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"It's very challenging for everyone": Developing an educational intervention to enhance care of hospitalized older adults with impaired cognition

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ABSTRACT

Purpose: To design and evaluate an educational intervention to enhance care of hospitalized older adults with impaired cognition.
Method: Pre- and post-focus groups were employed to design and evaluate the intervention.
Results: Four categories emerged from the pre-intervention focus groups: many knowledge gaps; reliance on outside expertise; limited involvement in care planning; and preferences for in-person training. Three categories emerged from the post-intervention focus groups: addressing learning needs/preferences; awareness and use of best practices; and many factors affect knowledge application.
Conclusions: The intervention resulted in self-reported improvements in knowledge and the ability to apply this knowledge into patient care.

Introduction

On any given day, more than 55% of acute care hospital beds in Canada are occupied by adults who are 65 years of age and older.[1] The unique needs of this population are well recognized. Without early interventions, older hospitalized adults are at higher risk of iatrogenic conditions such as pneumonia, decubitis ulcers, urinary tract infections, polypharmacy, deconditioning, poor nutrition, functional dependence, and injuries related to falls.[2] During their hospital stay, 30% will experience significant functional decline, most of whom will never recover to their previous level of independence.[3]

Addressing and managing dementia, delirium, and depression represents a particularly challenging area of care on acute care inpatient units. Research indicates that delirium occurs in up to 50% of older persons admitted to acute care units[4,5] while the rates of depression and dementia have been found to range from 12 to 45%[6,7] and 25–33%[8,9] respectively. However, there may be insufficient knowledge and resources in acute care to meet the needs of this patient population.[10] Numerous solutions have been proposed to improve the care of older adults in acute care (e.g., Hospital Elder Life Programs, Acute Care of Elderly units),[11,12] but many of these require additional staff resources and/or physical space, and have proven challenging to sustain in practice.[13]

An alternative solution is interprofessional elder care education and training to improve the knowledge, confidence, and skills of existing care providers regardless of their area of expertise. Lack of knowledge is a fundamental, but modifiable, barrier to providing better care to older adults with cognitive impairment.[14] Interprofessional education of acute care staff can reduce the incidence of delirium and improve outcomes for those who become delirious.[15–17] Clinical practice guidelines now stress the important role that such education plays in improving the management of older adults with delirium.[18,19] At the same time, participant involvement in designing an education session's content and delivery method is important to optimizing the relevance of the education and ensuring the content and format are tailored to their professional practice.[20,21]

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This study aimed to design an educational intervention to enhance the care of hospitalized older adults with impaired cognition and to evaluate interprofessional team members' views on whether and how the intervention met their learning needs and influenced their practice. The specific objectives were to: 1) evaluate a participatory approach to interprofessional learning in terms of the learner's experience, learning methods, and learning needs and 2) explore how team members put the knowledge/skills they acquired into practice, their confidence with doing so, and their views on how the new knowledge/skills made a difference to their practice.

Materials and methods

This study took a participatory approach to develop an educational intervention for interprofessional teams in acute care. The research team worked with interprofessional care team staff to design, implement, and evaluate an educational module tailored to meet the learning needs of staff wishing to learn how to care for older adults with dementia and responsive behaviors, delirium, and depression. For simplicity, we called it "cognition education." This particular topic was chosen because an educational needs assessment, conducted by the health region in 2011, identified caring for cognitively impaired older adults and their responsive behaviors as the highest learning need amongst frontline acute care staff in the health region. The study was approved by the Nova Scotia Health Authority Research Ethics Board.

