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Feature Article

Involving the consumers: An exploration of users' and caregivers' needs and expectations on a fall prevention brochure: A qualitative study

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ABSTRACT

This study aims to explore and compare nursing home residents', family members', and nursing staff's needs and expectations regarding a fall prevention brochure. Focus groups were carried out with 25 residents, 12 family members and 14 nursing staff separately, from three randomly selected nursing homes. Qualitative content analysis was used to analyze the data using a concept-driven coding frame. Results showed that residents want to be informed about dealing with extrinsic fall risks and coping strategies after a fall event. In addition, family members wanted to have detailed information on intrinsic fall risks as well as specific fall prevention strategies, such as body exercises. Of special importance for nursing staff was that not all falls are preventable even when preventive measures were taken. As the need and expectations of users differ substantially, one brochure could not comprise all postulated criteria and different brochures are necessary for residents and for family members.

Introduction

Falls and fall-related injuries are highly prevalent in people aged 65 and over,[1–3] with highest magnitude in nursing home residents.[1] In addition to the physical burden[4,5] and the psychological consequences[6] for affected older adults, falls lead to immense costs for the health care system.[1] Causes for falls are manifold and Boelens et al[7] categorized them into intrinsic risk factors (e.g. gait disorders), extrinsic factors (e.g. inappropriate footwear) and behavior-related risk factors (e.g. fear of falling). Of the three, extrinsic and behavior-related risk factors in particular are potentially modifiable in order to prevent falls.[7] Therefore, health care professionals are advised to adequately educate older adults on reducing these risk factors.

In the education of residents, information in brochures can reinforce the verbal instructions of nursing staff.[8] It is important to provide information in various forms (e.g. verbal, written, figurative), as people learn and process information differently.[9] The content of the various information sources should be the same or complementary. Empirical studies confirm that offering educational interventions where brochures and verbal information is provided will enhance older adults' knowledge,[10,11] which may lead to older adults adopting healthier behaviors. The effectiveness of brochures concerning fall prevention is not examined with regard to its use as stand-alone intervention, but rather as part of multifactorial interventions, which have been found to reduce falls.[12] It is noteworthy that it is not only effective in healthy older adults, but that also cognitively impaired persons can profit from combined verbal and printed information.[13]

Recommended fall prevention measures

International guidelines recommend providing residents at risk of falling with written educational materials in addition to verbal information about measures that can be taken to prevent falls.[14,15] According to current systematic reviews, evidence shows that only multifactorial interventions targeting multiple risk factors are effective in reducing falls in nursing home residents.[12,16] If falls are

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unavoidable, there is evidence that hip protectors can be used to reduce the risk of hip fractures slightly, but a slight increase of the small risk of pelvic fractures must be taken into consideration when providing hip protectors.[17] For residents with a risk of falling, international guidelines recommend multifactorial interventions, including a fall risk assessment, strength and balance training, a review of psychotropic medications and education on relevant topics.[14] Fall prevention should target not only older adults, but also family members, as it has been demonstrated that the opinions of others influence older adult's decisions.[1]

Optimal brochure development

Brochures should be theory-based[18] and fulfill evidence-based criteria, such as providing different unbiased care options, information about benefits and harm, as well as numeric data detailing current scientific knowledge.[19–21] At the same time, they should take into consideration readability, plain language and comprehensibility.[22–25] There are guides to structuring, inserting pictures, and ensuring attractiveness, as well as what must be considered when developing a brochure for older adults.[26] Guidelines and recommendations concerning the development of health care brochures endorse engaging the consumer and asking what they want to know about the particular subject.[24,25,27] However, the users are seldom involved in the development process[28,29] except when consulted for evaluation after the material is already developed.[30] This is a problem, because evidence exists that shows a mismatch between what the users need and expect, and what is included in a brochure.[31–33] The evaluation of an evidence-based booklet about fall prevention in independently living older adults[34] showed that they would prefer practical suggestions rather than statistics.[31,32] Yardley et al[33] investigated older adults' views on advice about fall prevention. Some fall prevention advice was seen as self-evident while others, especially hazard-minimization advice, was perceived as potentially patronizing and distressing.[33] Consultation of the users in the early process of a brochure development seems indispensable.

