Training Guide
&
Optional Exercises

Centers for Medicare & Medicaid Services (CMS)

Nursing Home Improvement

Satellite Broadcast & Web Cast

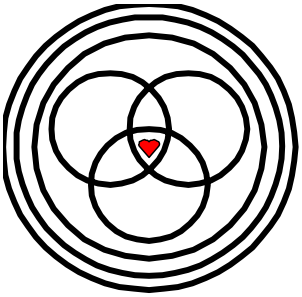
Four-Part Series:

From Institutional to Individualized Care

Part One:
Integrating Individualized Care and Quality Improvement

Friday, November 3, 2006

1:00 PM – 3:30 PM ET



Exercise for Section 2: History
Relationship Building: Paired Conversations

Description: This exercise allows people to explore a topic together in paired conversation. People share more easily one-on-one than in larger groups. Paired conversations strengthen relationships by allowing people to get to know each other personally. Knowing each other better provides a foundation for the difficult conversations that come up when we are making deep changes. This set of questions is designed for people to explore how nursing home care has evolved over time.

Logistical Instructions: Pair individuals together for a series of conversations with different partners. Tell participants you will give them a topic and time limit to discuss it with each other. Allow 3 - 5 minutes per topic. Here are some options, depending on the size of the and room capacity.

- **Table Pairing:** Have people pair with someone at their table or sitting near them. For each topic, have them pair with someone new in their group.
- **Line Dance:** Form two lines with people facing each other. One line remains stationary and the other line moves after each question. The last person in the moving line moves to the other end of the line. All other people move down one position. This allows each person a new partner for each question.

Discussion topics:

1. Talk about your first time ever in a nursing home. What were the circumstances and what was it like? What do you remember?
2. Discuss the changes you've seen in nursing homes over time.
3. Why do you do the work you do? What brought you into this work and what keeps you in it?
4. To paraphrase Maya Angelou *"We did the best we could with what we knew and when we knew better, we did it better."* What does this quote mean to you in relation to long-term care?

Discussion: We keep learning better ways to provide care, and as we know better, we do better. We are in a time now, that offers tremendous opportunities to advance excellence in nursing home care. Just as we look back in disbelief on what were the best practices of their time, so too, in the future we will look back in disbelief at many of today's practices that we are now challenging.

Exercise for Section 4: The Importance of Home
What is Home?

Description: Our own experience of home helps us to understand how important it is for us to assist residents in making themselves truly at home in the nursing home in which they live. This exercise draws from the work of Judith Carboni whose research on home and homelessness found that nursing home residents currently experience a great sense of displacement and homelessness in today's nursing homes. She found that this contributes to a "psychic despair" that undermines physical, mental, and psychosocial well-being. She believed that this despair can be reversed by restoring a sense of home. This exercise is designed to give participants an awareness of home as the relationship of person to place.

Logistical Instructions: In small groups, have people discuss what their own home means to them. After they have had sufficient time for a meaningful discussion in their small groups, draw from all the groups what came up in their discussions. Their answers will likely parallel the seven elements of home that Carboni found in her literature review. Share the elements of home and homelessness:

Elements of Home	Elements of Homelessness
♦ Identity	♦ Non-personhood
♦ Connectedness	♦ Disconnectedness
♦ Lived Space	♦ Meaningless Space
♦ Privacy	♦ Without Boundaries
♦ Power and Autonomy	♦ Powerless and Dependent
♦ Safety and Predictability	♦ Insecurity and Uncertainty
♦ Journeying	♦ Placelessness

Show the continuum that Carboni described from Homelessness, as a severely damaged and tenuous relationship between person and place to Home, as a strong, intimate, fluid relationship of person to place. Draw a parallel to the continuum from institutional to individualized care.

Discussion: Feeling "at home" is about ***how*** we live. Feeling "at home" is essential to our well-being.

