Please stand by for realtime captions

Good morning. Thank you for joining the New England Nursing Home Quality Care Collaborative. My name is Sarah Dereniuk-Dudley, and this is Part 1 on Improving Nursing Home Resident Mobility.

Before we begin, I have a few housekeeping items. This webinar will be recorded, and the presentation will be available in a few business days. The phone lines will be on mute for the presentation. We ask you to not put your phone on hold.

For any questions at any point enter them in the chat panel on the right and send your comments to participants. We will monitor these throughout the presentation. We will have plenty of time for questions during the presentation and will open the lines for you.

Lastly, if you find the presentation is a little cut off, use the arrow keys and/or the + or - two adjust your screen accordingly.

I'm pleased to have Florence Johnson join me later during the presentation. This webinar is intended for nursing home leadership and staff to provide an overview of strategies and resources to help residents maintain and improve mobility.

During the presentation we will discuss the basic definition of mobility, how encouraging mobility can lead to improvement, and several quality measure outcomes. We will identify strategies to take a person-centered approach to reducing falls and eliminating the use of bed and chair alarms and review the nursing home Change Package and apply strategies from the mobility bundle.

The first objective is to define and understand mobility and its importance for your staff to work on retaining and improving mobility for your residents. Mobility is not just walking. It is about strength and staying power. It means being able to move your body or have someone help you move from place to place. It includes walking, turning over in bed, getting up from a chair, standing, and using a cane, walker, or wheelchair to get around or moving from place to place with you or outside the nursing home.

Lack of mobility can have a negative impact on the overall quality of life for your resident. Encouraging them to be more mobile is a balance between autonomy and safety.

Staff can be afraid of a resident’s safety and may discourage mobility or choose to use a better chair alarm to prevent falls. However, limiting mobility increases the risk of falls. Immobility impact ADLs, increases falls, increases pressure ulcers, and impacts diabetes and the upper respiratory tract, sleep, and the overall health of residents.
For improving resident mobility, muscles and bones are strengthened which makes fractures less likely in the event of a fall. The overall risk of falling is reduced, and it improves their heart and lung function, sleep, and energy levels. The risk of pressure ulcers is reduced, overall mood improves, and residents have safer transfers and increased independence with ADLs. Residents are less socially isolated and participate more in group activities.

Increasing resident mobility has benefits for the staff. It facilitates self-care so residents can do more for themselves. It makes transfers easier and safer for staff and saves time. It promotes safe walking and enables residents to access toileting easily to promote continence.

Share your responses in chat. While you do this I want to talk about who has responsibility for helping residents to improve mobility. Is it physical therapy? A strong nursing program? Keeping residents as physically independent as possible is everyone's job. Nurses, aides, dietary, housekeeping, administration—the whole team. Mobility is an important part of your daily care and is as important as vital signs. It is as much about the environment as it is about care. Please continue to share your responses in the chat.

What are some ways to assess ability? The National Nursing Home Quality Care Campaign, formally known as Advancing Excellence, has a mobility assessment tool to use which is part of the mobility tracking tool that we will talk about in a few minutes.

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As a part of the program we are using data to drive improvement. The first step is to collect data by completing the monthly mobility assessment on every resident you are tracking using this mobility assessment form. The tool consists of six items from the MDS and two similar items. We will share a link to download and explore following today's session.

You can track and measure mobility using this MDS quality measure including the percentage of long-state residents whose ability to work independently worsened and the percentage of long-stay residents whose need for help with activities of daily living has increased.

Both of these measures are publicly reported on the Nursing Home Compare website and make up a part of your overall Five Star quality rating. Also, you can track improvement in mobility by looking at other quality outcomes that are the result of poor or increased mobility. This includes falling, falls with injury, pressure ulcers, and depression. As mobility improves you will find these quality measures improve also.