We plan to develop a high-quality fall prevention brochure that fulfills internationally postulated criteria, meets consumers' needs and can be used in educating older adults and their families. To ensure that there is a need for the development of a new brochure, existing brochures that were available in Austrian hospitals and nursing homes were assessed with the 36-item Ensuring Quality Information for Patients scale[23] regarding their content, structure (including layout) and identification data. The results showed that brochures available in nursing homes had significant shortcomings. The content was often not in accordance with the quality criteria for evidence-based patient information, and data on sources, patient involvement and financial support were generally lacking.[28] This study highlighted the need for the development of a new brochure.

This would need to be designed with consideration to different perspectives: those of the nursing staff (e.g. current standards of practice, experience with the information need of users), the residents and family members (e.g. information, presentation needs).[25] Therefore this study aims to explore residents', family members' and nursing staffs' needs and expectations regarding a fall prevention brochure.

Material and methods

Design

This was a qualitative study using a focus group approach. Needs and expectations of residents, their family members or informal caretakers and nursing staff with regard to fall prevention brochures were gathered and compared. Focus groups were used since they can guide product development,[35] primarily by gaining an understanding of values and opinions on the topic by the potential users. As recommended for product development by Krueger and Casey,[35] three separate focus groups were initiated, one for each constituent group (residents, family members and nursing staff).

Participants

A convenience sample of residents, family members or informal caretakers and nursing staff who were able to attend a 2-h focus group were included. The specific inclusion criteria for residents was being a long-term resident (having stayed at least since 6 months in the nursing home) and having a risk of falling – defined according to the National Institute for Health and Care Excellence[14] as residents over 65 years old with a fall history and/or gait or balance disorders. Residents with mild cognitive declines were not excluded as they represent the nursing home population. The nursing staff of the particular nursing home decided if an older adult was able to participate. Family members had to be relatives or significant others of residents, who make regular (at least weekly) visits. Nursing staff had to be nurses, nursing aids or elderly assistance workers (assistance workers who are responsible for entertaining residents and are educated to do basic care in older adults) working in the particular nursing home. Each focus group was intended to include five to eight people to ensure both breadth and depth of experience.[35]

Sampling

Austria has nine federal states with about 890 public and private nursing homes.[36] Roughly 66,000 persons receive nursing home care: this corresponds to 4% of persons older than 65 years and 18% of persons older than 85 years. The average entrant age is between 74.2 years and 81.4 years, depending on the federal state. No definition of "need of care" exists in the Austrian long-term care system. The assessment of need of nursing home care is instead based on individual requirements for services and assistance, based on doctors' or nurses' expert opinions.[37] According to the Austrian Prevalence Measurement of Care Problems survey, about 60% of nursing home residents have the medical diagnosis of dementia.[38]

Three Austrian nursing homes with more than 50 beds in the federal state of Styria were selected by computer-generated randomization from a ministerial database.[36] The directors of the nursing homes received an invitation letter in July 2014; additionally they were informed about the study by phone by the first author. One nursing home director declined to participate; therefore an additional nursing home was randomly selected. After the agreement of the directors of the nursing homes, potential participants were invited to a 30-min information meeting via information leaflet. During the information meeting, the first author informed interested residents, family members and nursing staff about the importance of the study, the study aim, inclusion criteria, the course of the focus group discussions, meeting dates, locations and informed consent. After the information meeting, informed consent for participation was obtained and an information sheet about the study was handed out. Participants who were not able to decide immediately were asked to think about taking part and indicate their decision at a later date.

Data collection

The nine focus group discussions were performed separately with residents, family members and nursing staff in each