



Pioneer  
Network

# **Integrating the MDS 3.0 Into Daily Practice**

**Webinar Series Two:  
Clinical Applications**



*Welcome!*

# **Integrating the MDS 3.0 Into Daily Practice**

## **Webinar Series Two: Clinical Applications**

Developed by B&F Consulting for the Pioneer Network's National Learning Collaborative on  
Using the MDS as the Engine for High Quality Individualized Care Funded by The Retirement Research Foundation



## Integrating the MDS 3.0 Into Daily Practice Clinical Applications

FEBRUARY 9, 2012

### **PART FOUR: Promoting Mobility and Reducing Falls by Individualizing Care and Eliminating Alarms**

#### TODAY'S PRESENTERS:

Joanne Rader

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Executive Director

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**Integrating the MDS 3.0 Into Daily Practice  
Clinical Applications**

# Promoting Mobility and Reducing Falls by Individualizing Care and Eliminating Alarms

Joanne Rader, RN, MN, PMHNP  
Rader Consulting

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## **Integrating the MDS 3.0 Into Daily Practice Clinical Applications**

# Do you have “alarm fatigue?”



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Think  
about  
your  
current  
alarm use



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Let's get our  
heads out of the  
sand and take a  
new look at the  
relationship  
between falls  
and mobility



What is the evidence base  
for the use of alarms  
as devices to prevent falls and injuries?

There is none

***Much as with restraints and siderails,  
we have false beliefs about their  
effectiveness.***

# Alerting devices

- Makes others feel safer
- Acts best as substitute call light
- If trying to remove not the best option
- If overused, staff ignore
- Best used temporarily in acute situations to determine patterns and needs
- Best if alarm goes off remotely, not at bedside



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What are we  
saving repaired  
hips for?

We need to let  
people use them

**“The overall goal of fall prevention is to minimize fall risk by eliminating contributing factors while maintaining or improving the older person’s mobility and autonomy”**

Rein Tideiksaar  
“Falling in Old Age”

# Restricting Mobility

- Increases risk of falls and injuries
- Decreases balance, endurance, strength
- Decreases bone health
- Increases skin problems
- Cause agitation or lethargy or both

**Let's take head out of sand and a fresh,  
clear, direct, evidence based look at falls**



One of the best  
ways to prevent  
injuries related to  
falls is to **keep  
people moving**

# Extrinsic risk factors

- Multiple medications
- Environmental factors
  - Physical
  - Psychosocial
  - Organizational (policies and procedures)

# Fall Risk Factors

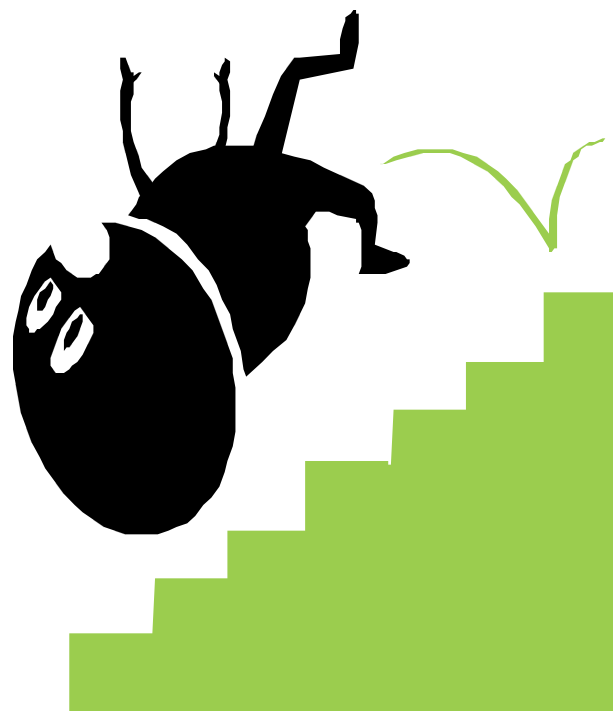
**Difficult to change:**

Normal aging

Chronic diseases

# Adaptable Fall Risk Factors

Living space  
Transfers and mobility  
Use of equipment  
Psychoactive drugs  
Policies and  
procedures  
Staffing



# Individualized Assessment

- Identifying needs/ risk factors
- Meeting needs / reducing risk factors
- Knowing the person – CNAs know a lot!!
- Assessing the internal and external risk factors and basing a care plan/ service plan on that

# **MDS 3.0**

## **is a great tool for helping you:**

- make this switch in focus related to falls and mobility
- create realistic plans of care based on resident choice, evidence based practices and realistic goals

# Example of unrealistic plan:

- Using 2 to 3 alarms on a person who is determined to remove them

# What MDS sections useful?

## ALL

- Section C – cognitive patterns
- Section D- mood
- Section E – Behavior
- Section F – customary routines
- Section G – functional status
- Section J – pain management
- Section J 13, 14, 16 - fall hx and assessment
- Section 0 – OT and PT, restorative

You can't look at safety  
without also looking at  
mobility, quality of life  
and choice!!!