Exercise for Section 5: Individualizing Care and Routines
Morning Routine

Description: We all have routines for how we start our day. We've developed these routines over our life-times and as we get older, these routines are a core part of feeling "at home." In this exercise, participants think about the importance of their own morning routines and how they are affected when something interferes with their routines. Not having our morning can throw off our whole day. The exercise explores the importance of morning routine for residents and what can be done to shift from institutional to individualized morning routines.

Logistical Instructions: Have each person write down their own morning routine — from the time they wake up to the time they leave home for work. Ask a few people to share their morning routines.

- What it is like when they are not able to have their normal morning routine, and how it affects their day?
- How they would be affected if they had their morning routine disrupted day after day?
- Could they have their morning routine in a nursing home?

In small groups, discuss the typical morning routine now in nursing homes:

- Are people able to maintain their routines?
- What is the impact of the facility's rushed institutional routine on residents and staff?

Explore what it would take to go from institutional to individualized routines:

- What can be done so people can start their day according to their own personal rhythms?
- How can staff know a resident's routine to be able to honor it the first day?
- How would this shift affect each department?

Discussion: We all depend on our routines for grounding. Moving from institutional to individual routines affects every department because the whole building is geared toward the institutional routine. Typically, residents who are able to express their needs may have a reprieve from the institutional routines. The key is to change the norm to one in which everyone's own routines are honored as a matter of course. We will see positive outcomes throughout the day when residents can start their day right.

Exercise for Section 6:
Integrating Individualized Care and Quality Improvement
A Case Study: Mr. McNally

Description: Moving from institutional to individualized care is key to "attaining and maintaining the highest practicable physical, mental, and psycho-social well-being of each resident." This exercise shows how institutionalized care inadvertently accelerates an individual's decline. It underscores how the entire caregiving system within a nursing home is organized in an institutionalized way and how changes in all aspects of care and services are needed to shift to individualized routines. Even further, it examines how interventions meant to prevent risk can actually cause harm and illustrates the value of health promotion over risk prevention. Through a case study, participants piece together information about a resident who has declined during a short stay at the nursing home because the nursing home tried to get him to fit into their routines instead of helping him maintain his own routines. Problems arise one after another, and each intervention makes the problem worse and creates new problems, compounding his decline.

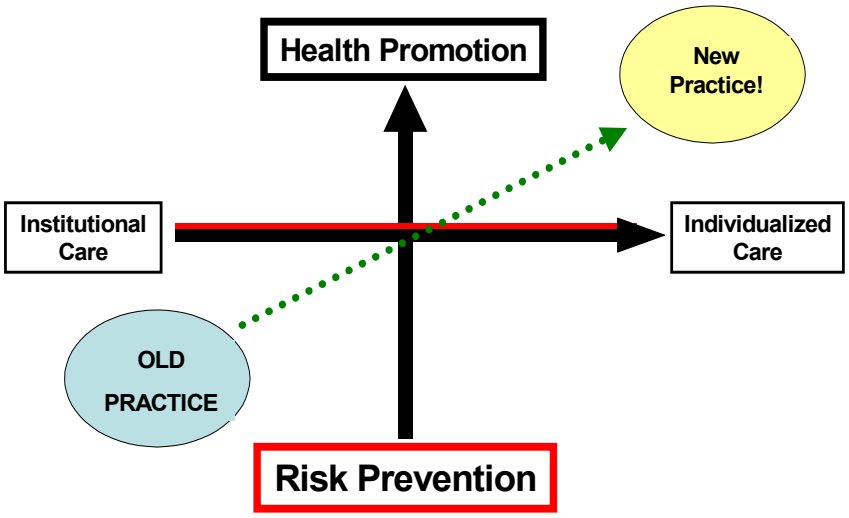
Logistical Instructions: Divide participants into groups of six to eight people. Give each group a set of cards that contain fragments of information about Mr. McNally, who lives at the nursing home. A master copy of the cards is located on pages 8 thru 14. Deal the cards out to everyone in the group. Some of the information is clinical and some is personal. All the information is necessary to determine what caused his decline and what could be done differently to achieve a better outcome.

