

## MacHSR Future Leaders Fellowship program Final reporting (Cohort 1)

**Name:** Anne Harrison

**Project title:**

*Attitudes, barriers and enablers to consumer engagement with the patient/carer-activated escalation process (for clinical concerns about patient deterioration): a mixed methods exploratory study.*

**Report:**

**Overview of original problem and rationale:** The patient/carer-activated escalation process links to National Safety and Quality Health Service (NSQHS) Standard 2 Partnering with Consumers, Standard 6 Communicating for Safety and Standard 8 Recognising and Responding to Acute Deterioration. Evidence supports decreased mortality, improved safety and outcomes when patients/families are engaged and partner with staff in planning care (Luxford & Newell, 2015; South et al., 2016; Vorwerk & King, 2016).

This escalation process, called REACH (Recognise, Engage, Act, Call, Help) at Mercy, aims to empower our inpatients/families to escalate care if they are concerned about clinical deterioration. However, from September 2020 to September 2022 there were only three patient/family-activated escalation calls received across the service and none were related to clinical concerns. This suggested lack of clarity about the process and purpose. Point of Care Audit data indicated approximately 50% of inpatients/families were not aware of the escalation process. Therefore, there appeared to be a 'procedure to engagement' gap. This was important to investigate, address and subsequently bridge in order to identify areas for improvement in this process to assist in improving patient care and safety.

**Methods:**

This mixed methods design study was co-designed with consumers and key stakeholders and as a result involved in two parts. Approval was sought and received for both parts from Mercy Human Research Ethic Committee.

Part 1 was an 'Exploration of the awareness and perceived understanding, comfort and confidence of nursing staff about the REACH (Recognise, Engage, Act, Call, Help) inpatient/carer-activated escalation process (for communicating concerns about patient deterioration): a mixed methods design.' This involved a survey of nursing staff involving both quantitative data (Likert scales) and qualitative data (open-ended questions). Quantitative data were analysed using proportions and qualitative data thematically analysed.

Part 2 is the 'Exploration of the awareness and perceptions of admitted patients and/or families about the REACH (Recognise, Engage, Act, Call, Help) inpatient/family-activated escalation process (for communicating concerns about patient deterioration): a qualitative study.' This study design is based on the principle that consumers at whom research is targeted have a right to provide input into it. This ensures the outcomes meet consumers' needs (Miller et al., 2017), is relevant and translates more readily into practice thereby more likely to be useful (NHMRC, 2016; Miller et al., 2017) and reduce research waste (Chalmers et al., 2014). Part 2 involves undertaking semi-structured interviews with up to 25 consenting, inpatients/families (or until data saturation achieved). The results will be thematically analysed and findings used to inform consumer relevant improvements in the process.

**Activities:**

Key activities undertaken included:

- Consultation and co-planning of the project undertaken with consumers and key stakeholders.
- Project governance established and provided by the Mercy Standard 8 Recognising and Responding to Acute Deterioration Committee.
- **Part 1** – An ethics application including project protocol for the first part (Survey of nursing staff) was developed, submitted and approved by the Mercy Human Research Ethics committee in November 2022.
- Following ethics approval Part 1 of the project was undertaken and completed and reported as per the ethics application. This included,
  - **Data Collection** via surveys (using REDCap) were distributed via links and QR codes in emails and on posters as well as paper copies of the survey provided to the designated wards.
  - **Data Analysis:** quantitative data were analysed using proportion of responses and qualitative data thematically analysed.
  - **Results:** Eighty-four responses were received. From the a-priori sample size calculations, a 53% response rate was achieved exceeding the target of 40%.
  - The staff who participated represented a range of, years of experience, gender, ward areas and campus which is considered to be proportionally representative of the anticipated characteristics of participants Table 1 (attachment 1 in appendix 1). The findings from the survey are displayed in Table 2 (attachment 2 in appendix 1).
  - Although most staff (84%) reported being aware of REACH escalation less than a third (31%) felt they understood the process and were confident to educate patients and families. Consequently they reported not educating patients/families about the REACH escalation process most of the time.
  - There were ten comments. In keeping with the quantitative data, the themes were lack of time/priority and needing education for both staff and patients.
  - **In summary** these finding suggest that,
    1. Although most nursing staff are aware of what REACH is, two thirds do not feel they understand the process well and are not confident about education patients, and in reality, most often education of patients/families about the REACH escalation process, is not occurring.
    2. Barriers were perceived for both themselves (staff) and patients/families. Staff perceived both the need for own education and difficulties of priorities/lack of time. For patient/families, staff perceived barriers that centred on the need for linguistically and culturally appropriate information and resources (eg videos brochures in admission packs) to assist time-poor staff in education of patients.
    3. Ideas for improvement focused on improved staff education and patient education via linguistically and culturally appropriate resources to assist patient education
  - **Reported:** A report of the findings of part 1 of this study and recommendations was prepared and submitted to the Standard 8 Committee on 22/2/23 (appendix 1).
- **Part 2:** With input from several consumers and the multicultural services manager, an ethics application (including study protocol) was developed and submitted to the Mercy Human Research Ethics Committee in February 2023 for this qualitative study exploring the awareness and perceptions of admitted patients and/or families about the REACH (Recognise, Engage, Act, Call, Help) inpatient/family-activated escalation process. Ethics approval for this second part was received in May 2023.
- This qualitative study has now commenced and involves undertaking semi-structured interviews with up to 25 consenting, inpatients/families (or until data saturation achieved). The results will be thematically analysed and findings used to inform consumer relevant improvements in the process.

