

ACE Best Practices

*Improving person-centered care and
integrating Quality Assurance/Performance
Improvement (QAPI) into day-to-day operations
in North Carolina nursing homes*



ACE Best Practices

Nursing homes across North Carolina celebrated their accomplishments at the conclusion of a two-year collaborative to improve person-centered care and integrate Quality Assurance/Performance Improvement (QAPI) into day-to-day operations. **The Action Collaborative for Excellence in Long-term Care (ACE) is sponsored by The Carolinas Center for Medical Excellence (CCME) and the North Carolina Long-term Care Ombudsman Program in collaboration with the Advancing Excellence Local Area Network for Excellence (LANE).**

ACE Best Practices is a celebration of the hard work and dedication of staff working in 161 ACE nursing homes. Shared by leadership teams at the last learning session in April 2014, this booklet includes tips for success, interventions, and methods for overcoming barriers in seven key areas. We hope that the staff, residents, and families at your facility will benefit from the experience and advice summarized in the ACE Best Practices.

Our deep gratitude goes to Barbara Frank and Cathie Brady for their expertise and contribution to the ACE series and to all of the facilities that have worked so hard to improve the quality of life and quality of care for North Carolina nursing home residents.

CCME Nursing Home Team

Jo Taylor, MPH, RN

Maria Fisher, MSW

Pat Tilder, BSN, RN

Joanie Howard, RHIT

Kellie Lewis, OTR/L

Sarah Stein, MPH

Anna Cook

Karen Southard, MHA, RN



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Leadership Presence

As a leader in your nursing home, your presence, responsiveness, and ability to create a positive work environment directly influence the care your facility provides and your organization's overall performance. Leadership is a skill that can be learned. Without effective leadership, transformational change is impossible. Helping your staff to develop critical thinking skills and qualities found in effective leadership is the key to sustained quality improvement.



ACE Tips for Success

1. Take the time to plan and prepare both administrative and direct care staff for changes in policies and procedures.
2. Communicate, communicate, communicate.
3. Keep communication lines with direct-care staff open.
4. Develop formal communication processes that transfer information up to administrative staff and down to direct care staff. For example, use huddles and stand-up meetings that include both management and frontline staff.
5. Hold staff accountable for the care they provide.
6. Do not micromanage. Ensure that staff know that the department heads are there to help.
7. Be proactive in order to resolve problems before they start.
8. Giving staff open accessibility to management creates a team atmosphere and improves communication flow.
9. Get out of the office and round to check in on staff and to provide help.

10. Model the behavior you want to see.
11. Empower Certified Nursing Assistants (CNAs) through education.
12. Listen, value, and respond to frontline workers' feedback.
13. Provide opportunities for staff to assume new responsibilities. It works!
14. Work to ensure that staff is tuned in to the residents' quality of life as well as their medical well-being.

Interventions

- Management staff take turns making rounds to hear staff concerns. They create reports and get them to the right department or person. A report also goes to the Quality Assurance (QA) committee. Problems are identified and resolved before they result in deficient practice.
- Assign 6–8 residents to each department head that rounds on these residents three times a day at breakfast, lunch, and mid-afternoon. He/She ask how the resident is doing and if there are resident or family concerns. These concerns are discussed at morning meetings.
- Have department heads check on all residents before the stand up meeting in order to address resident and family concerns in a timely manner.
- Have the director of nursing, clinical champion, or other strong leader direct the antipsychotic medication reduction program and act as a gatekeeper for all antipsychotic medication changes.
- Appoint a liaison to provide a management presence for residents and families after 5:00 p.m. and to manage new admissions.
- Assign department heads to work from noon to 8:00 p.m. on a rotating basis to identify problems and concerns on the second shift.
- Ask all department heads to maintain an open door policy for staff, residents, and families to discuss concerns and potential solutions at any time.
- Use huddles and standardized tools to improve staff communication from frontline staff to leadership. For example, all staff (aides, dietary, maintenance, and housekeeping) use the INTERACT Stop and Watch tool to report early resident changes. (<http://interact2.net/tools.html>)
- Implement “All Hands on Deck” to deal with busy periods. Develop a team spirit that helps staff feel more empowered and supported. Managers should be assigned a specific unit or neighborhood. (http://www.bandfconsultinginc.com/Site/Free_Resources/Free_Resources.html)
- Leadership can empower frontline staff by using one CNA as the scheduling coordinator for peer-to-peer scheduling in each household. Ask interested CNAs to apply for the position.