After all the clues are dealt, ask that in each group, all members share their information with each other to find out what happened to Mr. McNally. Encourage them to lay their cards out on the table and work together to group the information in order to answer the following questions:

1. What was Mr. McNally like when he first came in?
2. What caused Mr. McNally to decline?

Allow about 10 minutes for small group discussion. Then discuss as a large group what caused Mr. McNally's decline. The group will identify how Mr. McNally's decline was caused by imposing the institutional routine on him instead of helping him maintain his own routines and how each intervention compounded the problems.

Show the Pathway to Transformation slide:



Ask small groups to discuss which interventions for Mr. McNally belong in the lower left quadrant — institutional care to prevent risk. Examples include suppositories, sleeping pills, incontinence briefs, and alarms. Ask the groups, for each of these interventions, what could they do instead that would be an individualized approach that promotes health. An example is maintaining his own bowel function by helping him maintain his regular routines. While suppositories help alleviate constipation, their long-term use destroys the body's ability to maintain bowel function. Maintaining his personal routines promotes his health through individualized care and leads to a better long-term outcome.

Discussion: "Iatrogenesis" is a clinical term that describes a problem caused by the treatment. Our institutional measures to prevent risk can cause risk. Suppositories can disable bowel function. Alarms can inhibit movement and compromise skin. Organizing care around an individual's routines, instead of the facility's routines, can reverse this harm and help individuals thrive. OBRA requires homes to provide care and services to attain or maintain the highest practicable well-being of each resident. Practicable means capable regardless of circumstances. If Mr. McNally is capable of moving his bowels when given enough time, then we should not shift to suppositories which will eventually diminish his function.

Exercise to Accompany Mr. McNally Case Study
Alarming News About Alarms: A Personal Experience

Description: Chair and bed alarms were initially introduced to assist in restraint reduction as a tool to map individual patterns. They have come to be used on a long-term basis as a tool to prevent falls. However, they give a false sense of security because they rarely prevent a fall. Quite the opposite. They can contribute to falls and to more serious injuries from falls. They cause agitation for the residents who are attached to alarms and for those around them when the alarms go off. Residents try so hard to keep the alarms from going off that they sit as still and stiff as possible. In this exercise, participants are attached to an alarm for a short time, giving them a direct understanding of how constricting and isolating alarms are.

Logistical Instructions: Ask one person in each small group to wear an alarm and another in the group to re-attach the alarm when it sounds. Have the alarms on during the McNally Case Study small group activity and larger group discussion.

Limit the use of alarms to 30 minutes or less. Release people from the alarms. Ask those who wore the alarms to talk about what it was like. Ask what they felt physically. Many will describe discomfort and stiffness because of trying to hold themselves still so that they do not set off the alarm. Ask about their psychosocial experience and many will describe feeling isolated, anxious and embarrassed. Ask what it would be like to try to sleep with an alarm on and how an alarm would have affected Mr. McNally.

Discussion: Alarm use has steadily increased in the belief that they keep residents "safe" from falls. However alarmed residents still fall. Worse, alarm use can contribute to pressure ulcers, immobility, social isolation, and dehumanization. Alarms were introduced as a short-term measure for staff to come to know residents' individual patterns. Instead of short-term use, alarms are frequently used all day and all night. Staff often respond to the alarms rather than to individual needs. A common example is that when someone starts to stand up, instead of finding out what they are standing up for, staff's typical response is to encourage them to sit back down. The noise induces agitation in other residents who often call out to a resident whose alarm is sounding to sit down. Alarms makes it nearly impossible for a resident, or her roommate, to get a good night's sleep. By getting to know residents and supporting their needs, homes can eliminate alarm use.

