Facilitator Instructions

How to Use this Guide:
This guide offers learning material that can be used in part or whole, depending on the needs of the group. Each section after the Introduction can stand alone.

Teaching Method:
The guide includes opportunity to stop the webinar for a small group discussion and learning experience for participants to apply what presenters have said to the their own experience. Adults learn best through applied learning so the guide's learning experiences support reflection and time for participants to think about how to use what they have learned.

Background:
This webinar series supports nursing homes to engage staff closest to the residents in problem solving for better outcomes. It applies a core principle of quality improvement – results depend on systems, and systems depend on the relationships among those involved in the systems. This is called *relational coordination.* To be most effective, assessment, care planning, and quality improvement systems need the information and ideas from the staff closest to the residents to guide and document delivery of care.

The webinar series was part of a core curriculum used by forty-nine nursing homes who participated in the Pioneer Network's National Learning Collaborative on *Using MDS 3.0 as the Engine for High Quality Individualized Care.* Using B&F Consulting's method for activating high performance, the homes incubated four systems to strengthen their working relationships - consistent assignment, huddles, involving CNAs in care planning, and QI closest to the resident – and, as a result, reduced falls, alarms, pressure ulcers, hospitalizations, and antipsychotic medications The webinar series guides homes through B&F Consulting's 3 step method: (1) strengthen relational coordination systems, (2) apply systems to priority clinical areas, and (3) use staff's knowledge of residents to individualize care to improve outcomes. The webinars feature nursing home teams sharing how they use relational coordination to improve outcomes.

For the collaborative's free Starter Toolkit on *Engaging Staff in Individualizing Care* go to www.PioneerNetwork.Net

A word about language:
You'll notice that as the staff tell their stories, their language is sometimes less person-directed than their actions. Explain this to participants and use any examples from their language that provide learning opportunities.

Opening Process and Explanation:

Mix the group so that people sit with people other than their co-workers. While people might have some initial discomfort, they will benefit from talking with people they don't usually work with and will learn new ideas they can bring back to co-workers.

If people don't know each other, to get more comfortable sharing, ask participants to spend the first few minutes in a go-around sharing who they are, where they work, what their position is, and how long they have worked there.

Note: Learning Experience # 1 involves having participants where alarms to experience them personally. Prior to the viewing, make sure to have some alarms on hand.

Introduction to the Topic: Promoting Mobility

Time 3 minutes

Content Explain to the group:

Alarm use has been the standard of practice, as restraints were. We are now in a period of rethinking their use, as we understand more about their damaging affects, and about the role mobility plays in reducing falls with injury.

If you don't use it, you lose it. We now have the evidence that the best way to minimize injury from falls is to maintain mobility because only through weight-bearing activity do you maintain strong healthy bones. According to Mary Tinetti, MD, in The Patient Who Falls, JAMA 2010, the most effective strategies for reducing falls are exercise, physical therapy, cataract surgery, and medication reduction.

As Joanne Rader explains in the webinar, restricting mobility contributes to falls and falls with injury. Alarms, like restraints, restrict mobility. Alarms have negative impacts on strength and gait, sleep, skin, appetite and digestion, social engagement and mood.

With the proliferation of alarm use, has come alarm fatigue, where so many alarms go off, that staff are desensitized to the sound. The sound also contributes to agitation for residents and families and may actually contribute to people falling. Night time alarms wake other residents who may then try to go to the bathroom and fall. The common response, "sit down," doesn't get at what residents actually need.

The same process used for removing restraints works for eliminating alarms - individualized assessment, learning people's patterns, and looking at the "antecedent" to someone's rising.

Alarms were initially invented as a diagnostic short-term tool to learn some one's patterns in order to remove restraints. With critical thinking, a number of practitioners have questioned their use and succeeded in eliminating alarms while improving residents' mobility, thereby reducing falls with injury.

