Be Proactive, Not Reactive:
A Collaborative Approach to Fall Risk Identification, Prevention and Post-Fall Care for Older Adults in Saskatchewan

Stakeholder Event January 28th, 2022

Introduction and Key Messages

Who are we?

Other team members not here today: Alexander Crizzle, *University of Saskatchewan*
Kelly Froehlich, *Ministry of Health;* Daphne Kemp, *SHA*

Cathy Arnold
Researcher and Principal Investigator
University of Saskatchewan

Shan Landry
Facilitator
Saskatoon

Heather Dyck
Patient Family Partner
Birch Hills

Janet Barnes
Patient Family Partner
Saskatoon

Shanthi Johnson
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Jason Parkvold
Clinical Standards & PP Rural
Yorkton Health Center

Joy Richards
Webinar Technical Support
University of Saskatchewan

Michaela Lynds
Researcher
University of Saskatchewan

Laura Bouvier
Falls Prevention Coordinator
Sun Country Health Region

We acknowledge that we live and work on Treaties 6, 2,4,5, 8 and 10 and the Homelands of the Métis. We pay our respect to the First Nations and Métis ancestors of this place whose diverse histories, languages, and cultures enrich our communities.

"***To foster healthy ageing, we need to work together***.."
Director-General WHO

A Decade of Healthy Ageing in Canada Must Start with a National Seniors Strategy
National Institute on Aging Sept 2021

As of July 1, 2021, 16.7 % of Saskatchewan's population is 65 years of age and older Stats Canada

Falls leading cause of injury hospitalizations (77% - 85%)
CIHI, 2017-2021

Between the end of March 2020 and mid-May 2021, seniors age 65 years or older accounted for 93% of the deaths attributed to Covid-19
Stats Canada Oct., 2021