drove a hook and ladder for the fire department

wife died a while ago

is a night owl

wife was Shirley

used to love the smell of bacon cooking

admitted thru short term

has a picture of roses in a garden in his shadow box

Catholic

constipated
is taking meds for anxiety and agitation
incident report on him for hitting the night aide
has a UTI
widower for 12 years
needs incontinence checks at night
can toilet himself
is easily agitated

has lived alone a long time and developed his own ways about him
incident occurred during bathing, while in Hoyer lift
hates incontinence briefs
used to keep a bird feeder
sleeping pills PRN
sometimes has a few choice words in the morning
fell his second night here
came to B two months ago

male aide on the night shift usually has him for assignment

has Red Sox sticker in his shadow box

worked the evening shift at the fire department

incident occurred while giving him a suppository

recovering from a broken hip

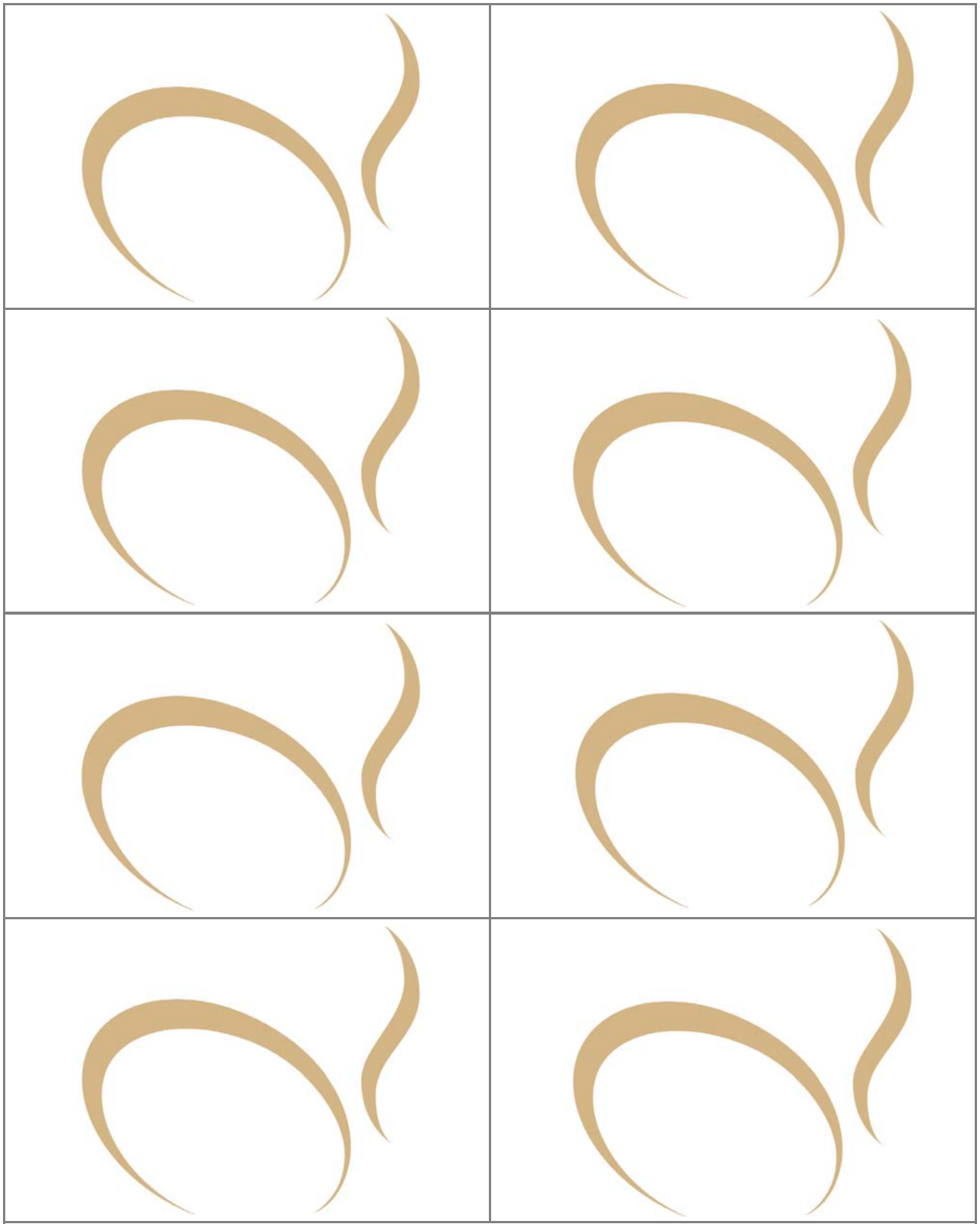
ambulate 2X daily

his daughter usually visits on the weekends

bed alarms

he's lost five pounds
used to love to make breakfast
recommend an increase in his meds for agitation
he talks back at the overhead pager
incident occurred during morning care
sometimes the night maintenance guy talks with him while he's doing the floors
this is the third incident
his grandkid brought him a potted plant and it's doing pretty well

 hums when he gardens	
 was very sweet when he first came in	



Case Study

Nursing Home Alarm Elimination Program: It's Possible to Reduce Falls by Eliminating Resident Alarms

I. Case Study Objective

This case study summarizes the elimination of resident pressure alarms and the relationship to fall prevention. The intervention occurred within a Massachusetts nursing home's 45-bed unit.

II. Facility Overview

Jewish Rehabilitation Center for the North Shore (Jewish Rehab) is a Massachusetts-based 180 bed, Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredited, freestanding, not-for-profit facility providing sub-acute, long-term, and dementia care. For years, it has been an active participant in Masspro's quality improvement initiatives, and is currently part of the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services, 8th Scope of Work Nursing Home Identified Participant Group (IPG).

