Institute for Musculoskeletal Health

A research partnership between Sydney Local Health District and the University of Sydney in musculoskeletal health and physical activity

Barriers and facilitators to supported implementation of multicomponent fall prevention interventions in hospital: a qualitative study

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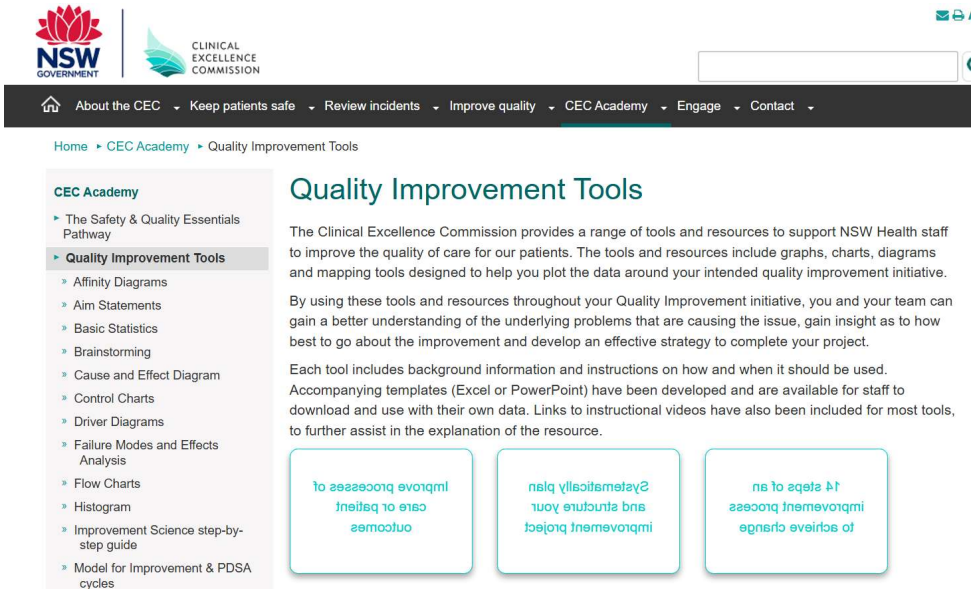
THE UNIVERSITY OF SYDNEY

Background

- Multicomponent fall prevention interventions (where patients or ward receive multiple interventions linked to individual risk profiles) can reduce patient falls in hospitals
- Implementation of these approaches in routine practice can be challenging and inconsistent.

Background

Quality improvement (QI) education and clinical facilitation may support the implementation of multicomponent interventions.



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Feasibility study: Supported implementation of tailored multicomponent fall prevention interventions in hospital

- Wards nominated a local team to lead the implementation of multicomponent fall prevention interventions, informed by local incident data, on their ward.
- Teams completed QI training: online or face to face
- 12 weeks of clinical facilitation from a health manager with QI and fall prevention experience

Feasibility study on 4 acute hospital wards

Ward no.	Ward type	Nominated ward leadership team	Mode of QI training	Fall prevention interventions selected by ward
1	Surgical	Nurse Unit Manager, Nurse Educator, Physiotherapist, Dietician	Online	-Optimising the safety of bedside environments -Improving ward mobility equipment management
2	Medical	Nurse Unit Manager, 2x Nurse Educators, Registered Nurse	Online	-Staff delivering oral patient education about fall risk and prevention strategies -Optimising the safety of equipment for patient attachments (especially intravenous (IV) poles)
3	Surgical & medical	Nurse Unit Manager, Nurse Educator, 2x Physiotherapists	Online	-Staff receiving education and training regarding safe patient mobility -Refining interdisciplinary staff communication processes about patient mobility status
4	Surgical & medical	Nurse Unit Manager, Nurse Educator	Face to face	-Staff delivering oral patient education about fall risk and prevention strategies -Staff receiving education regarding delirium identification and management.

Research Question

What are the barriers and facilitators to supported implementation (via quality improvement education and clinical facilitation) of multicomponent fall prevention interventions in acute hospital wards?

Methods

- Local staff team members invited to participate in interviews post the 12-week intervention period (n= 12, nursing & allied health)
- Interviews were conducted in-person, audio-recorded and transcribed
- Transcripts were analysed as a combined dataset using a qualitative descriptive approach. This involved inductive (data driven) coding and deductive coding to the i-PARIHS framework.