You can use the New England QIN-QIO Standard Analytic Report (SAR) to track changes in your quality measures over time. As a participant of this collaborative, you have access to these free quality tracking and monitoring reports each quarter. These reports track measures over time. As you can see, the red line represents the simple facility. The blue line is the state average, and the purple is the overall national average. You can see that the state and national average are following the same trend as of Q1 2017. The average was 18%.
You can see the simple facility is running higher than the national average and continues to increase. This trend should alert your team that improvements need to be made. This MDS 3.0 measure points to the percentage of long-stay residents who experienced a decline in independence of locomotion during the target period when compared to a prior assessment.

This is a measure that is defined as a decline in their ability to move around the room and to adjacent corridors on the same floor in a wheelchair. This measure reports the decline in self-sufficiency once the resident is in a chair.

This measure evaluates the quality of nursing home care with regard to the loss of independence and locomotion among individuals who have been residents for more than 100 days. The loss of independence and locomotion itself is an undesirable outcome. In addition, it increases the risk of hospitalization, pressure ulcers, circulatory problems, pneumonia, and overall reduced quality of life. Residents who have declined in independence and locomotion require more staff time than those that are more independent.

This quality measure is fairly new as of April 2016. It began impacting the Five Star rating system for nursing homes effective July 2016—50% weighted. In January it became 100% weighted.

The MDS measure reports the percentage of long-stay residents who need help with late loss of activities of daily living. This increases when compared to prior assessment. The four items are self-performance in bed mobility, self-performance transfer, self-performance eating and self-performance toileting. This measures what the resident actually did, not what the resident might be capable of doing within each ADL category during the seven-day outlook back according to a performance based scale. The resident's abilities should not diminish unless the clinical condition demonstrates that it was unavoidable.

Another tracking tool is the Advancing Excellence in mobility tracking tool. This is a workbook used to track mobility. (e.g., changing mobility, the timeliness of assessment, use of alarms and restraints, and the frequency and severity of falling). Your data will produce a chart to help you identify patterns and track processes. You can enter the outcome measures using this tool in each month to view the trends of the progress over time. The first step is to complete a monthly mobility assessment on each resident you are tracking using the mobility assessment form discussed a few slides back.

Some examples of strategies for encouraging nursing home resident mobility include walking programs to maintain and improve resident mobility. Many implemented this and resulted in numerous positive outcomes. These programs build muscle tone and strength and improve circulation and increase balance. Residents also experienced increased self-esteem and socialization as a result of participation. To improve the success of the program, be sure to educate staff on the benefits of walking and include the nurses aides within the interdisciplinary conference to develop effective individualized approaches. It may be helpful to have a start and stop point for the emulation route, changing the distance walked according to the individual needs. Facilities have found success in providing rewards for resident accomplishments such as offering a favorite food or presenting a certificate of recognition. Falls prevention is one of the best ways to reduce the severity of falls and by enhancing resident mobility.
Writing exercise programs promoting strengthening and balance and endurance could include weights, yoga, and a walking program. You can look for ways to add movement outside of scheduled exercise sessions during activities such as:

- A group stretch prior to playing bingo.
- Providing activities, environmental design, providing residents with walking and wheeling that is free of water and ensure that they are well lit and inviting.
- Ensure that appropriate footwear is available for the residents.
- Grab bars and support devices should be in place and well-maintained ensuring that it is of the appropriate height.
- Wheelchair seating and mobility from voting physical activity for residents using wheelchairs.
- Minimizing the use of wheelchairs in order to encourage undulation and decrease loss of leg strength.
- Pain management—assessing for and treating pain or other underlying conditions that could potentially limit mobility.
- Sleep—A well-rested resident is more apt to participate in physical activities. To promote adequate sleep, create a restful environment that limits nighttime noise and light and other disruptions.
- Last but not least, alarm and restraint reductions.

Now is a good time to turn this over to Florence to talk about reducing the use of alarms.

I would like to start by asking a question. How many people right now online has a facility using alarms? Enter yes or no.

Emily and Jennifer, open the poll.  >> Yes, please enter yes or no and let me know the response.

Okay. I'm not defining an alarm. Whatever alarm you use. Please respond appropriately. I do not have the polling results yet. Please continue.