Two acute care units participated in the study. Selection criteria included: 1) the unit Health Services Manager and the Clinical Nurse Educator supported study participation; 2) the unit admitted older adults as part of its patient population; 3) the unit was perceived by its Clinical Nurse Educator as benefitting from additional education in the care of the cognitively impaired older adult; and 4) the units differed from each other in terms of care focus and geriatric care resources. Neither unit was classified as a geriatric specialty unit. Study participants were members of the interprofessional care teams employed by the two study units. Nursing, occupational therapy, physiotherapy, social work, unit aides, unit managers, and unit educators were all invited to be a part of the study. On each unit, the Health Services Managers sent an e-mail to interprofessional team members indicating support of the study while the Clinical Nurse Educator posted a poster to advertise the study. The poster provided instructions for interested individuals to obtain more information. Individuals contacted a study team member if they were interested in participating. Written informed consent was obtained from all participants prior to their participation.

Study design

This study involved three distinct phases: pre-intervention focus groups to inform the design of the intervention; implementation of the intervention; and post-intervention focus groups to evaluate the intervention. The entire study took place from January–June 2015.

Four pre-intervention focus groups were held (two per study unit) to support the design and implementation of an intervention to meet the needs and preferences of interprofessional care team members. Open-ended questions and related probes were used to guide the focus group discussion. Participants were asked about their general needs and preferences related to cognition education, specific needs related to assessing and managing dementia, delirium and depression in older adults, and perspectives on the best ways to incorporate learning opportunities into their busy work environments. They were also asked to share stories related to their experiences caring for older adults who were cognitively impaired. A researcher [RU] experienced in qualitative methods facilitated the focus groups. Each focus group was audiotaped and transcribed verbatim by an experienced research coordinator. Focus group participants completed a pre-intervention survey to capture basic demographic data, learning preferences, and knowledge and confidence levels. Self-rated knowledge and confidence were assessed by asking participants to respond to the following statements on a 4-point Likert Scale (1 = Strongly Disagree, 4 = Strongly Agree): "I feel confident in providing care to older patients with dementia" and "I have adequate knowledge to manage behaviors associated with delirium/dementia."

Following the pre-intervention focus groups, the study team designed the intervention based on the data collected (see below), which was implemented on both study units in April 2015. Approximately, eight weeks after the education was implemented, three post-intervention focus groups were held to gain participants' views on the intervention; explore how they put the knowledge into practice; and identify additional resources or supports to help them care for older adults with cognitive impairment. Only those who participated in the intervention were invited to the post-intervention focus groups. Open-ended questions and related probes were drafted based on the research objectives and Phase 1 findings. The questions sought to solicit detail-rich stories from participants about their experiences applying the knowledge/skills in practice. The same researcher facilitated these post-intervention focus groups. As before, each focus group was audiotaped and transcribed verbatim. Focus group participants completed a post-intervention survey to capture knowledge and confidence levels. The pre- and post-intervention focus group guides are available online as Supplementary Material.

Intervention

The intervention was developed based on data acquired via the pre-intervention focus groups and incorporated principles from experiential learning and adult learning theory.[22,23] It involved a 60 min interactive training session on each study unit and provision of a resource manual for each unit. The interactive training incorporated Kolb's (1984)[22] learning cycles of concrete experience, reflective observation, abstract conceptualization, and active experimentation. Specifically, the training involved a 30 min didactic lecture on dementia, delirium, and depression, and managing responsive behaviors in older adults, followed by presentation of three videotaped clinical scenarios demonstrating common situations related to responsive behaviors (wandering, calling out, and personal care). Participants then selected the one scenario they found most challenging to address on their unit and engaged in an interactive group discussion of evidence-based management options related to that scenario. Finally, as a group and using their ideas, participants developed an interprofessional care plan based on what they had learned in the 30 min lecture. Two researchers [PB, CAM] with clinical expertise in caring for older adults with impaired cognition led these sessions. The training occurred on several occasions on each unit. The resource manual contained practical tips and guidance related to managing responsive behaviors in dementia care, delirium, and depression in addition to family teaching materials, a list of medications to be avoided in elder care, and point-of-care tools to facilitate patient care and management: e.g., "About Me" forms[24] to capture the patient's life story, behavior tracking templates, and tools to guide care plan development. In addition, the unit's interprofessional team was provided access to a website, developed by the study team that provided learning material, patient scenarios, and resources/teaching