Author's response to reviews

Title: A multi-faceted intervention to implement guideline care and improve quality of care for older people who present to the emergency department with falls

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Author's response to reviews: see over
Dear Ms Leigh,

I would like to thank the two reviewers, Dr J Close and Dr K Khan, for the very helpful and constructive comments and for editing this manuscript (MS: 1209482367441095).

I have made one correction to the manuscript I have changed the cut-off used for the FROP com screen from 3/4 to 2/3 to identify high risk fallers. Originally the 3/4 cut-off was used but early on in the project, due to lower than expected referrals, we changed the cut-off to 2/3. The FROP com screen was not required for referral and often not performed by staff in the decision making process and its uptake is not reported on in the paper. The publication by Russell 2009 also makes the point that a 2/3 cut-off may be more clinically useful. Figure 1 and the text on page 10 have been adjusted accordingly to reflect this.

Specific comments to the reviewers follow.

**Reviewer 1**

I have amended the manuscript in relation to the errors of grammar, clarity and comments generously provided by the reviewer. More substantial changes are outlined below.

1) New running head
   “Translating knowledge into practice by implementing a multi-faceted intervention to deliver guideline care and improve quality of care for older people attending the emergency department following a fall.”

2) Comment page 8 “May have been or were?”
   The design of the audit was such that we measured all the referrals from the emergency department to the relevant allied health services. The fraction of 4.9%, as the maximum figure, made the assumption that all these referrals were for ED Fallers. The reality is that some are likely to have been for older people presenting to ED for other reasons. The conclusion “May have been” is therefore the most accurate as we have not examined the characteristics of the patients that comprised the 4.9%.

3) Comment page 9 “this sentence doesn’t make sense”
   Old – “The key performance indicators to measure change were developed and comprised the proportion of ED fallers discharged home reviewed by CCT and the proportion referred for guideline care.”

   New - “Performance indicators to measure change were developed and comprised the proportion of ED fallers being discharged home that were reviewed by CCT, and the proportion of ED fallers that were referred for guideline care.”

4) Comment page 9 “how did they drive the change strategy”
That a good point I’ve changed to “support” as I did most of the driving . . .

5) Comment page 10 “This sentence does not make sense”
Old - “Audit and feedback of performance indicators provided at 1 and 3 months from the start of the implementation phase.”

New – “Audit and feedback of performance indicators were provided at 1 and 3 months from the start of implementation during meetings with CCT.”

6) Comment page 10
Old – “The pathway was designed to be simple, so as to require little additional ED medical staff input and have minimal impact on the ED length of stay.”
New – “The pathway design was simple to minimise additional ED staff input and the potential impact on ED length of stay.”

7) Comment page 11
Old – “Patients with definite syncope and delayed presentations >4 days were excluded.”
New – “Patients with definite syncope and delayed presentations greater than 4 days were excluded, the latter to minimise the number with multiple presentations.”

8) Reviewers question
“Are the cct’s functioning as a screening service or are they undertaking assessment with the facility to refer when need is identified.”

Answer screening.
See page 8 “Their primary role was to screen older people attending ED to identify vulnerable older patients for more comprehensive assessment and referral, prioritizing those who may be able to be discharged.”

9) Comment page 14 “still poor”
Old - The average quality of care index improved 75.3% from 18.6 (95% CI: 16.7-20.4) to 32.6 (28.6-36.6) out of a maximum score of 100.

Added - When benchmarked to the CEEU national audit scores, this improvement represented a move from the first quartile to the third quartile of all sites evaluated. Ref 29

10) Comment page 15 “How can this be determined”
We have altered the statement
Old - “However the FTE staffing levels did not have a significant impact on referral for guideline care (t=0.154, p=0.880).”

New - “Modelling via an ARIMA model for the effect of FTE staffing levels indicated that the increase in staff did not seem to have an effect on referrals for guideline care  (t=0.154, p=0.880).”

11) Comment page 15 “What about uptake of referrals and adherence”
This was not within the scope of the research project.
12) Comment page 16 “It improves health for the person rather than the health service.”
That’s definitely the intention, although unfortunately we did not measure if the actual health of the patients was improved.

Old – “. . . . required to improve health service.”
New – “. . . . required to improve health service delivery. “

13) Comment figure 1 – “Implication is that single intervention isn't guideline care”

Response - For the population group attending ED following a fall, a single intervention (except pacemaker insertion) does not meet guideline care criteria when a literal interpretation of the NICE guidelines is used. However, in recognition that referral for a single intervention is common clinical practice, to allow patient and clinician choice, to potentially be more economically effective, the single intervention option was included in the pathway and publication This view is consistent with the approach taken by others (Campbell, Age and Ageing 2006; 35-S2: 60-64)

14) Comment figure 2 “If these people are all being reviewed then where is the block in terms of guideline care. Why weren't they referred.”

Response – The intervention lead to a statistically significant increase in patients being reviewed by CCT but also a increase in those declined referral for falls prevention measures. There was no change (statistically) in the portion of people being reviewed by CCT and not referred. We did not evaluate “why” they were not referred but recognize this to be important block in the evidence to practice pipeline.

Reviewer 2

1) I have amended the manuscript in relation to the grammatical error noted.

2) I have considered reference to article “Multifactorial evaluation and treatment of persons with a high risk of recurrent falling was not cost-effective” by G Peeters but have decided not to include this reference. To include this work would involve discussion around the RCT which the analysis was based.

I thank you for your attention and assistance in improving this work in preparation for publication.

Kind regards

[Signature]

Dr Nicholas Waldron on behalf of all the authors
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