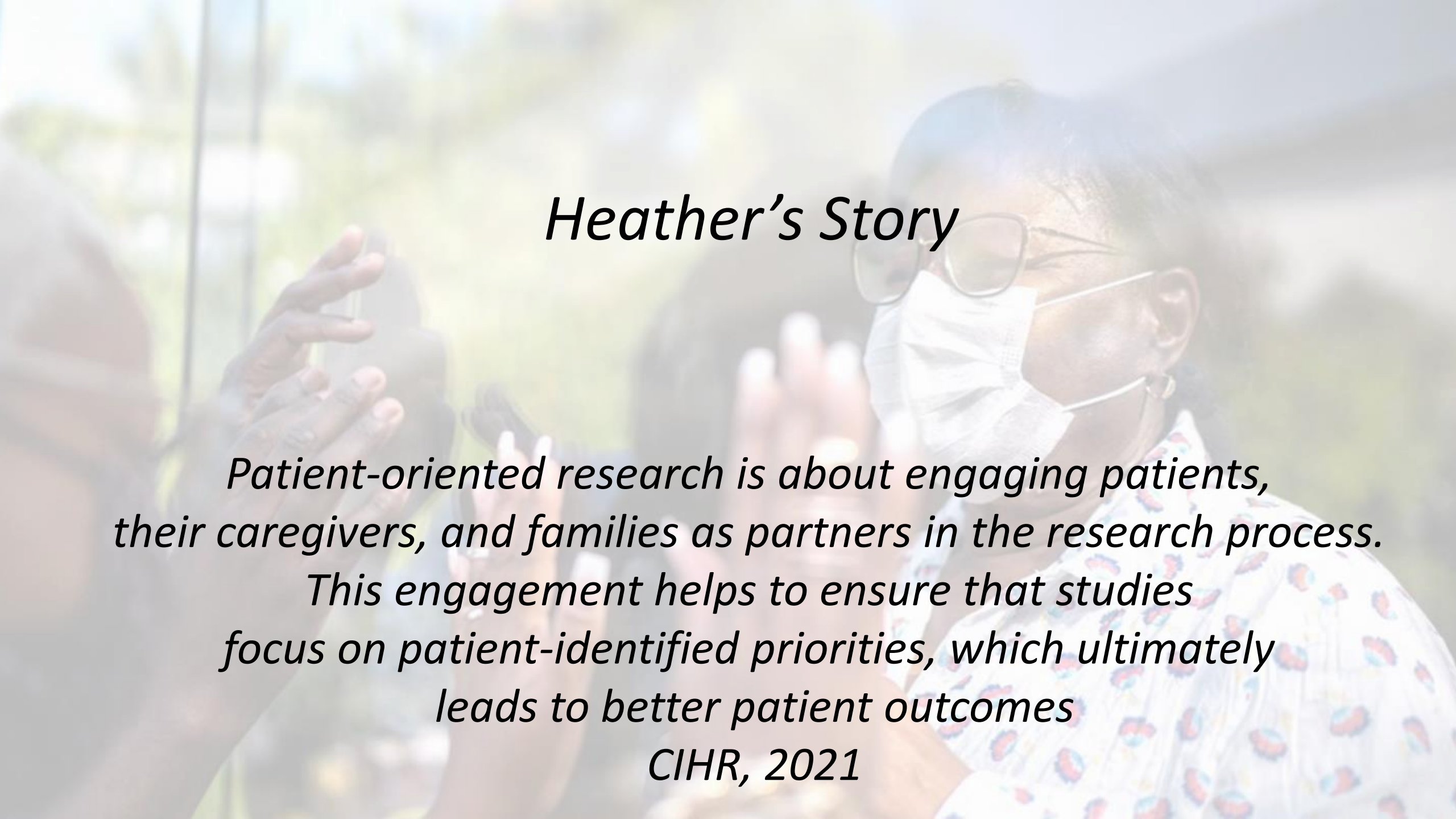
CALLS TO ACTION

- Age-Friendly Environments
- Combatting Ageism
- Integrated Care
- Long-Term Care

Seniors well-being in Canada: Building on lessons learned from the pandemic
National Seniors Council, Oct. 2021

The Path to Get Here and Next Steps

- Feb. 2018: Patient-oriented project with 12 team members
  - Collaborative approach to fall risk screening and assessment
- 2018-2020:
  - Scoping Review of Best Practice
  - Survey Health Care Providers
  - Focus Groups older adults and health care providers
- 2020-2022
  - Covid-19
  - Team consensus, knowledge translation, stakeholder engagement
- 2022-23
- Scale up project: family caregivers of people living with dementia
- Action follow-up



Heather's Story

Patient-oriented research is about engaging patients, their caregivers, and families as partners in the research process. This engagement helps to ensure that studies focus on patient-identified priorities, which ultimately leads to better patient outcomes

CIHR, 2021

Overview of Findings from the Project

Scoping Review, Survey, **Focus Groups**

Phase 1: Scoping Review

Williams-Roberts H, Arnold C, Kemp D, Crizzle A, Johnson S. Scoping Review of Clinical Practice Guidelines for Fall Risk Screening and Assessment in Older Adults across the Care Continuum. **Can J Aging. 2021 Jun;40(2):206-223**.

- Findings
  - 22 clinical practice guidelines for health care providers on best practice to identify fall risk and make decisions to plan prevention strategies
    - Prior **falls, walking/balance challenges** common to 19
    - Support needed for sustainable implementation

Practice Recommendations

- Screen all adults to identify risk, part of admission, after any change in health status or at least annually:
  - Identify history of falls
  - Identify gait, balance, and/or mobility difficulties; and
  - Use clinical judgement
- For adults at risk, conduct a comprehensive assessment to identify factors and determine appropriate interventions. Use a validated tool or approach appropriate to the person and the health care setting
- Refer adults with recurrent falls, multiple risk or complex needs to the appropriate clinician(s) or interprofessional team

iaBPG Clinical Best Practice Guidelines Sept 2017, Preventing Falls and Reducing Injury from Falls 4th Ed. RNAO

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There is knowledge of what to do

What is helping us and hindering us from doing it?