- Use an individualized approach to care that emphasizes residents' quality of life and customary routines in designing clinical care and providing daily services.

Overcoming Barriers

Wide variation in the ability of administrative management staff to note concerns, produce effective reports, and close the communication loop

- Round to ensure that managers are following through appropriately.
- Train and mentor those who need to learn leadership skills. Guide by example.

Department head concerns about the time involved in doing resident rounds

- Demonstrate that residents and their families are happier if concerns are addressed quickly so that less time is spent resolving formal grievances or in complaint surveys.

Concerns of department heads about criticizing other departments

- Emphasize that it is okay to let another department know there is a potential problem.
- Promote a culture of problem-solving, not blaming. Use Just Culture principles.

Concerns of staff on the second shift that management presence would be punitive, not helpful

- Consistently convey the message that the department heads are there to check in on staff not up on them.

Make sure department heads assigned to round on residents are actually seeing the residents

- Provide regular reminders to the department heads during administrator rounds.
- Monitor performance. Mentor and provide feedback.

Staff resistance to change

- Implement any project in stages. Go slowly. Explain what you're doing at each step.
- Enlist staff participation and keep them highly involved.

- Measure your impact, and let staff know the results.
- Keep repeating the message.
- Provide leadership by example.
- Educate staff about the goals and advantages of resident-centered care.
- Management must model the behavior they want to see.
- Management presence must be non-judgmental and experienced by staff as helpful.



Staff Stability

The high costs and negative consequences of absenteeism and staff turnover are major reasons why nursing homes produce poor outcomes. When the workforce stabilizes and staff develop the capacity to work as a team, resident outcomes improve, consumer satisfaction improves, and census rises. Staff stability is the foundation for a healthy work environment where satisfied staff supported by leadership can provide quality resident care.



ACE Tips for Success

1. Complaining staff can have good solutions. Listen and redirect their behavior towards problem-solving.
2. Managers need to model effective problem-solving on the unit with frontline staff.
3. Use shared leadership. Empower staff on all levels to do their work and to problem solve locally on the unit. For example, ask management to lead huddles with frontline staff so that they give input and participate in real time problem-solving.
4. Hold staff accountable for completing their required job duties. Be consistent and fair.
5. It takes time for change to occur and to stabilize your staff.
6. Analyze your data. Know why staff leave.
7. Take the time to hire right.
8. Reward staff for good work.
9. Provide support to your staff in different ways to reduce stress.

10. Educate department heads and be clear about what is expected of them.
11. Don't waste time on problem folks. Weed out the problem employees early.
12. Staff who are satisfied are more likely to recommend the facility as a place to work. Good caregivers recruit good potential caregivers.
13. Poor hiring decisions compound stress and instability.
14. Staff stability gives management the ability to accommodate staff requests for time off which helps to reduce stress.

Interventions

Staffing

- Eliminate agency staff. You may need to work with fewer staff until you have the right people in the right positions. All staff (starting with those in leadership positions) can work together to assist with resident care.
- Use consistent assignment to ensure that a nurse aide cares for the same resident every time that he/she work. Pilot consistent assignment on one unit that has the best chance of success and then spread it throughout the facility.
- Assign even workloads to frontline staff. Ask staff to rate residents by the degree of assistance they need. Then divide up the assignments so that residents with higher acuity are spread evenly across all staff.
- Each aide has a consistent assignment each day that he/she work. Give them a choice in the permanent assignment.
- Train all staff on all halls in case an emergency occurs.

Hiring and Orientation

- Consistency during the interview and hiring process helps to find the right people. One individual conducts the interview depending upon the department and one individual decides who will be hired.
- Round-table hiring and interviewing uses a multidisciplinary team approach. CNAs are included in the hiring process.
- A month long mentor program provides support to new hires. If more time is needed, extend the mentorship period. The assigned mentor is a staff member with a positive attitude who is trained in the role and can promote a positive culture.