We will move on. I’m here to talk about personal alarms. A personal alarm is a device that emits a warning signal when a person moves. These alarms can be pressure sensitive. If the person is laying down or sitting in a chair, any body movement will activate the alarm.

There is a seatbelt alarm. This is usually used for people who do not have [INDISCERNIBLE] support. A lot of facilities use these thinking it is to support the person's trunk. There's also an attachment used in the back of a wheelchair. It attaches to a piece of clothing so if they move or make a movement at all, it will set off an alarm. In the last slide Sarah talked about sleep and having the resident well rested.

Imagine having the alarm going off all the time. How much sleep can you get with this noise in the building? We already have loud noises from staff and regular activity on the unit. Now we are adding personal alarms.

Florence, in the polling results we had 23 people respond yes, and the rest we did not get responses from. That is a good place to start. Hopefully, the ones that didn't respond didn't have time to put in an answer.
As you look at the MDS, the definition of a restraint is any physical restraint that is manual, physical, mechanical/material, or equipment attached to the resident keeping them from moving freely or being able to access any part of their body.

I told you about using the seatbelt alarm to control the trunk. If I am a resident that likes to bend over and touch my feet and you put me in a seatbelt restraint, that is a restraint. I like to access my feet.

Don't kid yourself by saying we are supporting the trunk. If you keep the resident from doing something they wanted to do with something on their body that is considered a restraint. However, a resident with a seatbelt alarm that can undo it on demand it is not considered a restraint.

Based on the definition a seatbelt alarm would be considered a restraint. As a matter of fact, any alarms that I've listed would be considered a restraint because it keeps the person from being able to move or access parts of their body.

FTag 221 tells us the resident has the right to be free from any restraints imposed for the purpose of discipline or convenience that is not required to treat the medical condition of the resident. Think about that. We have residents living with dementia and we give them psychotics because they have behavior we can't control. Based on that, that would be considered a restraint. As you go through your day, think about the different forms of non-physical restraints we put on the residents.

How do residents respond to alarms? As you go through life, you are taught that if an alarm goes off, you are immediately supposed to run away from the alarm because there is a fire alarm. If you have a vehicle with an alarm built in and the alarm goes off, your immediate response is to move toward the vehicle. We are groomed to believe that with an alarm our immediate response is to move. Yet, we have the residents in facilities with alarms on them, and we tell them “don't get up, sit back down.” If you are baking cookies and the alarm goes off, the response is to go to the oven and get the cookies. We are trying to undo the warnings.

Residents respond to alarms, and they want to get away from the noise. They learn the behavior of not to move every time they get up. Now they come non-weightbearing and non-mobile because every time the alarm goes off, it makes a noise and they are told to sit down. Now we make them immobile, and this opens them up for possible pressure ulcers.

Most of the time an alarm lets you know that something is happening. Most of the time in the facility at the time we hear the alarm, the resident is going down or has been down. For example, I was in a building three years ago doing a chart audit. I was on the unit by myself with three to four residents in a wheelchair with alarms. One resident kept getting up and the alarm would go off and she would look around to see if someone was coming. No one came and she would sit back down. The third time she did this, she finally got up and went into her room and was there two to three minutes. She came back out and sat back down and the alarm was quiet.
Staff becomes muted to the alarms. What is the purpose of having the alarm on the resident? Going through the day, how many times do you get up and walk around? How many times do you adjust yourself in your seat? Could you imagine that if every time you did that an alarm went off?

On a resident and I don’t have an alarm but Mike the roommate has an alarm or the person next to me in the dining room has an alarm, I will also be triggered by the noise. How often do residents disable the alarms? We don’t think about why they are doing it nor our response. How often does a resident protest about having an alarm put on either physically or verbally? We seem to ignore the resident’s refusal to have the alarm put on because we know better. We are used to the noise and we forget it is going on.

Think about why you are using the alarms that you use on your residents.

