another level of commitment!

Collaboration

CDHB:

- Involvement in set up of the project – clinical considerations made explicit in design of evaluation
- Regular meetings (weekly – fortnightly) to discuss implementation > fed into evaluation process > added to richness of data collection
- Real-world, useful and practical > knowledge translation is integrated, current and ongoing
- Fun!

BAIL:

- Having a research focus raises the quality of the overall project
- Richer information gathering – particularly from a qualitative perspective including patients
- Independent and neutral challenge to the project and reasoning
- Helped drive data gathering
- Supported ongoing reflective practice for the whole of the project

Questions