- Develop goals and establish milestones with the new hire. Check in and review goals every 30, 60, and 90 days.
- New hires are introduced and oriented to all departments and the services each provides. A meeting is arranged with the new hire and the department head as part of the orientation program.
- Be very clear in your expectations of each employee. As part of orientation, each employee is given a checklist pertaining to his/her specific job duties and expectations for performance.

Building a Team Culture

- Frequent rounding by leadership 2–3 times per day to “check in” and not “check up” on staff provides an opportunity to get input from direct care workers. Staff feel supported when leadership responds to questions and solves their problems quickly. (http://www.bandfconsultinginc.com/Site/Free_Resources/Free_Resources.html)
- Round frequently on new hires to be sure they have what they need in order to do their job effectively.
- Assign administration and department heads a unit for “All Hands on Deck” during meals seven days a week. They are responsible for answering call lights, helping get meal trays out to the residents, and assisting in the dining room. This reduces stress for frontline staff and increases a sense of teamwork. It also gives everyone first-hand knowledge of the work load and staff dynamics. Adapt the process as demands and the resident population change. Leadership needs to follow up often with department heads especially in the beginning to monitor their participation. (http://www.bandfconsultinginc.com/Site/Free_Resources/Free_Resources.html)
- Distribute satisfaction surveys to all staff every quarter. Leadership responds to comments and concerns. Staff feel heard.
- A staff-driven team meets monthly to brainstorm ways to improve staff morale and meet the needs of staff. Leadership supports their ideas. These result in improvements to the workplace culture.
- Use a “no blame, no shame” approach to leadership so that the work place environment is non-punitive. Staff are held accountable for doing their job but not punished for unintentional mistakes.
- A multidisciplinary team meets weekly in a “circle meeting” to problem solve and identify the root cause of problems related to processes and systems throughout the facility.

Overcoming Barriers

Poor communication about care and performance expectations

- Ensure that communication about resident interventions is spread across all shifts for consistency of care. Use huddles and stand-up meetings to exchange information quickly.
- Ask all staff for input. Include frontline staff.
- Develop a strong orientation program that communicates clear expectations to new hires.

Finding and hiring committed staff

- Attract the right people. Use refer-a-friend bonuses instead of sign on bonuses.
- Target your ads.
- Screen carefully.
- Focus on character traits during the interview process.
- Make a good first impression.

Getting the right person for the right job

- Don't hire people just to plug holes.
- Once hired, provide the new employee with a solid orientation period, a mentor, and ongoing education and training.

Difficulty in changing the mindset of staff and creating a different culture

- Work to empower all staff members. Bring frontline staff into the conversation and problem solving process.
- Treat all staff fairly and equally.
- Leadership needs to model the positive behavior.

Challenge of high acuity level of residents

- Discuss the level of care needed for each resident with staff and divide the assignments equally.
- Provide training and support when needed.

Lack of buy-in by department heads

- Leadership sets the example. If department heads are unable to adapt to the new culture and expectations, they should be changed.

Negative staff attitudes

- Leadership needs to round throughout the facility in order to listen, learn, and involve all staff in finding solutions to expressed concerns and negative attitudes.
- Make staff who are vocal with their concerns part of the solution.
- Give staff more control over their work.

Complaining instead of problem-solving

- Ask staff to help solve the problem instead of using discipline to punish them.
- Bring those who complain into the process. Get their input.
- Model teamwork.



Consistent Assignment

Consistent assignment occurs when residents are consistently cared for by the same CNAs and nurses on each shift. This strengthens relationships between caregivers, residents, and family members. Consistent assignment also allows caregivers to intervene earlier when changes in the resident's behavior or physical condition occur because a consistent caregiver knows the resident's individual patterns and baseline condition.



ACE Tips for Success

1. Don't keep moving staff around. This defeats the concept of consistent assignment.
2. Don't assign a CNA or nurse to a resident if he or she is not a good fit for the resident.
3. Make sure expectations are communicated from the top. Consistent assignment only works if you have buy in from everyone at all levels.
4. If there is no consistent assignment, the newest staff member is likely to become a floater, which may add to staff turnover in the long run.
5. Consistent assignment is important for both short-stay and long-stay residents.
6. Consistent assignment is especially important for those residents with higher acuity who need more care as well as those with dementia.
7. Consistent assignment can seem overwhelming, but if you stick with it, you will find it is do-able.
8. Consistent assignment results in satisfied staff, satisfied residents, and satisfied families.