Jewish Rehab's leadership team is experienced, and the results of their resident and staff satisfaction surveys, and certified nursing assistant (CNA) turnover rate rank them in the top tier of their IPG peers. The average score of their Resident Satisfaction Survey was 2% higher than the average score of all the participating IPG's. In particular, the residents felt that the staff cared about them, made them feel safe, and allowed them to participate in decision making. The average score of their Staff Satisfaction Survey was 10% higher than the average score of all participating IPG's. In particular, staff felt that there was good communication, they understood the goals of the facility, and felt pride being a member of the team. Not surprisingly, their CNA turnover rate was less than approximately 58% of the other participating IPG's turnover rate.

Their Falls Committee consists of an interdisciplinary team of department heads, staff nurses, and CNAs, that meets every one-to-two weeks to review falls and evaluate intervention successes. In addition to the weekly Falls Committee meeting, a separate Falls Review Committee meets every morning for 15 minutes to discuss falls that have occurred in the prior 24-hour period, and identifies the root causes and the appropriateness of any related intervention(s). This Committee is composed of department heads and nursing management.

Of note: The unit on which this case study is based has CNAs and nursing team leaders with consistent assignments.

III. Problem Statement

The Assistant Director of Nursing (ADON) who was the chairperson of the Falls Committee was concerned that resident falls remained high, despite the work of two committees and multiple individualized interventions.

IV. Steps to Problem Identification

Although the facility held a facility-wide "Falls Fair" to educate staff about the common causes of resident falls and appropriate interventions, and demonstrate the facility's pressure alarms, the fall rates for three subsequent months remained high.

Consequently, the ADON presented to the Falls Committee, the idea of eliminating resident pressure alarms to actually prevent falls. Her rationale focused on one 45-bed unit where over half of the residents had either a bed or chair pressure alarm or both, yet the number of falls continued to be high. She observed the following:

- Alarms were reactive rather than proactive because they only indicated to staff that the resident had moved or had already fallen.
- The noise produced by the alarms agitated residents so much that residents fitted with alarms did not move at all to avoid activating the alarm. This put them at risk for ADL decline.
- Residents not fitted with alarms were often heard calling to staff to turn off the alarms and telling residents fitted with alarms to remain still.
- Residents with dementia experienced increased agitation.
- CNAs were often distracted from other important duties, including ADL care and communication with residents.