#### Achievements to date:

- ✓ Baseline data were collected including benchmarking with other services.
- ✓ The study was co-designed with consumers and key stakeholders to ensure its relevance.
- ✓ Two ethics applications were prepared, submitted and approved (one for each part of the study).
- ✓ Part 1 of the study (survey of nursing staff) has been completed and reported (appendix 1).
- ✓ Subsequently recommendations, of increasing nursing staff education about the REACH escalation process, were endorsed and are being actioned.
- ✓ This study was presented to the MACH Council Meeting in May 2023 and to the Mercy Health, Allied Health, and Research Seminar in August 2023 (appendix 2).
- ✓ A Mercy Research Committee, Small Research Grant was awarded (July 2023) to assist the continuation of Part 2 of the study.
- ✓ Part 2 of the study has commenced with recruitment of participants (patients/family) for semi-structured interviews.

#### Significance and impacts:

This inpatient/family escalation process is an important mechanism for giving patients/families a voice to engage with health professionals assisting earlier identification of clinical deterioration and improved outcomes.

Responses from six public hospitals who participated in a benchmarking exercise found many identified the need to review current escalation processes and reported the need for more consumer involvement to identify ways to empower consumers to partner in their care.

This is consistent with the principle of, 'doing it with us, not for us', (Department of Health, 2011; Turk et al. 2017); that those for whom the intervention is intended have a right to provide input to ensure it meets their needs (NHMRC, 2016). There is increasing acceptance that involving consumers as partners in healthcare can improve safety, patient experience and outcomes (South et al., 2016).

This project will improve understanding of the reasons why inpatients/families don't engage in using the escalation process, factors hindering engagement and enablers that could be harnessed to design effective improvements in the process. The outcome will be evidence to inform consumer-relevant improvements in the process.

It is planned to share findings through conference presentation and if possible through publication as it is highly relevant to many services.

#### Future plans for continued activity:

Part 2 of the study is continuing with recruitment of participants (patients/family) for semi-structured interviews. The combined findings from both parts of the study will provide evidence to inform consumer-relevant improvements in the process. This study has received a Mercy Research Committee, Small Research Grant (awarded July 2023) to assist the continuation of Part 2 of the study beyond the fellowship.

#### Resulting collaboration:

The opportunity of this Fellowship has led to successful appointment to an inaugural Allied Health Research Lead role at Werribee Mercy Hospital working and collaborating with the Associate Professor of Allied Health. It has also led to becoming a member the Mercy Health Research Committee and to invitations for collaboration on both internal and external projects.

**Acknowledgements:** I would like to acknowledge the support from Mercy Health to enable me to undertake this Fellowship, MACH for giving me the opportunity and for the support and expert guidance from my supervisor Prof Dave Story, from the consumer advisor Ms Colleen Hartland and from the whole MACH team who so generously gave of their time and expertise. Thank you.

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## Appendix 1: Study Part 1 Report

# Health Services Deteriorating Patient Committee Agenda Item: 6.4



**Meeting Date:** 22/02/23

**Subject:** Summary of findings from survey of nursing staff about the REACH (Recognise, Engage, Act, Call, Help) process

**Proposed Resolution:** Findings noted by the committee and proposed actions endorsed

### Strategy Fit:

- Care first

### Quality Goals Fit: *Delete irrelevant dot points*

- Person Centred Care – Care and services are designed and delivered to be collaborative, responsive and create the best possible experience for each individual.
- Safe – Care and services are designed and delivered to minimise the risk of harm.
- Effective and Appropriate – Care provided is right for each person and based on the best available evidence and knowledge.