MDS and new survey process  
supports this

## Making Sense of Behavior:

*All behaviors have meaning...*

***It is our job to try to figure it out***

- Behavior monitoring- critical assessment of behavioral patterns (**Section E**)
- Previous coping styles (**Section E, F, G**)
- Lifelong activities

*Could “wandering” really be a way to self-medicate for Alzheimer’s disease?*

## Section J: fall hx and assessment

# **SPLATT Fall Assessment**

**S= Symptoms**

**P= Previous falls**

**L= Location**

**A= Activities**

**T= Time**

**T= Trauma ( use MDS code)**

## Functional status: Section G

- “Beef up” your data
- Carefully measure and document ambulation (how, how much, how often)
- Link to Section F customary routine and choice; document resident patterns and wishes

**PT and OT can provide good guidance for your care plans and documentation**

## **Section G: functional status**

### **The Up and Go Test (TUG)**

- **Sit and rise from chair**
- **Walk to and from toilet**
- **Use toilet (including clothing management)**
- **Get in and out of bed**
- **Turn around (180-360°)**

# Importance of Consistent Assignment

- Have as few people as possible “touching” and interacting with new person
- The best of the solutions for improving safety and mobility and understanding the meaning of behaviors, will come from the CNAs, if they know residents well

***“Best way to reduce lawsuits is  
to have positive relationships with  
family and person”***

- **Be Proactive**
- **Be trustworthy, consistent**

# External Environment

- Organizational
- Physical
- Psychosocial

# Modifying the physical environment:

The route to  
person-directed care  
and restraint/alarm-free care



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# Physical Environment:

- Personalization
- Noise level
- Lighting
- Floor covering
- Furniture
- Seating and mobility devices
- Activity or stimulation level
- Spaces for privacy, socialization
- Safety and security



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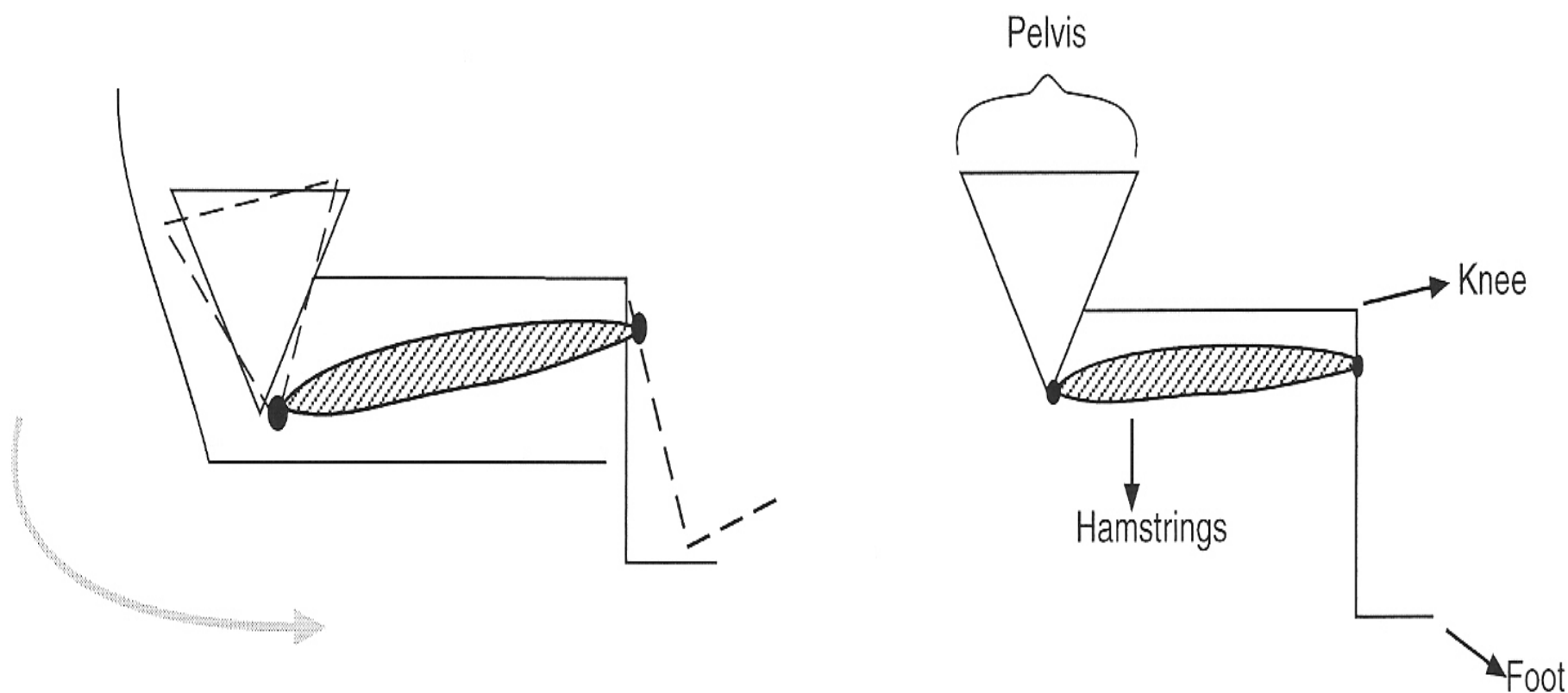
# What is wrong in this picture?



