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Building Interprofessional Teams through Evidence Based Practice Training in Falls Prevention

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Case Study

Building Interprofessional Teams through Evidence Based Practice Training in Falls Prevention

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Objectives

1. Analyze an Evidence Based Practice (EBP) program on falls prevention as a vehicle for successful interprofessional team-building.
2. Examine ways that organizational characteristics can affect team functioning.
3. Compare interprofessional team-building in two sites.
4. Discuss elements of interprofessional teams that contributed to practice changes.

Background

EBP programs on falls prevention can be effective in reducing the

recurrence of falls in older adults, especially when implemented through an interprofessional team approach. At the same time, conducting the EBP program can reveal characteristics of the implementing team that help make the intervention more or less successful. We examine the implementation of a 24-content hour EBP program on reducing falls at two different sites having different organizational and staffing patterns in order to determine important contributors to and barriers against practice changes in interprofessional teaming.

Evidence-based practice is the “judicious use of current best evidence in conjunction with clinical expertise and patient values to guide healthcare decisions” (Titler, 2008). There is a need to examine how EBP training engenders changes in interprofessional team functioning and development. “Evidence-based practices (health care and otherwise) respond and adapt to the contexts in which they exist, increasing the need for organizational planners and evaluators to have frameworks they can tailor locally to unique project environs”

(Manchester, 2013, p. 25). In settings that support team-based practices, behavioral changes after staff trainings are viewed as ongoing processes that occur within collaborative systems (Titler, 2008).

Our Virginia Geriatric Education Center (VGEC) conducted two case-based EBP trainings in 2015 and the following discussion is intended to illuminate how participants in each setting began planning ways to implement EBPs within the contexts of their respective teams. We hope to illustrate their exploration of opportunities for using EBP to prevent falls in their different organizational settings.

The Evidence Based Practice Training Program: Rationale and Function

Falls and the management of falls in older adults should receive interprofessional focus, because falls can be both a sentinel event, signaling the presence of various risk factors, and a triggering event at the start of a cascade of negative consequences. The risk factors for falls are complex and require interprofessional assessment and treatment.

Inside This Issue:

VCoA Editorial, 6
DARS Editorial, 8
Needed Nutrients, 9

ARDRAF Final Reports, 10
Cultural Competence, 12
Moral Bucket List, 14

VCoA Focus: C. O'Hara, 16
Open Enrollment Clinics, 17
Calendar of Events, 18

The best treatment plans derive from focused research which produces evidence-based practices. The Virginia Geriatric Education Center (VGEC), an interdisciplinary consortium of Virginia Commonwealth University, Eastern Virginia Medical School, and the University of Virginia, developed a seven-week training program that is built around a comprehensive, interprofessional approach to assessment, treatment, and care designed to strengthen interprofessional teamwork and reduce the risk of falls among the team's patients.

The program includes seven 2-1/2 hour sessions that are supplemented by on-line resources that the VGEC has identified as helpful and relevant. Participants can access these resources outside of these six sessions, and they include required and optional readings. The faculty teaching these sessions, representing Medicine, Nursing, Occupational Therapy, Pharmacy, Physical Therapy, and Social Work, collaborate to introduce evidence-based practices in managing and preventing falls through a case-based, team-oriented approach. The interprofessional teaching team uses actual or composite profiles of older, complex patients as the focus of presentations and interactive discussions among all participants, with the intention of stimulating interprofessional actions among the participant learners.

Over the course of six weeks the EBP program defines falls, identifies risk factors, demonstrates falls risk assessments and interventions, and suggests appropriate interprofessional team approaches for care plans and follow up. On the seventh

week, members of the VGEC teaching team meet with the participant team to discuss if and how changes have been made to interprofessional practice at the site and how the team plans to improve their approach to managing falls moving forward.

In 2015, the VGEC conducted two complete seven week programs; the first (Case Study 1), at a small, rural PACE (Program of All-inclusive Care of the Elderly) site; the second (Case Study 2), at a large, urban, multi-unit health care organization with both in-patient and out-patient services, as well as home visit and long-term care services; in both instances, team-care was the existing practice model. These circumstances offered an opportunity to assess not only how the interprofessional training was received and implemented but also barriers to practice changes and characteristics that differentiated changes in implementation. We considered aspects of stakeholder commitment and organizational characteristics, along with team structure, function, culture, and communication to be potential facilitators and barriers to using the training as a springboard for changing practice around falls prevention.

Case Study 1

The rural PACE had an intact interprofessional team whose members were affiliated with the following disciplines: Advanced Practice Nursing, Health Administration, Medicine, Nursing, Nutrition, Occupational Therapy, Personal Care, Physical Therapy, Quality Assurance, Recreational Therapy, Social Work, and Transportation.