Interventions

- ❑ Establish a CNA preceptor or mentor training program. The preceptor or mentor practices consistent assignment, and the new staff member who trains with him or her learns the concept of consistent assignment and gets to know the resident(s) at the same time.
- ❑ Have a “go-to” person for new hires to help them learn policies and to answer any questions.
- ❑ Use a CNA to schedule the daily assignments.
- ❑ Have hall teams arranged by task such as a shower team, so that the resident is familiar with the people who will care for and bathe him or her.
- ❑ Right from the start, train CNAs to be with either short-stay or long-stay residents. Each has a different role to play (caretaker vs. cheerleader).
- ❑ Use consistent assignment on all shifts, not just weekday daytime shifts.
- ❑ Arrange the staffing schedule so that each nurse and CNA works two halls consistently.
- ❑ Use electronic or printed care cards. Update these cards on each shift and make them available to staff on the next shift.
- ❑ Staff stability is critical to the success of consistent staffing.
 - a. Perform root cause analysis (RCA) on all callouts.
 - b. Have a policy that staff must call out at least two hours before the shift begins.
 - c. Assign paid time off (PTO) instead of sick leave, so that staff will have to use potential vacation time, instead of just sick leave for a call out.
 - d. Give each staff member his or her own email account to facilitate communication about schedules. Create a policy that email must be checked on a regular basis and specify so in your policy.
 - e. If you use an electronic medical record system, put messages on the system for employees to see.
 - f. Create a focus group to discuss issues related to attendance. Be sure to include CNAs in this group.
 - g. When hiring new staff, get the residents’ input by including them in the interview process.
 - h. See additional interventions in the section, Staff Stability.

Overcoming Barriers

Callouts

- If a staff member calls out, require them to work the next available shift.
- If the staff member calls out on a holiday or weekend, have a policy in place stating that no incentive pay will be attached to those hours.
- Have 1:1 conversations with staff who frequently call out.
- Perform root cause analysis on each callout. Break down each one by staff member, assigned resident(s) or hall(s), day of week, shift, time of year (holidays, school schedule), and the reason given for the callout. If you see a pattern such as childcare, talk to the staff member. Be flexible in the schedule to resolve the problem, when possible.

Challenging residents and units

- Have other staff members pitch in as much as possible to reduce the care burden and give CNAs a break.
- Provide a sympathetic ear to direct care workers so that they can blow off steam.

Burnout

- When a staff member is tired of working on a hall, frustrated, or wants a change, do your best to accommodate him or her.
- If you notice that a staff member is starting to burn out, be proactive, talk to him or her, and temporarily reassign when necessary. This may result in a temporary loss of consistent assignment for the sake of preserving staff stability.

Incorrect or conflicting resident information shared with family

- Ensure that all staff understand who should share medical information with the family.
- Eliminate multiple sources of information for families. Select just one or two capable staff members for this purpose.

CNAs contacted by the family off-shift to discuss a resident

- Make sure that the family is introduced to other CNAs who care for the resident, so that they have someone each shift with whom they can report any issues or concerns.

Staff turnover

- Let all staff know that they are appreciated either verbally at meetings or in newsletters.
- Hand out small tokens or gifts.
- Conduct a pizza or ice cream party for an entire hall.
- Designate an “employee of the week or month” and give that employee a special parking space.

Resident attachment to one particular CNA

- Have more than one CNA assigned to a resident or hall if possible, so that if one CNA is off, another available CNA is familiar to the resident.

Conflicts between staff members because of strong bonds with the resident

- Talk to specific staff members either 1:1 or together to resolve the conflicts.
- Help staff see the value of consistent assignment. Do this as soon as problems are identified.

Lack of computer knowledge

- Have experienced staff from other buildings or units provide education. Give new users an entire shift of training.
- Have CNA peer mentors.

Reduction in workforce, limited overtime, and reduced financial resources

- Talk to the administrator or corporate contact.
- Make the business case for having an adequate number of staff and for implementing consistent assignment.
- Relate consistent assignment to improved resident outcomes and family and resident satisfaction.