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# Tight hamstrings are common

hamstring pull out of chair





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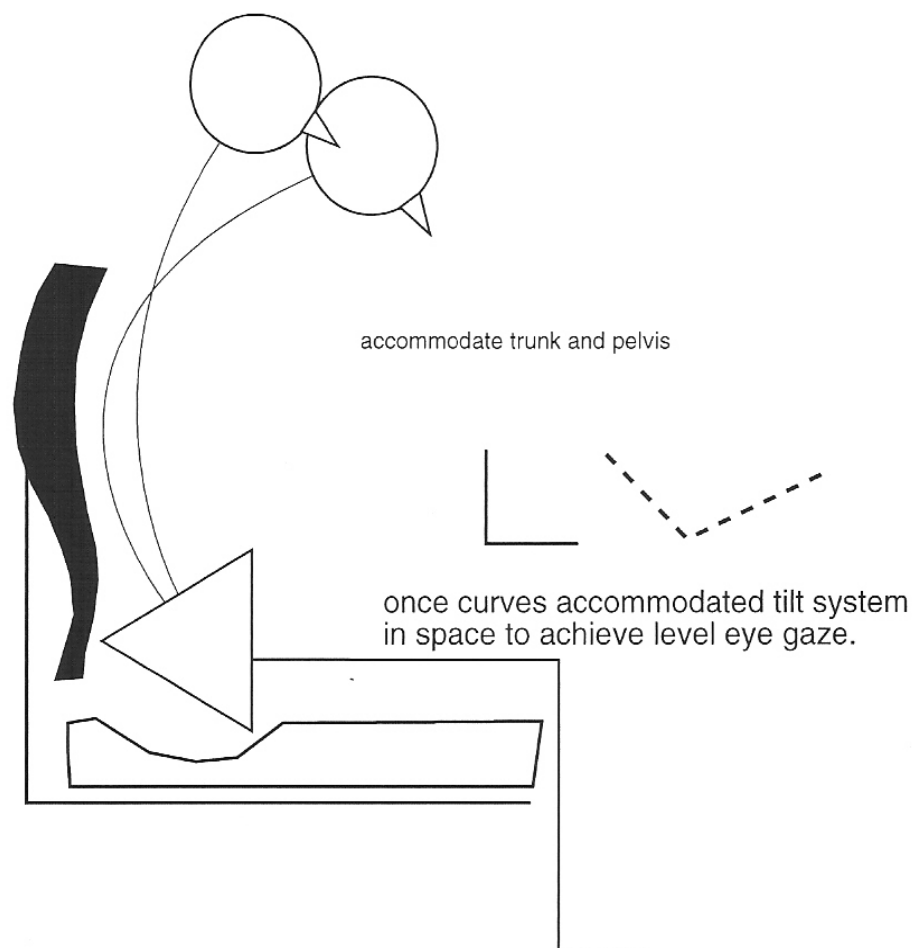
### The “Blob” in the Geri-chair: dependent in all ADLs



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Figure 12B

Custom  
contoured  
back and seat  
to achieve  
level eye  
gaze and  
trunk stability





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Art in a customized  
wheelchair:

Able to feed himself,  
assist with transfers,  
brush teeth with  
cuing, move short  
distances in w/c  
by self, interactive  
and social