Limitations

- The intervention and implementation strategies were light touch
- Interviews conducted a relatively short time post the intervention
- Small sample size
- One hospital

Methods

i-PARiHS (Promoting Action on Research Implementation in Health Services. *Harvey G, Kitson A. PARIHS revisited: from heuristic to integrated framework for the successful implementation of knowledge into practice. Implement Sci. 2016;11:33.*

SI = f (E, F, R, C)

Where SI = successful implementation
E= Evidence (intervention/ innovation)
F= Facilitation (implementation strategies)
R= Recipients
C= Context
f= function of

Results

Barriers and facilitators were identified relevant to the:

1. ***Innovation****:* multicomponent fall prevention interventions informed by local data
2. ***Facilitation****:* QI education and clinical facilitation
3. ***Recipients****:* Ward staff teams
4. ***Context:*** Hospital ward and facility

INTERVENTION *(multicomponent fall prevention interventions informed by local data)*
FACILITATORS

Blame-free critical thinking	*"I think it was a really positive mindset shift, in understanding that it's not that anyone was doing anything wrong, but being able to pick up the signs of narrowing things down to see how they could be improved and now being able to integrate that into practice." Ward 2, P3*
A fresh approach to a stubborn issue	*"It's different to anything else I've ever done before, the fact that we were given the opportunity to have the education and do something that's our own, and like, I think, like, that's really empowering, which is awesome." Ward 4, P2*
Incrementalism	*"I thought it was valuable in the sense that it's about making change in like small blocks of change rather than something big. And just yeah, starting with a small thing to try to change certain stuff" Ward 1, P1*
Local integration	*"We combined it with manual handling that is a pre-existing compulsory education course. Which actually worked out really well" Ward 3, P1*

INTERVENTION *(multicomponent fall prevention interventions informed by local data)*
BARRIERS

Insufficient guidance about change ideas	*"There was just lots of different ideas and not a lot of decisions or action. We would just sort of go around in circles… I think we needed someone that could pick up that we didn't know what we were doing and just give us a little bit more guidance" Ward 4, P2*
Slow-moving interventions	"*I think if you go too slowly and start too small then you can lose interest" Ward 2, P2*
Limited floor staff engagement	"*In terms of like disperse ward staff they didn't know enough about the project for them to be supportive of it" Ward 2, P1*
Unvalued change ideas	"*they kind of just felt like it wasn't relevant. We couldn't motivate them, wanting to tidy things up. And yeah, I think that that's where it lost steam a little bit" Ward 1, P2*
Interventions perceived as extra work	*"it's hard to ask staff and encourage them to want to participate in projects that they might have to look at doing outside of work or outside of their paid hours, when in hours they might not be getting breaks, they're working so hard already" Ward 2, P1*

Facilitation (quality improvement education and clinical facilitation) FACILITATORS

Space for learning	*"It was really good doing that two-day QI course prior. And then you have a really good understanding and you're ready to go.. it helps give you space where you can actually think" Ward 4, P1*
Skilled facilitation	*"The clinical facilitation was amazing… it really guided and was able, like at times when I didn't think we had done anything. She would be able to be like, no, this is actually producing work. But I think when you're in real time, it's hard to capture that." Ward 2, P2*
On-ward facilitation	""*That contact time is really important… cause it's so useful to have that guidance with these kind of QI things, especially when it is so busy like someone that's kind of across it and has the ideas and kind of can help pull you along a little bit." Ward 2, P1*
Novel and responsive education	*"It's different being with a physio teaching you how to get someone up at the bedside, rather than just like someone taking you through an education session." Ward 3, P2*

Facilitation (quality improvement education and clinical facilitation) BARRIERS

Poorly defined roles and goals	"*Sometimes it felt like we didn't always achieve that much in the time between. To have some, like, very specific goals or something like that between... Something that we needed to achieve before that time we're meeting again." Ward 4, P1*
Lack of accountability	"*I've seen this with so many projects that people are keen but then they don't follow through and like, it's almost they need a contract, but like some type of expectation set that you sign and say, yes, I'm willing to give this time and see it through" Ward 1, P3*
Isolated QI knowledge	"*Us on the team could, like I understood the methodology behind it. Like doing, you know, starting small, but the staff couldn't. And they, you know, they were like what's the point" Ward 4, P2*

RECIPIENTS (ward staff project team)
FACILITATORS

Enthusiastic MDT	"*"I enjoyed the fact that we could actually come together as a multi-disciplinary team to do a project like this and so I think that went really well." Ward 1, P2*
Pre-established team rapport	"*"On our ward there is a history that the physio and nursing staff work well together…I think having them (physios) on board made it easier, just like easier for motivating us to keep going with the project" Ward 3, P3*
Empowered decision making	"*"I think for me what's been really important is that I can actually opt in for things here… there's often times where we are like, for whatever reason, like forced to undertake different things, make changes, we never get... unlike here no one asked for our opinion on how we can make things work, how it can work well, or you know the option to give feedback.*
Pre-implementation orientation	"*You actually need that four weeks beforehand to get your head around your strategy and your approach." Ward 2, P2*