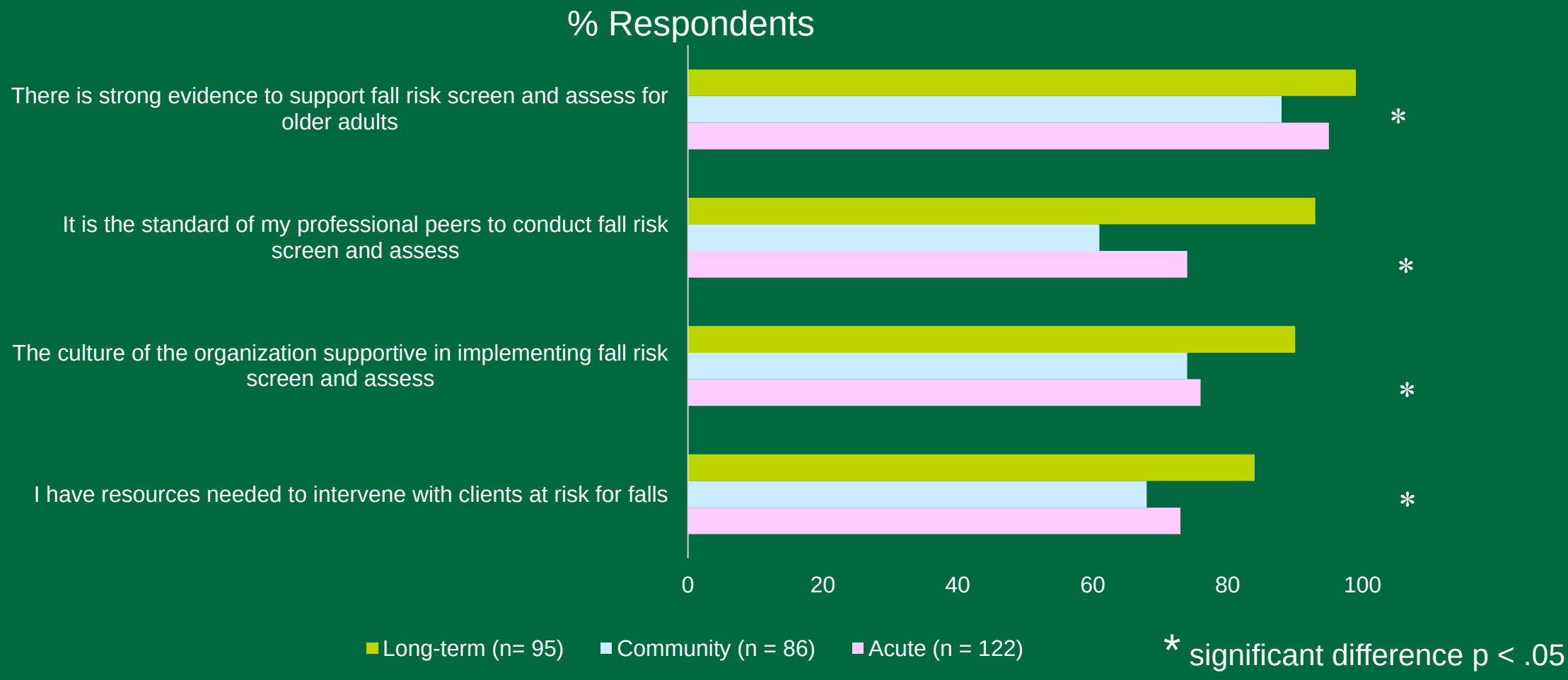
BE WHAT THE WORLD NEEDS

Phase 2: Health Care Provider Survey

- 323 respondents, 59% urban, equal distribution across acute care, long term care, community settings
- 63% nurses; 87% female
- 63% reported that they had received ANY training for fall risk assessment
- Most were NOT familiar with clinical practice guidelines
- 38% graduated < 10 years ago