## **Observations that should trigger seating assessment:**

- Leaning or sliding in wheelchair/ chair
- Use of tie –on restraints
- Use of geri chair as restraint
- Crying and yelling
- Agitation and restlessness
- Seat belts over abdomen
- Use of tray tables, lap pillows
- Skin problems r/t pressure

# Importance of involving therapies

## Section 0

- To assess how to improve safety in physical environment
- To assess for best ways to maintain or improve function and mobility
- To help determine the best assistive and mobility devices

## Have/Use variety of chairs

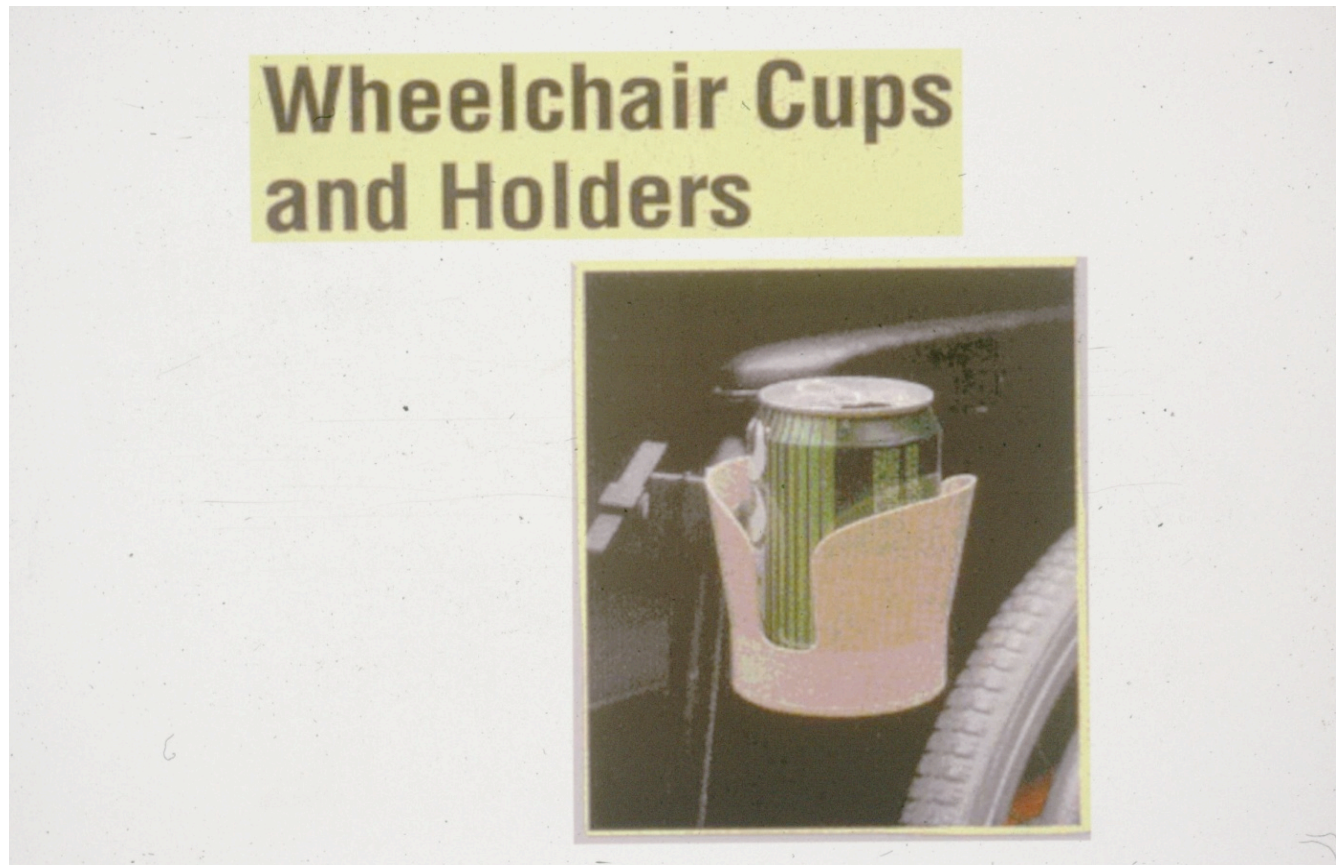


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# Example of individualized fall prevention