Our culture changed three years ago. We had a meeting to talk about alarm reduction. I asked facilities using alarms to bring us some alarms. We had 150 people in the room. We put them in different areas of the room. They didn’t know the alarms were under their seats. We also held some in our hands. Every once in a while you would hear an alarm go off as people adjusted themselves, and occasionally we would manually hit the button so the alarm would go off. This was a half-day session, and within an hour or two, people asked to stop the alarms. They didn’t realize how annoying and intrusive the noise of an alarm could be. As staff we walk through and go in and out and the residents live with this 24 hours a day, seven days a week.

Here are some justifications that we use as professionals to use alarms:

- To tell us when the person is moving or about to fall. When was the last time you got a resident in the middle of a fall because the alarm went off? We also say that helps prevent falls. I’ve never seen an alarm that prevented a fall. It tells us when the resident is just about to hit the floor.
- We have no other means to keep our residents safe.
- We must do better. We must find other ways to keep the residents safe. In some ways we are contributing to falls. We have these alarms go off. Here is another story about a resident. I was in another building and without fail after every meal the gentleman would say, “Nurse, I need to go to the bathroom.” The nurse says just a few minutes. They would say just a few minutes. He realized if he took off his seatbelt, the alarm would come off. The alarm would go off and everyone would come running. After a few minutes he would take up the seatbelt, and all of a sudden three people helped him to the bathroom. It was reverse conditioning. He conditioned staff to say I will give you three chances; but on the third chance, I’m going to the bathroom whether you like it or not. He gets the attention he needs—three people every time he took the seatbelt off.

How do you go about reducing alarm use in your building? It’s important to have buy-in from your family members. It’s important to let the family members know your goal. Families are concerned about their family members, and they only want the best for them. It’s up to you to be upright and give them the history behind why you are doing it, the legal reasons why you are doing it, and the fact that it improves quality of life for the family member.

They should be given a defined plan, a timeline, and an opportunity to ask questions and verbalize concerns. The last part about asking and verbalizing concern should not be a one and done, it should be continuous. Families should have an open door to whoever is in charge, the doctors, and the champion on alarm reduction.
You need to have buy-in from the staff. It's important for your staff to buy-in before you get to the families. If the staff doesn't do this, they will derail whatever you're doing. They will go to the families and bond with them and get them to say, “Look at what they are trying to do.” They are putting your family member at risk. Get your staff to understand what you are doing and get the buy-in. That's about 50% of the struggle right there.

If the staff doesn't buy in and they don't understand the importance of their role, you will not succeed. They will think it's a fad. They think if they give it time it will go away. To be prepared for pushback, your staff will tell you this is what we've always done. You are putting the residents at risk. You have the data and education and rules for participation behind you to let the staff know why you are doing this.

To start, please do not go through your whole building and start taking off everyone's alarm. Start small. Start with one unit, maybe one or two residents. Then, do your PDSA cycles and keep everyone up to date. Try using a storyboard especially for the families. Use your data. Show the units how successful your attempts are, and when you have a hiccups, own that. Don't be afraid to share it with your staff.

Once you are able to successfully reduce alarms on one unit, then you can start to move on to other units. Please, always celebrate any success you have. Any quality improvement you try to do, celebrate and recognize the work done. Once you started the journey, you need to have a commitment with all your staff—a commitment that you will no longer go back to using alarms. Start by saying from this date forward we will not apply alarms on any new residents. It's important to let people know ahead of time when they are visiting your facility that you are alarm free or going alarm free so that they are an educated consumer making the right decision for themselves.

Alarms should not be an option for any resident who currently doesn't have one. Now you are committed to alarm reduction and you won't apply it to any new resident coming in. Any residents with no alarms will not have one placed on them.

If a resident has a history of consistently removing the alarm, that is your low hanging fruit. Maybe this person doesn't really need it. Look at having PT and OT work with them to get them more stable and weight-bearing. If the alarm scares or agitates the resident, please take it out. If the resident suffers with the alarm on, do not replace it. It defeats the purpose of your goal.