UNIVERSITY OF SASKATCHEWAN

Results: Enablers or Facilitators by practice setting



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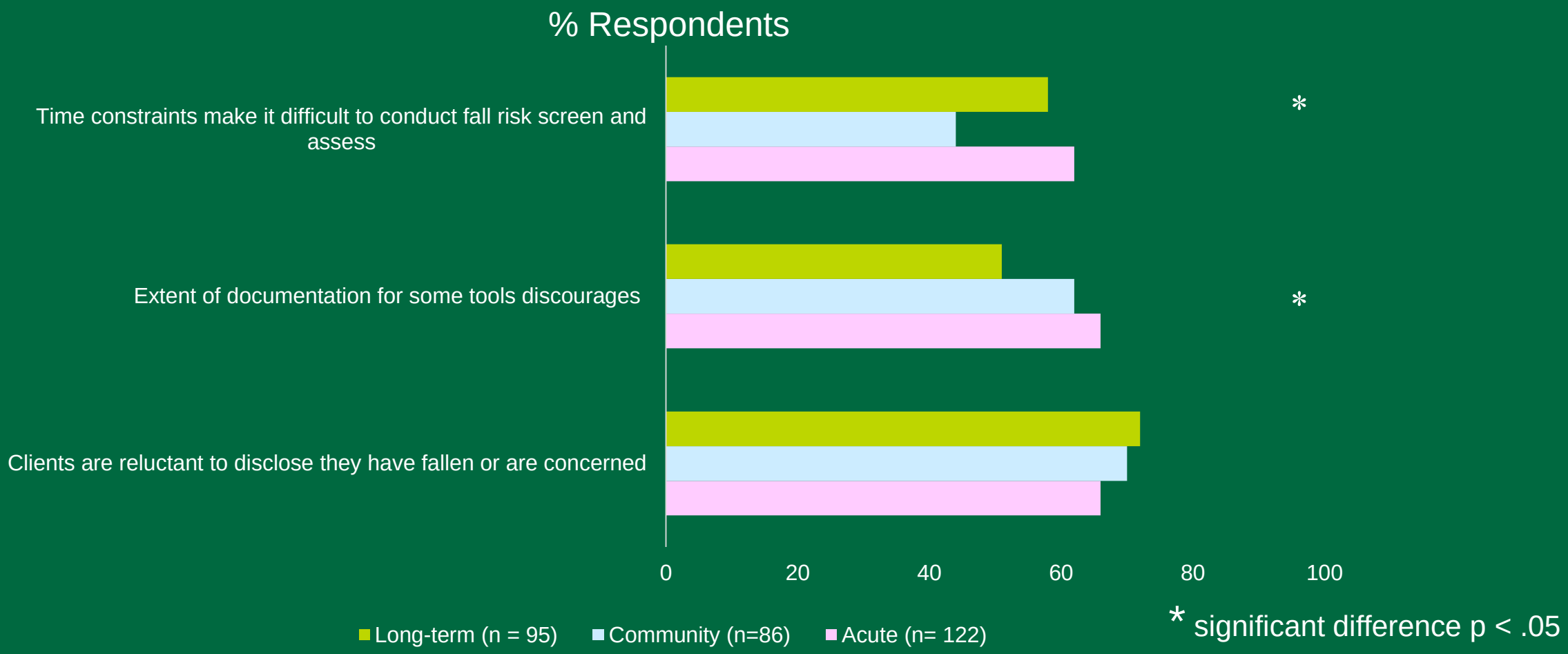
Results: Challenges by practice setting