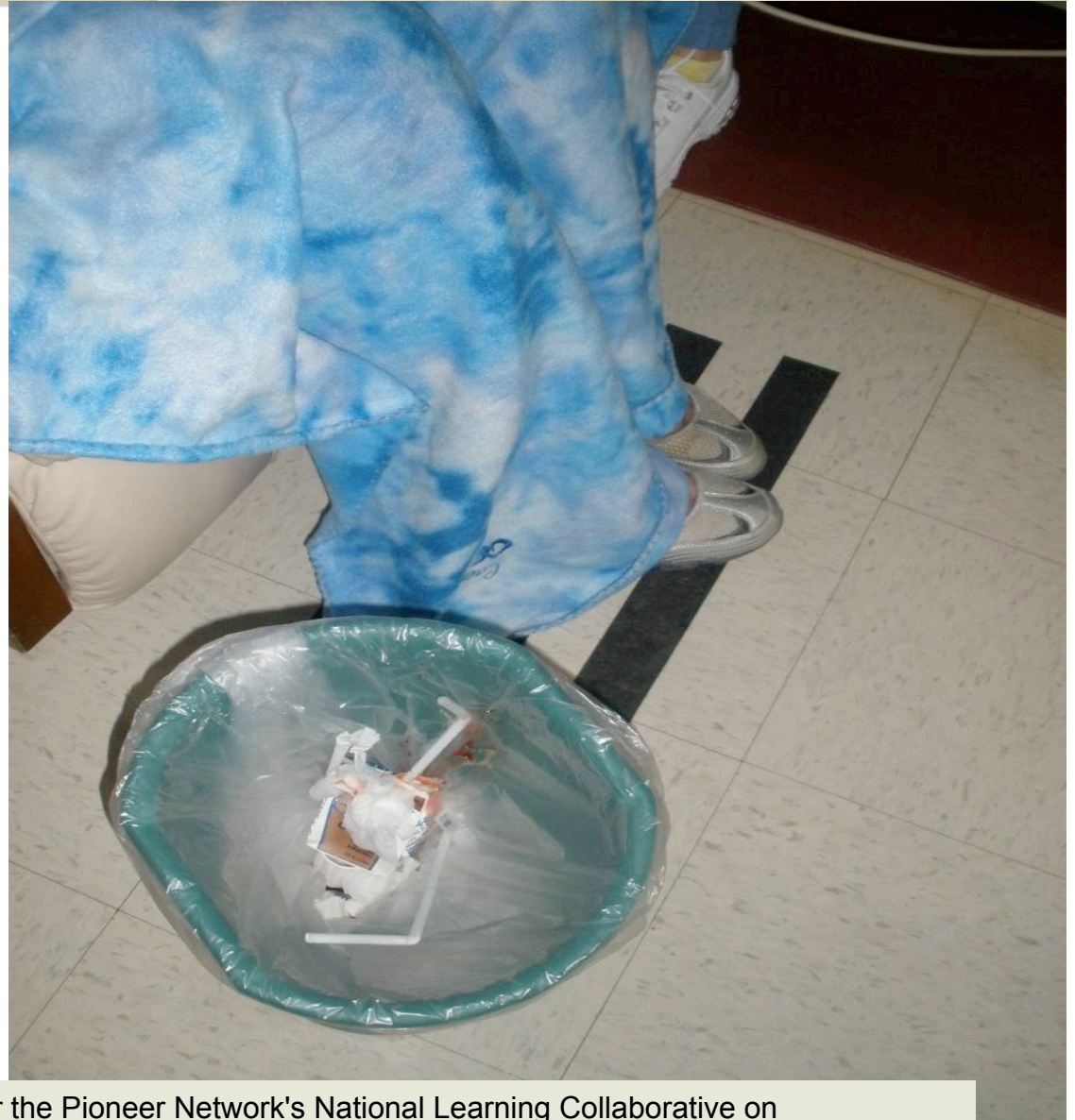


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# Environmental adaptations