Include marketing in your work to reduce alarms. Have them include in all your marketing tools that you are an alarm-free building. Make sure that the families know ahead of time that you are not using alarms. If a resident is on an alarm reduction program, set a time limit. If a resident has not had a fall in three months, remove the alarm and keep it off.

As a team, look at setting a goal for when you want all the alarms reduced in the building. You must have boundaries on your goals. If you just leave it open and you don't have set milestones, you could go one to two years and still have alarms in your buildings.

Once you take off the alarms, get rid of them. Staff will find them and revert back to what they are comfortable with. If I can't find it, I can't place it on someone.
I have a friend that tells me this all the time. I would like to share this. Don't talk about it, be about it. Don't talk about going alarm-free or why to do this. Make a decision today that you are going to be alarm-free. I would like to offer the Connecticut team of the New England QIN-QIO a fall conference September 21 in Connecticut. We will have more information coming up. We hope you can join us. >>

Thank you, Florence. With all the information you have gathered during today's presentation, what are the next steps? First, access your quality measure reports. They will be sent out via email for Q1 for the team in the next couple of weeks. If you aren't on the distribution list, please contact your QIN-QIO nursing home state lead.

Focus on the ADL measure and complete a root cause analysis to identify why a resident's need increased in order to identify intervention.

In order to evaluate the processes and guidance, join us for Part 2 of this webinar series Thursday, August 31. Two high-performing nursing homes in New England will present on they implemented strategies to improve ability and reduce false.

In addition the package was developed and updated over time to help nursing homes participating in the collaborative to select priority focused areas and implement tests of change. In the package is a menu of potential improvement including strategies and specific actionable items that any nursing home can choose to begin. This highlights purposes of improving quality care and focuses on successful practices of high-performing nursing homes with specific replicable actions.

Utilizing the nursing home Change Package from the mobility bundle into your nursing home includes six strategies. Define mobility for each unique individual, find a place or space to move, provide supportive equipment, train staff and residents, support and encourage, and address physical and psychological needs that inhibit mobility.

Each strategy in the bundle includes specific actions that your team can take to implement change. Joshua will share a link in the chat to access this change package.

Just checking in with Joshua to see if there are any questions in the chat. Again, to ask a question and unmute your line, press #6.

We had some participants mentioned using a team approach and revamping the restorative program. Jennifer Lane, specifically, if you would like to elaborate we would love to hear you.

Thank you. If you can't join over the line to ask a question, feel free to ask your question in the chat. Has anyone joined on the line yet?

If we don't have any questions, we will move forward. Again, we will host the second part of this webinar series. If you have questions, bring them up during Part 2; or, if you have any questions that weren't answered or you were unable to ask them, reach out to your state lead.
Links to the resources shared today are listed here. You can access a copy of these slides from the reminder email that went out this morning or find it on the website, Healthcare for New England.org under the events section.

Don't forget to mark your calendars with our upcoming collaborative events and educational opportunities. Part 2 takes place 8/31. On 9/14 we will host a webinar with the Veterans’ Home in Maine. On 9/26 in Massachusetts the New England QIN-QIO is hosting an all-day pain management seminar. These are just a few of our many upcoming educational opportunities. Check out the website for more information or to register.

This is Morgan. We forgot to put the event you are mentioned on a slide. I didn't catch it. Sorry. That's okay. I quickly moved on. We have another event coming up. Florence mentioned this earlier. We will present on preventing falls. This will happen in Connecticut on 9/21. We are running a contest to win complementary entries to this conference. Each winner will receive two entries. We will announce the winners on 8/31. To enter, find the New England QIN-QIO on Facebook between 8/10 and 8/30. If you already follow us, share our post about the contest. It was posted today on Facebook. This will earn you an entry. Here is the link to the Facebook page.

Following today's webinar you will be directed to a survey to provide feedback. Your input helps us to improve the educational sessions and provide you meaningful programs in the future. Also, within the next few business days, we will send out an email to everyone containing a link to today's presentation and the recording of the webinar. Thank you all for your attendance. Have a great day.

Thank you, Sarah and Florence.

[Event concluded].