BE WHAT THE WORLD NEEDS

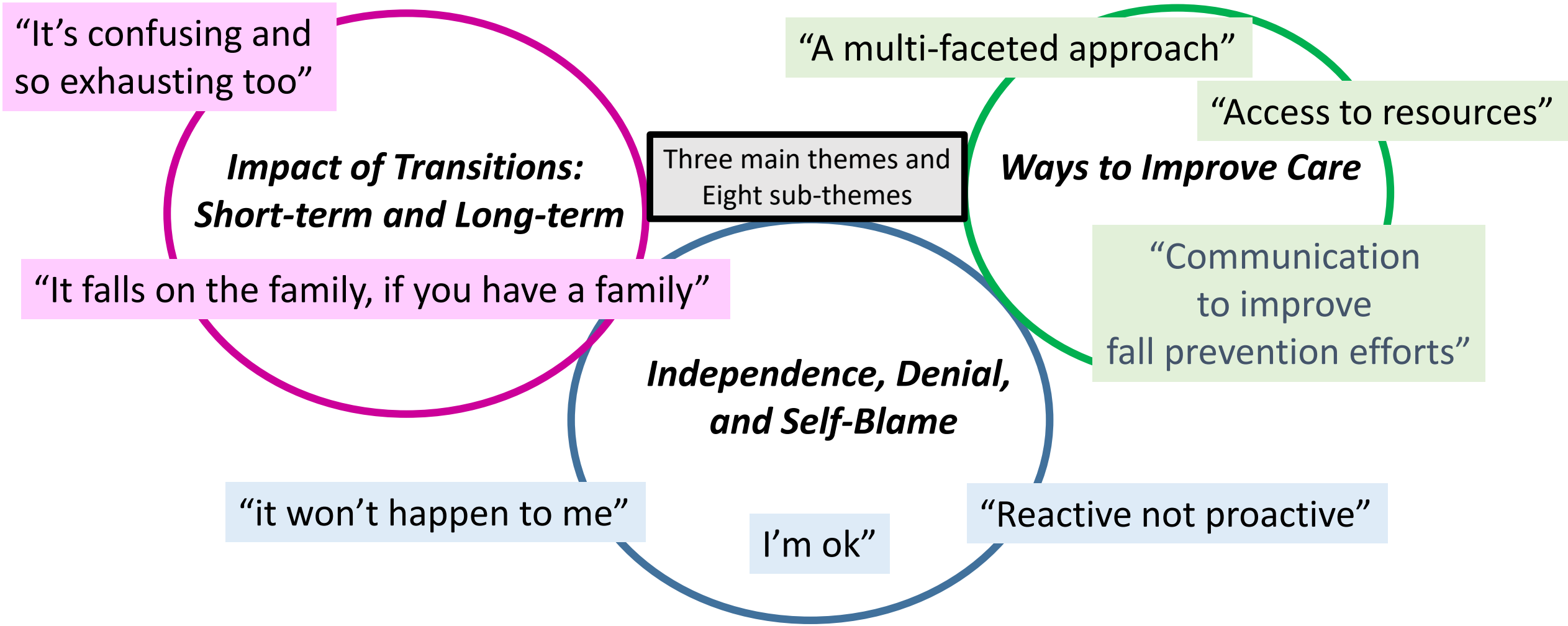
Phase 3 Hearing the Stories

- Focus groups with older adults/caregivers who experienced injurious falls, and health care providers who provide care to older adults
- 29 older adults/family caregivers (58% rural) and 12 health care providers participated
- Questions: story of the fall/s, perceived risk, health care received, transitions after the fall, future fall prevention
- The experience of falls ranged from ***minor scrapes/bruises to death***

“..I fell, I was baking,
and I climbed on a stool to get something very high and then I stretched for it,
I got dizzy and off balance. I fell on the floor and was unconscious,
I hit my head on the island….I was unconscious
on the floor until my daughter came home.
Then they called the ambulance and I went to the hospital,
I had four broken ribs and my shoulder is fractured,
my head had a severe hit there but nothing with the head.
After that I spent about 15 days in the hospital and then I went home
…I never fell again. But I’m always off balance.”

P5-U2

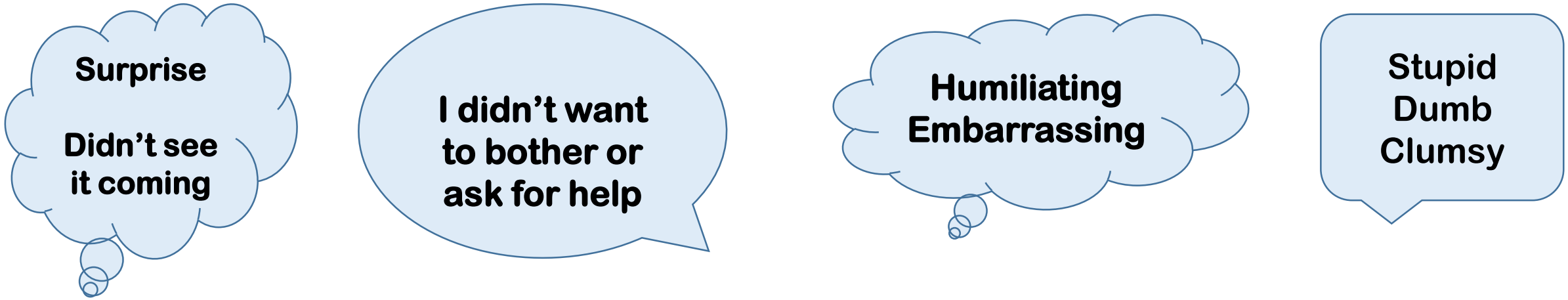
Focus Group Themes:
"Be proactive rather than reactive"