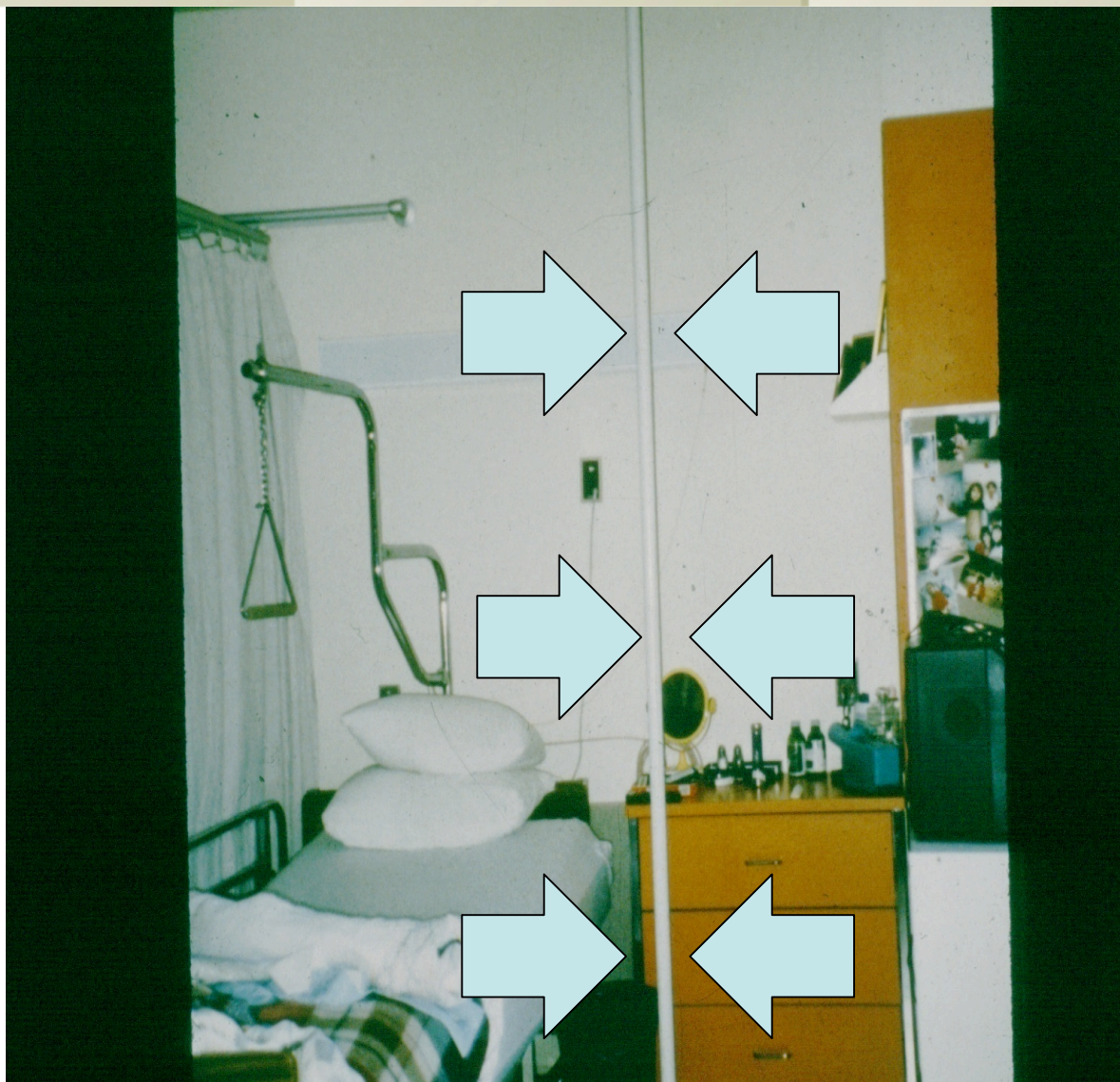
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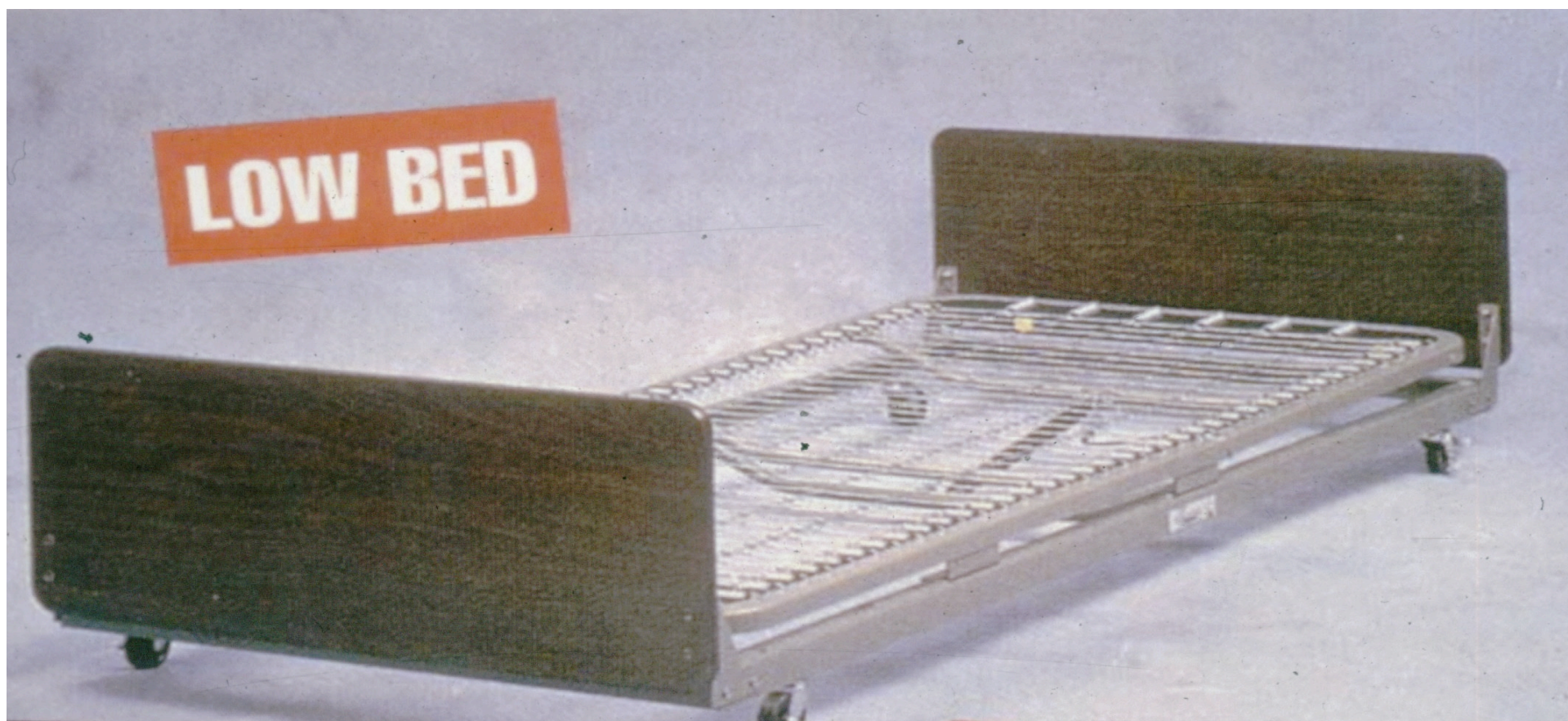