RECIPIENTS (ward staff project team)

BARRIERS

Inadequate team leadership	*"And you know we have had three NUMs in the last year and a half.. that interrupts the continuity of the care. And like plannings and projects and everything like it" Ward 2, P1"*
Juggling clinical vs non-clinical responsibilities	*"It's really hard to sit down and get office work done when, you know, we might be short staffed on the floor. You feel bad. it does have a huge knock-on effect." Ward 2, P2*
Team capacity	*"I think that's where, again, it highlights the importance of it not just being the CNE and the NUM. Because otherwise you've got two people that have to navigate priorities of a project when everything's the priority." Ward 1, P3*

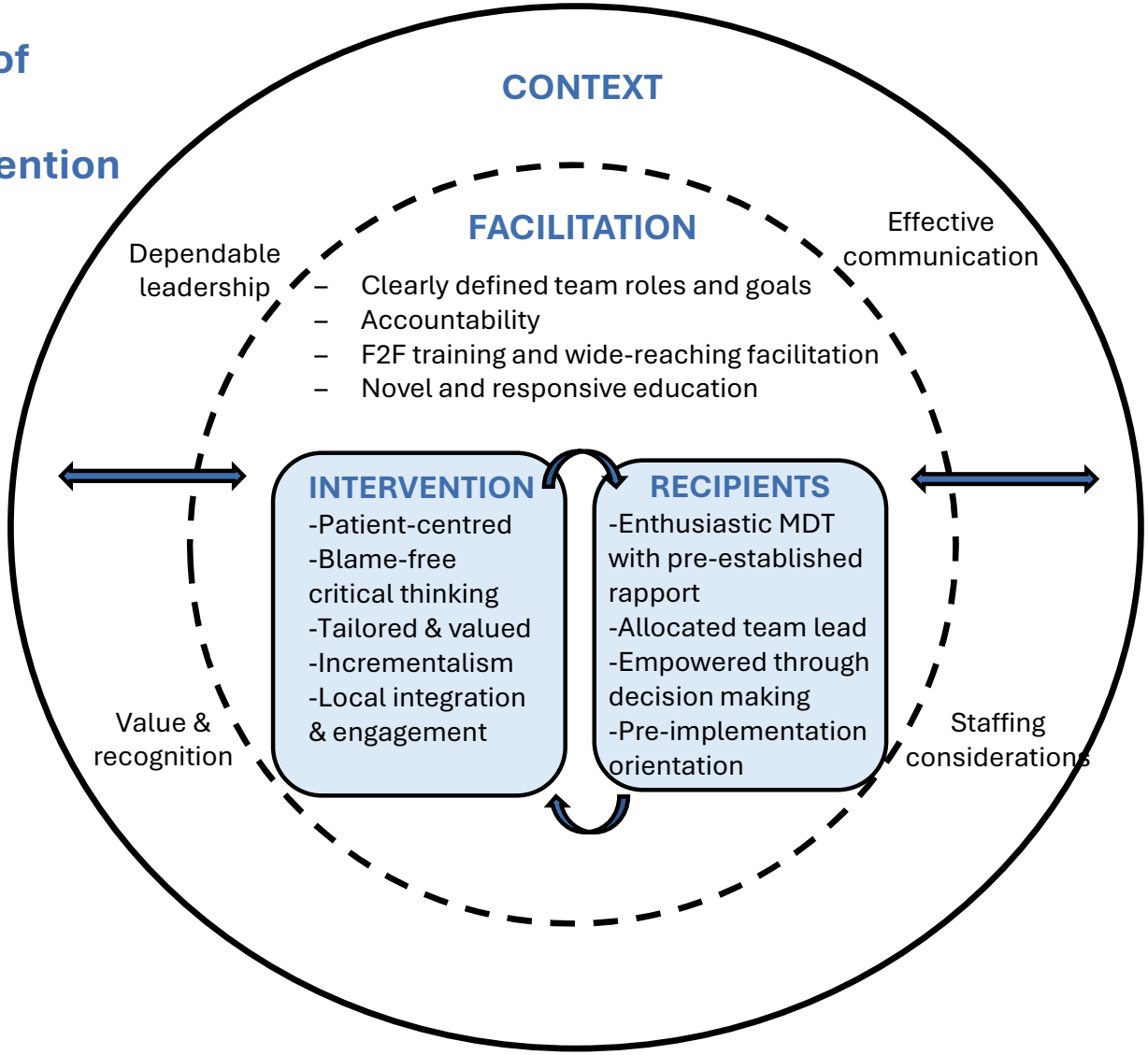
CONTEXT (hospital ward and facility)
FACILITATORS