“It won’t happen to me”

Independence, Denial and Self Blame

“I thought I knew enough about falls not to fall, and yet I did everything that I shouldn’t when I did fall. I didn’t think it would happen to me.” P4-U1



“I’m ok”

Independence, Denial and Self Blame

“I felt embarrassed. I just thought, ‘Oh I hope no one’s seen me!” But I think I got up right away, I wasn’t sure, but I did not feel good.” P6-U2

Health Care Providers:

Not all history information provided or shared from one provider to the next

Denying seriousness of injury
Waiting days/weeks to seek medical attention

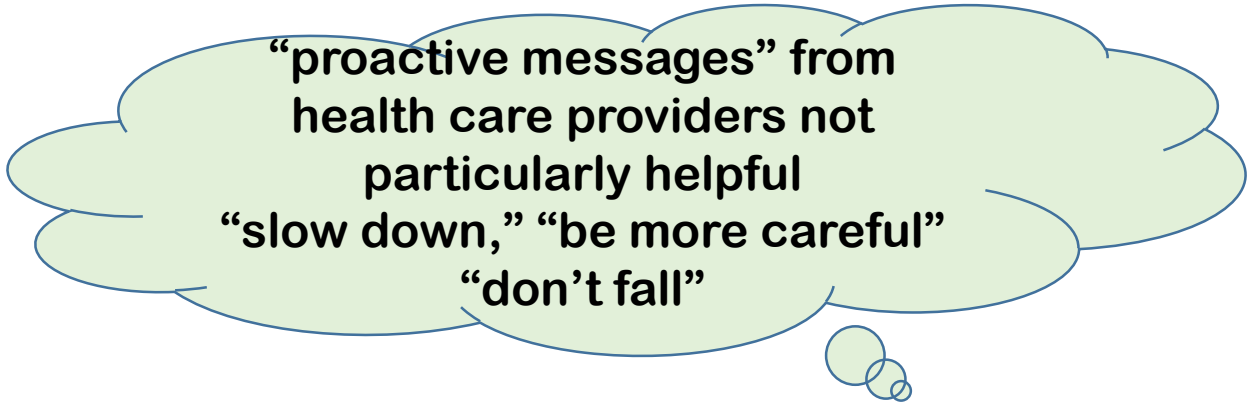
“Reactive not Proactive”

Independence, Denial and Self Blame

“I think when I went to the emergency, the nurse and the doctor, they do the tests and they come in and they tell me the results, you know, but they never really go into prevention or that kind of thing.”

“I just think whenever anything’s always reactive rather than proactive. Something has to happen first before anything is done but that’s just life if you ask me….” P6-U2

”Being in primary healthcare we should be more proactive, and we’re reactive. It’s the phone call, they’ve fallen, right?.. we’re not doing it,.. going in and assessing risk.” HP6-U2



“It’s confusing, and so exhausting too”

Impact of Transitions: Short Term and Long Term

“And not being able to sleep, so getting up and being confused. He always hated us to leave, he felt so alone. He said so many times, ‘I’m frightened. I’m afraid.’” P0-R

“I needed to get up and smudge and pray. Smudge and pray during the day or before bedtime, I do a lot of that” P5-U1

“So I don’t know how you get hold of them. I wanted to smudge but nobody around.. Those things that are important to people who are not there.” P4-U1