### Background:

The REACH (Recognise, Engage, Act, Call, Help) Patient/carer-activated escalation process links to three of the NSQHS standards (Standard 2 Partnering with Consumers, Standard 6 Communicating for Safety and Standard 8 Recognising and Responding to Acute Deterioration). Evidence supports decreased mortality, and improved operational outcomes when patients, families and/or carers are engaged and partner with staff in planning care. The REACH process aims to empower our patients and their families/carers to escalate care if they are concerned. However, at present there seems to be a 'procedure to engagement' gap which is important to investigate, address and subsequently bridge in order to improve patient care and safety. Therefore it is important to explore and identify areas for improvement in this process.

After liaison with key stakeholders including a consumer representative, the first step in this study was to survey nursing staff to explore their understanding and confidence with the REACH process and their perceptions of barriers and enablers to the process. This project was approved by Mercy HREC. (A second separate study, to explore the barriers and enablers for patients and carers toward engagement with the REACH escalation process, will soon be undertaken pending ethics approval).



## Results:

Surveys were distributed via links and QR codes in emails and on posters as well as paper copies of the survey provided to the medical, surgical (Level 4, 5, C3 and D3) and paediatric wards at WMH and the gynae-oncology ward at MHW. Eighty-four responses were received (24% electronic response; 76% paper copies). From the a-priori sample size calculations, a 53% response rate was achieved exceeding the target of 40%.

The staff who participated represented a range of, years of experience, gender, ward areas and campus which is considered to be proportionally representative of the anticipated characteristics of participants Table 1 (attachment 1).

The findings from the survey are displayed in Table 2 (attachment 2).

Key findings were,

- 82% were aware of what REACH was
- Only 31% felt they understood the REACH process well (with 69% stating only a little, somewhat or not at all)
- Only 31% reported feeling confident educating patients/families about the REACH process
- 43% reported feeling comfortable about patients/families using the REACH process
- More than two thirds reported 'less than half and time' (41%) or 'never' (38%) educating patients about REACH on admission
- In terms of education at other times, 50% reported 'never' and 31% 'less than half the time'
- Key barriers identified were time (62%), patient cognition (57%) and language diversity (47%) and lack of own education (40%)
- Key improvements centred on two main areas,
  - staff education (nurse-focussed education [69%] and ward champions [50%]);
  - and patient education/resources (linguistically [61%] and culturally [48%] appropriate information, videos [59%], information in admission packs [52%]).
- There were ten comments. In keeping with the quantitative data, the themes were lack of time/priority and needing education for both staff and patients.

## Discussion:

In summary these finding suggest that,

4. Most often, education of patients/families about REACH, is not being provided

5. Barriers are perceived for both themselves (staff) and patients/families. Staff perceive both the need for own education and difficulties of priorities/lack of time. For patient/families, staff perceived barriers that centred on the need for linguistically and culturally appropriate information and resources (eg videos brochures in admission packs) to assist time-poor staff in education of patients.
6. Ideas for improvement focused on improved staff education and patient education via linguistically and culturally appropriate resources to assist patient education

### Outcome Sought:

The committee note the findings and consider, alongside findings from the next phase (the 'Exploration of the awareness and perceptions of admitted patients and families about the REACH (Recognise, Engage, Act, Call, Help) inpatient / family-activated escalation process'). And then use the combined findings to inform a multi-system improvement implementation plan as indicated.

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(Appendix 1 continued)  
**Attachment 1. Table 1 Participant characteristics**

Number of surveys returned: N = 84

Participant characteristics	Number responses	Findings
<b>Years of Nursing experience</b>	84	< 1 year 5% 2 to 5 years 29% 6 to 10 years 21 % 11 to 20 years 24% > 20 years 21 %
<b>Gender</b>	84	Female 92% (77) Male 4% (3) Other Prefer not to say 5% (4)
<b>Type ward on at time of participation</b>	84	Medical 38% Surgical 14% Mixed Medical/Surgical 35% Paediatrics 12% Other 1%
<b>Mercy Campus at time of participation</b>	84	MHW 11% WMH 89%
<b>Mercy employed or agency</b>	83	Mercy employed 96% Agency 4%