Importantly, the PACE site Director, although not a clinician, was supportive of this EBP-Falls training and attended every session. His commitment was reinforced when the initial estimate of the frequency of falls among PACE participants was shown by analyses of patient records to be a gross underestimate. During the very first EBP session, there was a collective perception among the trainees that falls were not really an area of large concern, since they occurred so infrequently. Seeking clarification, the site Director left the meeting to gather falls data from his office next door. Before the session concluded that day, he returned with the data to show that the falls rate was many times larger than generally perceived.

Trainee team membership was defined broadly, from transportation staff to clinical providers, and input from this broad perspective was considered and respected during the training activities. Trainee team members were united as a single team and most of the team members were co-located when performing their work.

The VGEC interprofessional EBP-Falls training implementation began by engaging the stakeholders at the site. Champions for the program were identified early on and the training team visited the practice site and met the trainee team prior to the first session. From the beginning, trainee team members expressed shared interest in improving their practices around falls prevention and commitment to using the training opportunity to guide change. The site Director was fully engaged throughout the train-

ing, demonstrating the importance of the issue and the training as a pathway to finding better solutions for the organization.

During the training and team discussions, the trainee team identified several salient matters: that social workers and pharmacists were not fully engaged as team members; that, although occupational and physical therapists knew about fear of falling as a risk factor for falls, social work had a greater appreciation of its prevalence; and that using evidence based assessment tools is important. Further, that program participants received their pharmacy services in a variety of ways and, therefore, pharmacist input was often not available to the trainee team. The training team members identified the need for consistent medication assessment related to falls risk and identified opportunities to engage a pharmacist in the process. There was also an expressed intention to increase the number of disciplines involved in team meeting discussions related to patients who fall or are at risk for falling, notably paraprofessional nurses, the transportation staff manager, and the site Director. Trainee team members recognized that falls were a significant issue among their patient population and were committed to doing something about it. Individual team members were able to identify opportunities for practice change and were supported by their other team members.

Case Study 2

The large, multi-unit organization had interprofessional teams by practice setting, including in-patient and out-patient, and home visits.

Trainee team members were affiliated with the following disciplines: Kinesiotherapy, Medicine, Nursing, Advanced Practice Nursing, Occupational Therapy, Physical Therapy, Pharmacy, and Social Work.

This program included trainee team members from two separate teams providing care for different groups of patients receiving care from the institution. There was also a falls prevention physical therapist at the facility who was able to work with both teams to identify opportunities for the teams to incorporate the training content into the team practices. Team members included in the training were primarily the health care provider members and some team members worked virtually (through the EHR) with the rest of the team rather than participating in team discussions and decisions directly. Not all of the team members who work within each of the teams participated in the training, but the allocation of the time of a large number of providers to participate demonstrated institutional commitment to the program.

The VGEC EBP-Falls training implementation in this site similarly began with securing stakeholders. In this case, however, champions were not identified immediately and engagement involved multiple pre-training meetings, in large part to work through the bureaucratic issues (scheduling, who would be made available to participate in the training, location of the training, information technology firewalls) inevitable in a large organization. Trainer team members had no contact with the trainee teams prior to the start of the training to establish rapport and shared goals. Members

of two clinical teams participated in the trainings and, while the teams had some commonalities in the ways that they were addressing falls, there were also differences unique to each clinical team. Overall institutional buy-in and support for the training as a means to foster practice change were less evident to the participants, but the trainee teams were actively engaged in the training program, and team members who may not have interacted with each other previously were able to learn from each other's experiences.

The participation of the falls prevention physical therapist, who was a champion for improving practice and could support practice change over time, contributed to the success of the program. She was able to translate the training practically for the specific setting, making it more directly relevant to the trainees. During the training and group discussion, the trainee team identified several salient matters: that, although assessments might be performed, they were not being used by the team as effectively as they could be to inform team decisions and interventions; that the role of one member of the trainee team was to focus on falls and she was able to share opportunities for improvement with the other team members that were specific to the care setting; and that there were ways that team members might collaborate more effectively with the falls prevention physical therapist. Social work was added as part of one of the teams to address falls because of the training, yet physical therapy remained as a referral from the team. Previously, the kinesthesiologist or occupational therapist

had not been involved after a fall as a matter of course; but, after the training, there was a new-found realization that the composition of the post-fall team needed to become more comprehensive.

Commonalities and Differences between Sites

As illustrated in these two cases, there were a number of commonalities between the sites. Training participants were generally open to changing their way of working to achieve the team goal of managing and preventing falls. In both instances, we saw a clearly stated intention to foster greater inclusion of all relevant providers in team meetings. There was also a sense that expanded communications would result in better outcomes. Having champions in each setting to provide continuity after the training enhanced the opportunity to foster change in practice for the long term. During both of the trainings, input from all team members was respected and carefully considered during in-depth discussions. Attendance at both sites was robust, and ultimately, buy-in from both was strong.