Dependable leadership	*"It was great that the ward manager was on board as well. So he was helping, you know, getting people into it as well. The enthusiasm of the consultant too, you know really showed that she wanted us to do this and we can do this here. And really helped motivate us to be involved." Ward 3, P1*
Effective team communication	*"They are really good at communicating with each other too. Like if you know, they tell someone that's like, in charge on the weekend, like can you please hand this over." Ward 4, P1*
Executive recognition	"*And that recognition of the work we're doing, coming from executive, seeing the work we've put in, the heavy involvement- that helps. It can help staff to keep doing a really good job." Ward 3, P1*
QI a valued process	*"I love quality improvement projects. They're important…People want to be engaged in quality improvement" Ward 4, P2*

CONTEXT (hospital ward and facility)
BARRIERS

Competing priorities	*"A lot of these nurses are like, not doing anything about that, they move on and think I'm going to focus on this part of care instead because they think there they can actually make a difference. This is what I see and what I can try to fix." Ward 1, P2*
Staggered work schedules	""*The rotating roster makes it really difficult and we've also got 12 hour staff, so most of our senior staff are 12 hour staff and they do 50% night shifts so we don't, so I … only see them six to seven days out of a month." Ward 4, P1*
Staffing challenges	"*We are really short staffed, so it does make it incredibly hard to allocate people onto a project." Ward 2, P2* *"I can actually see how more and more and more are being added these roles, and you don't get time to do the things you want to do, which really sucks" Ward 4, P1*

Successful implementation of multicomponent hospital fall prevention programs



Conclusion

Tackling barriers and leveraging facilitators relevant to the intervention, facilitation, recipients with continued local adaption may enhance the impact of QI education and clinical facilitation to support effective multicomponent fall prevention interventions.

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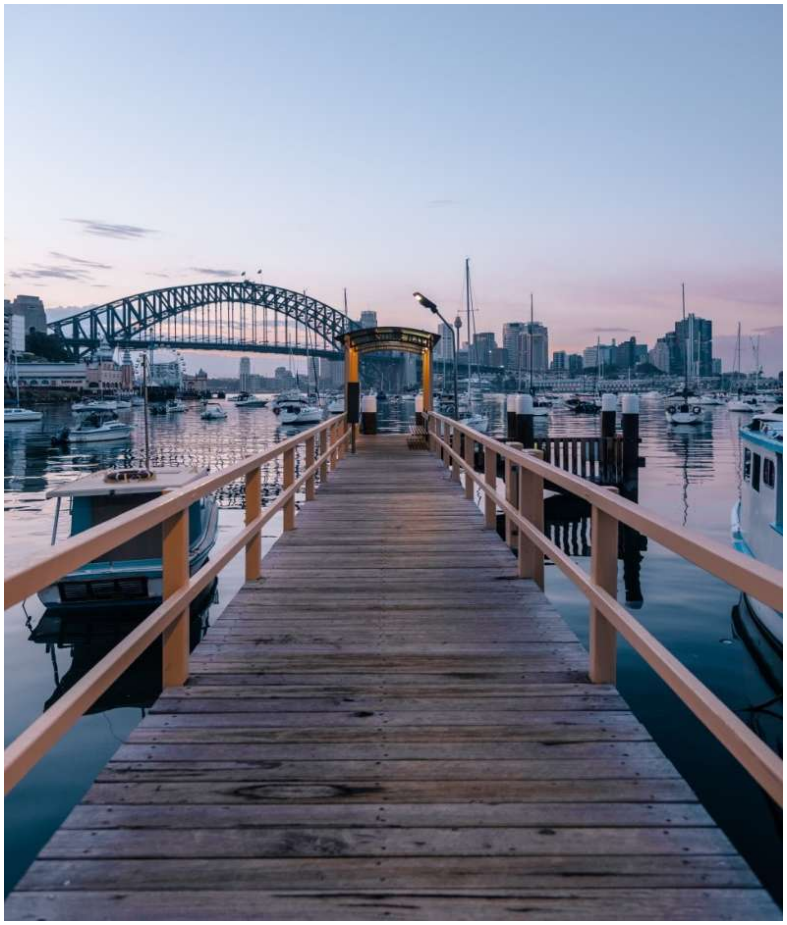

Thank you

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