**(Appendix 1 continued) Attachment 2. Table 2 Summary of Results**

Number of surveys returned: N = 84

Question	Number responses	Findings	Comments
<b>Awareness</b> Are you aware of what REACH is?	84	82% aware of REACH 18% not aware	N/A
<b>Understanding</b> How well do you feel you understand the REACH process?	84	30% only a little or not at all 39% somewhat 31% well or better	N/A
<b>Confidence</b> How confident do you feel educating patients and their families about the REACH process?	83	40% Not confident 29% somewhat 31% confident	N/A
<b>Comfort with use of REACH</b> How comfortable do you feel about patients/families using the REACH process?	84	Not comfortable 12% A little / somewhat 45% Comfortable 43%	N/A
<b>Frequency education on admission</b> In reality of a busy ward, on average, how frequently do you manage to be able to educate new patients/families on admission about the REACH process?	84	Never 38% Less than half of time 41% Half the time 13% Most times 9%	No comments
<b>Frequency education at other times</b> How frequently do you manage to be able to educate new patients/families about the REACH process at other times during the patient stay (i.e. other than on admission)?	84	Never 50% Less than half of time 31% Half the time 11% Most times 9% Other 1%	Other comment: "During POC audits"
<b>Barriers</b> Please select the key barriers to you as a nurse, being able to educate patients and their families about REACH (select all that apply).	84	Time 62% Patient cognition 57% Language diversity 47% Lack of own education 40% Particular shifts 39% Cultural diversity 21% Other 8% Fear Reach call reflect badly on me 2%	Other comments: Theme of time - "It's not prioritised" "Ward too busy" "Not in admission info pack" Theme of lack of education - "Lack of my education" "Don't know enough about it" "Too shy"

Question	Number responses	Findings	Comments
<p><b>Improvement ideas</b> What do you think would improve patient and family engagement with the REACH process?(select all that apply)</p>	84	<ul style="list-style-type: none"> <li>-Nurse-focussed education 69%</li> <li>-Linguistically appropriate information for patients 61%</li> <li>-Videos about REACH on hospital TVs for patients/family 59%</li> <li>-Information brochures sent pre-admission 52%</li> <li>-Ward champions 50%</li> <li>-Culturally appropriate information for patients/families 48%</li> <li>-Patient/family education 38%</li> <li>-Link to educational video sent to patients prior to admission 27%</li> <li>-On-line resources 19%</li> <li>-Other 5%</li> </ul>	<p>Other comments: Theme of patient education – “Have Posters in every room” “Include info in admission packs”</p>
<p><b>Other Comments section at end</b></p>	1	<p>“On a surgical ward our patients are either straight out of surgery so under anaesthetic or straight from ED when already the admission process is half an hour with the risk screening and chasing up of medications &amp; add the language barriers. The REACH program doesn't come up unless there is a difficulty getting medical teams to the ward.”</p>	

Appendix 2 – Copy MACH Council presentation

**ATTITUDES, BARRIERS AND ENABLERS TO CONSUMER  
ENGAGEMENT WITH THE MERCY PATIENT AND CARER INPATIENT  
ESCALATION PROCESS: A MIXED METHODS STUDY**

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MERCY HOSPITALS VICTORIA LTD  
MACH SUPERVISOR: PROF DAVID STORY**



**Identified Problem**



Lack of engagement of admitted patients and carers with the REACH (Recognise, Engage, Act, Call, Help) inpatient and carer activated, escalation process for clinical concerns about inpatient clinical care or health status.

**Importance**



When patients/families are empowered to engage and partner with health professionals, evidence suggests this may help earlier identification of deterioration and improved outcomes<sup>1</sup>

1. Vorwerk & King, 2016





12/08/2023



# PROGRESS

## MIXED METHODS DESIGN

### ACHIEVED



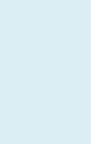
-  Baseline data collected (eg. calls last 12/12, benchmarking with other services)
-  Co-designed study with consumers and key stakeholders
-  Ethics applications submitted for each of the two project phases
-  Phase 1 - Survey of nursing staff completed and reported

### Survey Results

- 53% (n=84) response rate
- 82% staff aware of REACH but only 31% felt they understood the process and were confident to educate patients/families
- Most often patient/family education about REACH not occurring
- Main barriers - need for more education and lack of time
- Enablers - Education and linguistically and culturally appropriate patient resources were identified by staff as enablers