Organizational practices described in Webinars 1-3 - consistent assignment, shift huddles, just-in-time unit-based QI and high involvement care planning - will accelerate success in eliminating alarms. This is truly an interdisciplinary process with therapy, social services, activities, and nursing working together with staff closest to the resident, to identify and respond to residents' needs.

This webinar is in two parts. In Part One, 30 minutes long, Joanne Rader, noted for her seminal work to eliminate restraints, talks about alarm elimination. She shares with the audience the medical and organizational processes needed to promote mobility through individualized care, and thereby eliminate alarms and reduce falls with serious injury. In Part Two, 25 minutes long, staff from two nursing homes describe how they did just that.

Learning Experience # 1 Alarms: What's It Really Like to Wear Them?

Time Volunteers wear alarms while listening to part one of the webinar

15 minutes to discuss the experience

Process

Ask for one volunteer at each table to wear an alarm. Ask the person sitting next to them to reset it if it goes off.

Pause the webinar at the end of Joanne's portion. Discontinue alarm use.

Debrief - One by one ask each person who wore an alarm to describe what they experienced. Some will speak to the physical discomfort, while others will talk about the psychological affects – how it affected their concentration, its isolating impact, and their concern about disrupting others. Gently probe to get full explanations from each person who speaks. Highlight the main themes and tie them back to Joanne's presentation.

We understand best when we have a personal experience. Encourage homes to do this same exercise with their leadership team and/or nursing staff, as a first step in eliminating alarms.

Learning Experience # 2 The *How* of Change

Time 20 minutes

Process

Prior to resuming the webinar, ask people to take notes on practices described by the next speakers that were key to their success in promoting mobility, reducing falls, and eliminating alarms. Play Part Two of the webinar, through to the end.

Use a Learning Circle to share initial reactions to what the staff from the two homes presented. Remind people that in a learning circle, the learning is in the listening, and that they should hold questions or comments until everyone has spoken.

Invite room-wide sharing about table discussions.

Ask if anyone in the room has had success with removing alarms. If anyone has, ask them to describe what they did and how they did it.

Content

Probe and review the following areas:

1. **Organizational practices** – consistent assignment, shift huddles, interdisciplinary on-the-spot assessment and care planning

2. **Environmental factors** - Look at when people tend to fall and assess root causes such as noise, change of shift, policies for dining room, other environmental antecedents

3. **Assessment and Care Planning –**
    a. **Goals -** shift from preventing movement to promoting mobility
    b. **Explain –** your rationale for your strategies
    c. **Input –** from staff closest to the resident
    d. **Agile –** change plans on the spot as you learn what will work best for residents
    e. **Customary routines –** know and follow residents' routines to anticipate when they will be getting up or needing to rest
    f. **Holistic approach –** look at mood, behaviors, functional ability, and customary routines all together to understand what a resident needs.

4. **Role of Therapy** In addition to traditional strengthening functions–
    a. **Outside the gym –** to assess seating, mobility in the resident's room
    b. **Payment issues –** coding evaluations, assistive devices, and therapy

5. **Education –**
    a. **Families** have been taught that alarms prevent falls. Explain the research for what you are doing instead. Enlist their help and advice along the way.
    b. **Physician**s need to be educated as well and be an active part of this process. As you are considering taking alarms off, you need to talk it through with them and invite them be active participants in the process, taking on such role as speaking to hesitant families. Medical Directors can take a lead in communicating the goal of the alarm elimination with physicians.

6. **Process –**
    a. Work with a few residents at a time, starting with the easiest.
    b. Use *antecedent* logs, which track why a resident's alarm when off – what they were doing or needing or responding to in the environment - to know residents' customary routines

7. **Resources – see list**
    a. TUG and SPLAT – described in slides (note which slides these are so you can refer back to them)
    b. Stop and Watch, a tool from the INTERACT program
    c. www.joataylor.com/resources - environmental assessments; fall prevention strategies
    d. **Falling in Older People: Prevention and Management**, by Rein Tideiksaar, 4th Edition, 2010, Baltimore: Health Professions Press