Transitions challenging for health care providers too: communication, transfer of care, resources

Fast deterioration
Deconditioning

Trauma Triggers

“It falls on the family if you have a family”

Impact of Transitions: Short Term and Long Term

“I think in a lot of situations when someone goes into the hospital and they get discharged there isn’t any real advice. You’re going home, maybe they expect your family or your husband or someone to look after that person but if they’re by themselves I don’t think they really give you any advice or follow up.” P3-U2

“A friend that came and started harvesting with us. So, I’m going to put one of these in here right now, and he did that quite well” P2-R4

Family caregivers need support in transitions to home particularly in rural settings

Health care provider challenges with time, other priorities

Tragedy
Loss
Guilt

“Access to Resources”

Ways to Improve Care

“I went to RURAL hospital and they got me ready to take me by ambulance to URBAN hospital and I had to wait. I was there a week ‘cause I had to get my elbow prepared and then after they decided it was—they got the thing on it, I got back RURAL hospital, then ambulance back to URBAN hospital. I had to pay for that one but I don’t think I could’ve sat in a car because I wasn’t supposed to put my feet down on the ground yet. I stayed there for, I was in the hospital counting both hospitals for a month.” P3-R1

“Well, I don’t know that people know where to go. That’s kinda the common theme. I’m always amazed when I go into someone’s home on a home visit that they don’t even know about CPAS, and they’re desperate for help. So to me, a lot of it is about sort of knowledge about how to find the resources and where they’re available.” P0-U

URBAN experience: not aware of resources
RURAL experience: Resources not available

“A multi-faceted approach”

Ways to Improve Care

- Recommendations for change WIDE RANGING..
  - more community based, early and affordable programming/education, education for school aged children, a provincial strategy, more full time fall coordinator positions in health care; more impactful messaging
  - more consultation with family and support for transitions home.
  - Health care providers and older adults ***all emphasize the help and importance of a team approach and communication***.

“A multi-faceted approach”

Ways to Improve Care

“It would be wonderful if there were community-based exercise programs or information sessions, coffee and a video on how to prevent falls or how to fall-proof your house or- the social interactions that also have an education portion get lots of people to come if there’s a social aspect as well.” P0-R

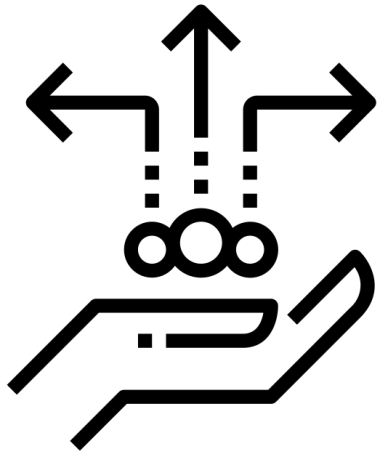
“Communication important way we could improve fall prevention efforts”

Ways to Improve Care

“Communication was something that I had marked down as a barrier to ensuring that fall prevention is happening , ‘cause it is hard, we all document in different areas.” HP1-U2

Transitions to home important:
Finding time, consistency in documentation

In-home assessments, team approaches, a centralized registry, include family caregivers, have a fall plan in place



Boiling it Down.. What do we want to share?

EIGHT Key MESSAGES and Recommendations for Health Care Providers

MESSAGES 1 to 3 *Evidence Based, Training, Confidence*

- Increase awareness and support for applying clinical practice guidelines
- Enhance training - More training, more confidence
- Early, consistent education, access to resources
- Examine why gaps in confidence and support in community settings

MESSAGES 4 and 5: *Rural Needs and Transitions*

- Address access needs
  - Mobility, travel, family and home support, community programming

- Improve communication and transition care gaps

Messages 6-8 *Education, Community, Inter-disciplinary*

- Fall prevention co-ordinators are important champions, but spread thin
- Find creative ways to connect and collaborate with community organizations
- Emphasize team inter-disciplinary approach

Why are we getting together today?

- OBJECTIVES: ***Knowledge sharing and inspiring action***
- OUTCOMES***: Action planning and commitments for positive change***

- Facilitator: Shan Landry