### COMMENCING

Care first

-  Phase 2 commenced now
-  Semi-structure interviews with consumers then thematic analysis of data
-  Study design based on principle that consumers at whom research targeted have a right to provide input into it, to ensure the outcomes meet their needs<sup>2</sup> is relevant and translates more readily into practice thereby more likely to be useful<sup>3</sup> and reduce research waste<sup>4</sup>

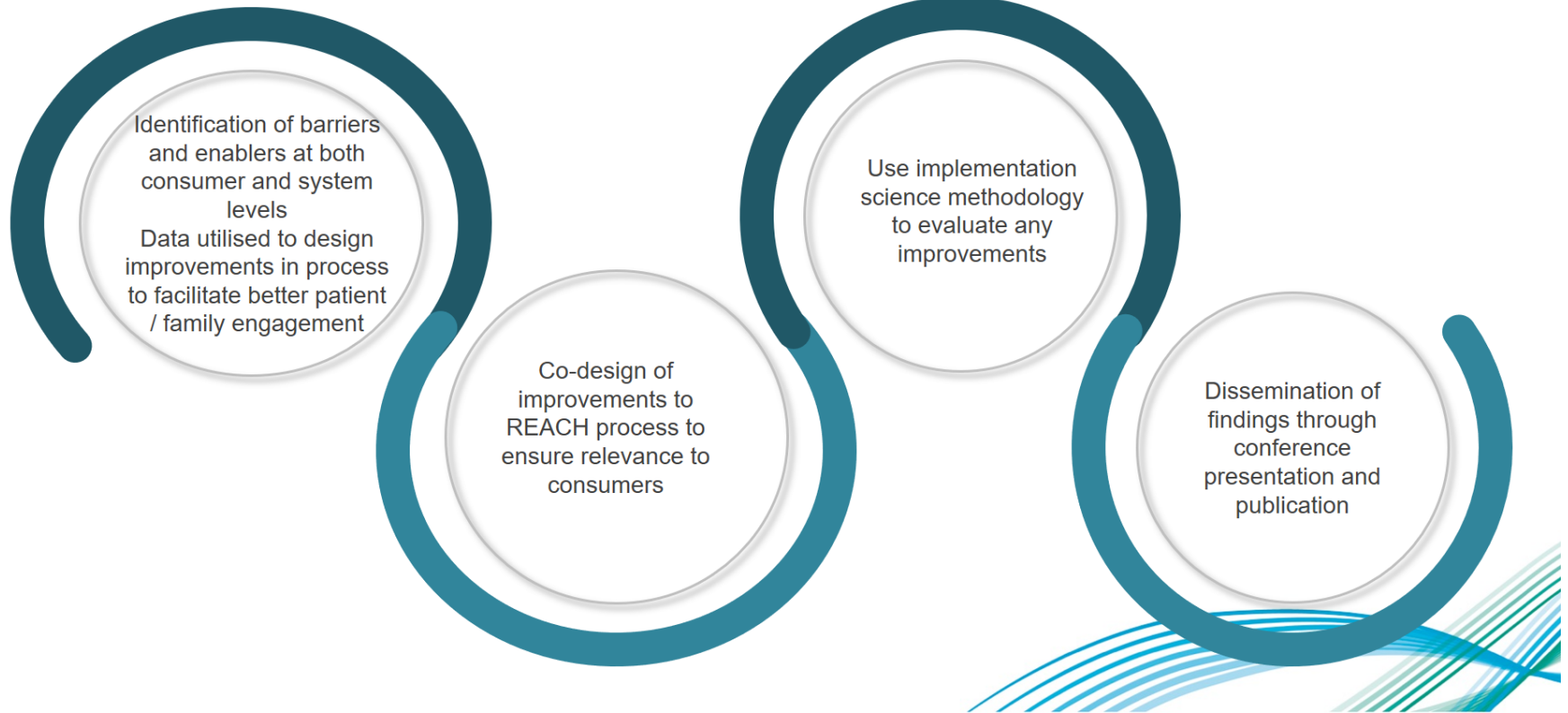
2. Miller et al., 2017; NHMRC, 2016; 3. Miller et al., 2017; NHMRC, 2016; National Institute for Health Research INVOLVE, 2012; 4. Chalmers et al. 2014





# WHERE TO FROM HERE....

## IMPACT AND OUTCOMES SOUGHT







# Learnings / Tips



## Relationships are key to success

Supervisors and key stakeholders including consumers



## Ethics

Start asap - always longer and harder than you think



## Surveys

The presentation and article about 'surveys' very helpful



THANK YOU  
ANY QUESTIONS?

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