We learned some lessons in comparing and contrasting the two sites. In dealing with the challenges encountered, it became apparent that degree of engagement by program leadership affected attendance by a site's training participants. The leadership needs to walk the walk as well as talk the talk. We found that we needed the leaders not only to encourage attendance initially, but also to attend regularly in order to maintain level of attendance. When all team members are

not present in the training, the team is then tasked with bringing those absent members up to speed on the team's direction. For example, one participant told us, "I am receiving more timely information on Falls Risk Ratings for newly admitted patients from the staff who have attended. Will need to encourage that same communication from the staff who did not attend."

Key Elements for Success

We have noted several important contributors to successful interprofessional practice change when examining these two cases. First, securing stakeholders, that is, having buy-in from organizational leadership, is essential for success. Stakeholders need to see how comprehensive training on multifactorial risk assessments and interventions can reduce serious fall-related injuries. This commitment will lead them to invest the requisite human and fiscal resources, such as allocating staff training time and improving upon data collection methods in electronic medical records. It is also helpful to engage stakeholders collaboratively in program planning to ensure that training goals are in line with the quality improvement aspirations of the health practice itself. Second, our trainings served as an effective stimulus for fostering changes in interprofessional team-building. As one participant told us, "Providers have become closer as a result of the training. As a team, they now have a stronger sense that they can make an impact on the lives of those they serve. By working more closely together they feel they can collectively use what they learned

to make a difference in how they look at falls and the ways to prevent them." Third, we realized the importance of reinforcing different elements that contribute to practice changes. Success is enhanced when we can consistently use the beginning of each session to help trainee teams reflect on how the previous session's content was or should be synthesized and applied to practice. The more that the team reviews and contemplates the content presented, the better able we are to achieve optimal assimilation. Finally, these two cases illustrate the benefits of expanding the disciplines and providers involved in interprofessional teams dealing with falls prevention and management.

We were singularly successful in teaching the advantages to be gained when teams operate in both lateral and vertical modes on the professional continuum. Training resulted in greater involvement of paraprofessional staff in the conduct of fall risk and balance assessments. As examples, at the large, multi-unit site, we learned that the falls champions included a CNA and an LPN; we learned that the definition of a fall was not uniformly applied to dementia patients; so the unit addressed this internally by developing a falls template; similarly, the other team at this site expressed their intention to develop an interdisciplinary falls protocol as soon as they could reconvene their falls committee. At the rural PACE site, the home care department is now rotating participation by the home care nurses on the falls team to make sure that there is representation from those who see the participant in environments where the

latter are either in total control or have no control; the transportation department is assigning someone to the falls team meetings; and the social workers are taking turns participating as well.

Expectations for the Future

The extent to which EBP training ultimately facilitates collaborative-care role sharing will be the strongest indication of success. As the teams we have trained evolve through the behavioral changes that characterize levels of use (Hall & Hord, 2010) of an EBP in a team context, we should see observable and evaluable markers or anchors indicative of evolution (Manchester, 2013). Teams should progress from: 1) initially trying out EBPs in coordination with others on the team and learning the mechanics of the practices (Mechanical Level), to 2) becoming comfortable performing the EBPs (Routine Level), to 3) looking for ways to improve procedures and refine the practices (Refinement Level), to 4) full collaboration in performing the EBPs by filling in performance gaps as different team members step into shared roles and provide diverse skills (Integration Level). Finally we would like to see teams exploring new ways to implement the EBPs for sustained team performance within their health care systems (Renewal Level).

The professionals at each of our training sites had a sophisticated appreciation of evidence-based practices. Both groups were eager to incorporate new assessment tools. The rural site was intent on vigorously re-examining their assessment procedures and supple-

menting their practice with screening and assessment instruments promoted in the evidence-based literature. Similarly, participants at the corollary site were committed to having the Timed Up and Go Test (Podsiadlo & Richardson, 1991) administered by the occupational therapist during home care visits; there was also an interest in applying the Home Safety Self Assessment Tool (Horowitz et al., 2013; Tomita et al., 2013). Both sites stated their intention to incorporate a falls efficacy scale, specifically the FES-International (Yardley et al., 2005). Finally, our analysis of learner attitudes as factors that affect health care professional programming (structures, processes, outcomes) remains of tantamount importance as we plan for our next EBP training series.

Study Questions

1. How can organizational policies or structures promote or inhibit the adoption of effective interprofessional teams?
2. What elements in each of the two settings seem crucial to fostering effective interprofessional team work?
3. Which aspects of the EBP training contributed to success in encouraging the application of evidence based practices?
4. What changes in interprofessional team functioning and development can be fostered through EBP training?

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