Use of  
transfer  
pole

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## Bed height and slippers



# Physical Environment

- Noise level
  - Alarms
  - Overhead paging
- Lighting
- Floor covering
- Furniture
  - Height and type of chairs, beds



# Organizational Environment

- Philosophy/culture

## A culture change:

- No one who works or volunteers in the care setting walks by a person who has the call light on or is calling out without acknowledging the need and asking if they can assist.
- As much as 50% of the time, it is something that does not require special training to address

## It is about:

- knowing the person
- finding the root cause of behavior
- honoring the person's wishes while developing safety plan
- modifying risk factors (internal and external)



## Integrating the MDS 3.0 Into Daily Practice Clinical Applications

Choose to act on side of ***resident choice and mobility***, not a false sense of safety, based on inaccurate assumptions

- Do your assessments
- Be proactive
- Involve those closest to the residents
- Involve those most afraid of
- Document, document
- Follow your own plans
- **Keep people moving!**

## Helpful resources

- [www.joataylor.com](http://www.joataylor.com) - for environmental assessments, including engineering and nursing assessments, and fall prevention information
- [www.PioneerNetwork.net](http://www.PioneerNetwork.net)
- [www.KendalOutreach.org](http://www.KendalOutreach.org)
- [www.theconsumervoice.org](http://www.theconsumervoice.org)



# Thinking Differently: Working Together to Individualize Care, Promote Mobility and Reduce Falls

- Todd Mann, Administrator
- Robin Beauchamp, Director of Nursing
- Beth Nowak, Rehabilitation Coordinator

**Golden Living at Sycamore Village,  
Kokomo, IN**

# We had room for Improvement

- High staff turnover
- High number of alarms
- Many falls

***“We were a special focus facility”***

# We began with a group

- ADoN - falls champion
- Therapy
- Two Unit Managers
- Social Service
- Activities
- Maintenance

## We met weekly

- Overview of all alarmed residents
- Decided together which alarms to eliminate
- We set our target at removing five per week

***“thirty minutes”***

## We started with the easiest

- Week one - Five residents who had not had a fall in over six months
- Week two - Residents who had not fallen in three months
- Then we looked at residents who had gone less than 60 days without a fall
- Finally we moved to residents who had a recent fall

# Interventions

- Therapy
- Changing resident environment
- Adaptive equipment
  - Halo bars
  - Assist bar in bathroom