V. The Pilot Test

Alarms were removed from several residents who had not had any falls for a significant period of time because the causative factor for their previous falls had resolved (e.g., urinary tract infection). Surprisingly, the residents remained fall free upon removal of the alarms.

Drawing from this success, the ADON and the Falls Committee selected additional residents for alarm removal. The criteria for resident selection remained the same as for the previous group of residents: the root cause of previous falls had been determined to be episodic and the acute condition had resolved. Again, the effort was successful.

MASSPRO 245 Winter Street Waltham, MA 02451
TEL 781.890.0011 FAX 781.487.0083 www.masspro.org

VI. Implementation Plan

Based upon the success of the two prior interventions, the team developed a plan to progressively eliminate all 25 alarms on the unit over a four-week period. Prior to implementation, all staff received education on the falls prevention strategies to be used once the alarms were removed. The Falls Committee made it clear that the success of the intervention depended on the involvement of staff throughout the facility.

Alarm removal began on the unit where residents tended to have mild-to-moderate dementia and poor safety insight, but, were still relatively mobile. The choice of this unit was based on the fact that it had an excellent chance to be successful due to its consistent staff and consistent assignments. Additionally, a success on this type of unit would support the ADON's position that alarm elimination was an appropriate goal, as this unit had a high fall rate.

CNAs were very receptive to the program. Licensed nurses were initially a bit hesitant. The basis for this hesitancy was because they understood their responsibility as licensed staff to maintain resident safety and felt that the alarms assisted them in accomplishing this. However, they recognized the success of the pilot and came to support the plan, actively participating in its implementation by talking to families about the program and the resident specific intervention that would be utilized in place of the alarms.

A central part of the intervention was that nursing staff would need to anticipate the needs of the residents, rather than respond to an alarm. In other words, they would need to change their mindset from being reactive to being proactive. Due to the facility's workflow style of consistent staff assignments, the CNAs and licensed nurses knew the residents well and were able to develop individualized care plans to anticipate needs. Alarm assessments had typically been completed on a quarterly basis and were used to document the continued appropriateness of alarm use. Now it became a tool to document the resident's participation in the alarm elimination program.

VII. Program Design

A hall monitoring system, comprised of an interdisciplinary team including department heads, therapists, and the administrator, was initiated. Hall monitors were educated about patient safety, falls, and resident specific safety risks. Three times per week, each hall monitor took a 15-minue block, during which they would be in the unit monitoring for resident safety and taking direct action when necessary.

This monitoring program was in place from 7:45am –3:15pm, five days per week. Monitors shared their observations and actions at daily review meetings designed for plan modification. In addition, on the 6:45am – 2:45pm shift, a non-clinical unit aid monitored the unit for resident safety. The monitoring program remained in effect for two months. Alarm use was reduced during the first month, with the second month serving as an extra period of resident supervision while the system was evaluated and modified as needed.

The 2:45pm – 10:45pm shift developed its own monitoring program using a resource aide whose function was to focus on agitated residents and those who were at high risk for falls. The 10:45pm – 6:45am shift developed its own plan as well, increasing level of surveillance, adjusting book times, and increasing rounds.

Staff used activities to help reduce falls. The rationale was to decrease the amount of resident agitation experienced by providing additional activities, and thus decreasing the risk of falls.

On weekends, the nursing staff implemented a hall-monitoring program, including increased visibility of the weekend supervisor on the target unit, and heightened awareness by the housekeeping staff to be hyper-vigilant about resident safety. Since the same CNA staff worked both on the weekend and during the week, they had a good understanding of the safety needs of the residents. The weekend plan worked well, with falls that had already been low remaining low.