# High Involvement

- CNA's
- Their involvement gave us insight in resident habits

## Tools

- Consistent Assignment
- Communication Books
- Huddles
- Stop and Watch



# A Strong Rehab Team

- On board with alarm reduction
- Used flexible “***out of the box***” thinking

## Falls Champion

- New interventions were noted on daily assignment sheets
  - What type of transfer is needed
  - Do we need mats on the floor?
  - Bed in low position
- Skilled therapy
  - Balance
  - Toileting
  - Urinary incontinence
  - Speech
  - Cognition

## It took having an Interdisciplinary team

- We grouped people in terms of how difficult it would be:
  - Easy
  - Medium
  - More Difficult

# Easy

- Alarms had been used as a preventative measure
- Those who were easy once we really looked
- We used an antecedent log to track falls
- Therapy involved
- Wheel chair was changed
- Therapy log

## Group two

- More falls
- Cognitive impairment
- Individualized approach
- Smaller wheel chair

## Hardest

- Frequent falls
- Physical therapy for balance and strength,
- Assessed and put in place adaptive devices
- Therapy and nursing worked closely
- Put in place a walking program 2-3 times a day
- Carefully assessed the environment
- Took longer

***We individualized the care~  
We looked at what are the underlying issues?***

## Why does this person have these falls?

- Strengthening
- *Go right to the room and assess them in their room*
- Watch the CNA's as they provide care
- Skid strips on floor
- Where should the grab bar go?
- Functional aspects of life
- Time of day may be the issue

***An increase in mobility led to a decrease in falls***

## ***Out of the box*** therapy

- We look at peoples habits
- Urinary incontinence
- Environment
- Family
- Other staff
- Problem solving therapy
- Look at the whole picture

***“It’s really problem solving therapy”***

# Sometimes we can use visual cues

When it's urinary incontinence:

- Picture of a toilet on the door
- Blue line that leads to the bathroom
- Colored toilet seat

# Our results

- 52 resident with alarms down to 5
- The remaining alarms are because families want the alarm
- We would like to eliminate all alarms

# Fewer Falls - Fewer Injuries

- Reduced our falls by 50%
- Reduced our falls with injuries by 60%

# Staff were initially skeptical

- Less agitated residents meant less behaviors
- Less work because residents fell less
- Less agitation
- Residents moved freely by themselves
- Residents were able to reposition themselves
- Staff were able to help with building mobility by assisting residents with walking more ~ this helped residents gain strength

# Less stress on staff and residents

- Noise reduction
- Residents were able to sleep uninterrupted
- Residents were able to help themselves more
- Staff are better problem solvers
- They don't wait for the data now

# Better staff engagement

- More working together
- We relied on our staff
- Communication improved
- Management looked at root cause
- Alarm may mask the true reason for the fall

# Working better together

- CNA's let therapy know when something was working or not working
- Management had to look for the root cause of the fall

***The alarm was masking  
the true reason for the fall***

# Families

- Families appreciated the reduction in falls
- Made the visit a better visit
- The process helped us to look at other systems and fix other issues
- It takes a team to do something different
- Don't be afraid to think outside of the norm

***“We graduated off special focus list!”***



## Integrating the MDS 3.0 Into Daily Practice Clinical Applications

We've done it before,  
we can do it again  
*It's all about trust*

Jinx Oberly RN NHA

Brandywine Golden Living Center  
Greenfield, IN

# Measure First

- We started by identifying How many alarms do we have?
- Of 120 residents 67 had alarms
- We took this on just as we had reduced restraints

# Antecedent log

For the week we looked at:

- When did it go off?
- What did the individual want?
- What did the staff do
- How was it resolved?

# We tried to remove five per week

- Unneeded alarms
- We removed the easiest first
- We went from 67 alarms to 2
- The remaining two don't go off, but family members want them on

# We Made Some Simple Changes

- Turned bed around to residents strong side
- Adjusted the seating in dining room
- We did it slowly
- We waited until we knew what was really going on
- Picked easier alarms to remove first

# Family Trust

- We kept them informed
- They relaxed as they were informed
- They gave us ideas, and insight
- We were able to know residents better with the family's input
- It's important that they are a part of it

# Impact

- Noise level reduces
- Calmer environment
- Staff trusted managements lead

*We recognized that there is a panic  
when an alarm goes off*

- We shifted to anticipating needs
- We learned not to over react



# Our Families' Response:

*"I can sleep at night knowing that  
you're doing everything for my mom"*



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*Thank you for being with us today!*

Join us for other upcoming webinars in this series

**MARCH 22, 2012, 2 PM EST**

**PART FIVE:**

**Individualizing Dining: New Practice Standards**

**APRIL 19, 2012, 2 PM EST**

**PART SIX:**

**Smooth Transitions in Care:  
Getting New Residents Off to a Good Start**

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