VIII. Program Implementation

During Week One, the 6:45am – 2:45pm shift disengaged the resident alarms on the target unit. These interventions were implemented as part of their reorganized thinking of proactive approaches. At 2:45pm (the end of shift), staff turned the alarms on again.

During Week Two, the alarms were turned off at 7:00am and remained off until the end of the 2:45pm – 10:45pm shift.

During Week Three, the alarms were turned off at 7:00am, and remained off for all three shifts.

During Week Four, the alarms remained off during all three shifts and residents continued to be monitored for safety.

The Falls Committee evaluated the plan both daily and weekly during the first and second months of implementation, making modifications as needed.

IX. The Results

Impact on quality of life was evidenced by less agitation of residents due to decreased noise of alarms. Staff also experienced less anxiety and a better workplace environment within the unit.

As a result of the implementation of this program, the proactive approaches outlined above were identified as successful fall preventive strategies.

Using real-time information provided by falls incident reports the ADON tracked and trended data on a monthly, quarterly, and annual basis. During the final quarter of 2005, that encompassed the months of alarm reduction and increased resident monitoring on the target unit, there was a 32% reduction in the quarterly average of falls for this unit, when compared to the average number of falls for the first three quarters of 2005.

Incidentally, this unit also experienced a reduction in the number of pressure ulcers identified for the final quarter 2005, as compared with the first three quarters of 2005. This could be the result of residents' toileting in advance of need, and more frequent ambulation and positioning, which were a part of residents' individualized fall prevention plans.

In addition, there was a 21% decrease in the CMS "Prevalence of Falls" quality measure when comparing July 2005 – December 2005 to October 2005 through March 2006. Both six-month periods shared the two-month intervention interval and subsequent evaluation. Additionally, the Director of Nursing has reported that the increase in activities on the unit has had an impact on the "depression" quality measure.

X. Moving Forward

In late 2005, the ADON assumed the role of Director of Nursing, after having been with the facility for nine years. She is continuing to lead the facility in its progressive implementation of the alarm elimination program on each of the facility's three other units. The basic implementation plan has remained the same with some modification to accommodate for the varying resident population and characteristics that exist on each of the three units, including:

- Sub-acute
- Long-term care
- End-stage dementia

As the facility has continued its work, it has identified the need to change the starting time of Falls Committee meetings in order to allow for greater and more consistent participation by CNAs, who are recognized as a valuable and integral part of the process.

XI. In Summary

As the alarm elimination program continues to be implemented throughout the facility, the Director of Nursing will utilize quality measure reports to correlate alarm elimination with changes in quality measures other than just the prevalence of falls, including:

- Depression
- Behaviors
- Incontinence
- Pain
- ADL decline
- Little or no activity
- Pressure ulcers

Preliminary anecdotal data suggests that a relationship does exist. However, with the increase of MDS data available over time, the Director of Nursing hopes to be able to make a direct correlation between the intervention and positive outcomes.

This material was prepared by Masspro, the Medicare Quality Improvement Organization for Massachusetts, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily represent CMS policy. 8sow-ma-nhqi-06-31 casestudy-aug

QUALITY PARTNERS™ OF RHODE ISLAND

235 Promenade Street ◆ Suite 500, Box 18 ◆ Providence, RI 02908
Phone: (401) 528-3200 ◆ Fax: (401) 528-3210 ◆ www.qualitypartnersri.org

CONTACT INFORMATION

Marguerite McLaughlin
Manager of Educational Development
(401) 528-3259
mmclaughlin@riqio.sdps.org

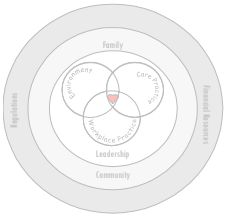
B & F consulting

(401) 245-0965

CONTACT INFORMATION

Cathie Brady
cbrady01@snet.net

Barbara Frank
bfrank1020@aol.com



The enclosed material was prepared and assembled by Quality Partners of Rhode Island and B&F Consulting under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 8SOW-RI-NHQIOSC-102306-2