Resistance to change

- Have a 1:1 discussion with staff to address concerns and provide reassurance.



Huddles

Huddles can occur anytime and in any location as a quick meeting to discuss critical information. These brief stand-up meetings are a vehicle for real time problem-solving on the unit and elsewhere in the facility to exchange information and address resident and staff needs quickly. Huddles are an important quality improvement tool that staff can use to improve the flow of communication and their ability to address issues in real time.



ACE Tips for Success

1. Huddle promptly after an incident.
2. Keep the huddle short and conduct it on the unit.
3. Use nurse leadership to facilitate the huddle.
4. Huddle at the beginning and end of each shift.
5. Keep huddle times flexible.
6. Engage staff and respond to their input and ideas.
7. Use huddles to connect with staff and exchange information quickly and effectively.
8. Keep it positive with staff and make it constructive. If staff begin to blame another person or shift, redirect the comments to address the topic or concern.
9. Keep doing it. It takes practice. Eventually most huddles will shorten in length to 5–15 minutes.

10. Educate staff about the benefits of huddles.
 - a. Prompt exchange of information
 - b. Resident updates
 - c. Real time problem-solving
 - d. Efficiency
 - e. Involvement of frontline staff
 - f. Everyone on the same page
 - g. Continuity of care
 - h. Early catches
11. Use incentives for participation. Reward those who come. Recognize and point out successful cooperation and improved communication.
12. Showcase residents when huddles improved care, saved time, or prevented an unnecessary event such as a hospital transfer.
13. Use a whiteboard or other means to record ideas and information.
14. Encourage discussion instead of using a checklist. Nurse leaders should include all those present in the discussion. Ask, "What do you think?"
15. Make sure the environment is conducive to asking questions and having an open discussion. Check noise level, potential interruptions, and privacy.
16. Begin using huddles with your strongest charge nurse and CNA team. Start small as a pilot project. Once these staff members have mastered the use of huddles, they can help other units adopt the process.

Interventions

- Use a shift huddle at the start and end of the shift to gather nurses and CNAs together to share information and provide resident updates. Do it at a central location on the unit or as a walking round from room to room.
- Use a huddle to update staff on a new admission. Bring unit staff together to review important elements of the resident's care and needs. This can happen before the resident arrives so that staff can prepare ahead of time for individual issues. Include other staff such as the social worker and dietician.
- Conduct a post-incident huddle to review an event, conduct RCA, and plan interventions.
- Huddle using the INTERACT Stop and Watch tool to discuss a change in condition and what follow-up assessment is needed. (<http://www.interact2.net/>)
- Try the huddle as a stationary meeting on the unit. Try doing a huddle as staff walk from room to room or through the entire unit. Be flexible and conduct the huddle in a way that helps staff share information and address the issues at hand.
- Do a post-fall huddle using the 10 questions from Empira. Re-enact the fall. Make a sketch or take a picture to capture details. (<http://ccmemedicare.org/default.aspx?pn=ClinicalTopicResources#Falls>)
- Use a Learning Circle as a huddle at shift change. Include frontline staff and family members. (<http://www.pioneernetwork.net/Data/Documents/LearningCircleKeane.PDF>)
- Do hands-on learning in a huddle when there are questions about care. Demonstrate the steps of care that staff need explained.
- Expand the use of huddles from just nursing to housekeeping, dietary, and all other departments. Employees can call a huddle about any issue related to resident care or services.
- Med techs can huddle to discuss the resident's medications at the change of shift.
- At the beginning of the shift, distribute a form for staff to record resident changes and needs. Use that content for the huddle at the end of the shift.
- Conduct a restorative huddle with residents to hear what they want to report about their progress, meals, and any concerns. Use three restorative aides per 12 residents to gather resident input before starting the usual restorative program.

- Put chocolate out on the desk to keep people in a nearby huddle. Have tea and coffee as an incentive to come together.
- Remember a huddle can be initiated by anyone. Encourage any staff to call a huddle whenever they need to discuss an important situation or change.
- Allow huddles to occur naturally anywhere, anytime. Form a huddle with just two people on the unit.
- Huddle to share the 24-hour report. Get frontline staff involved.
- When the director of nursing attends the change of shift huddles they can be used to organize his or her communication with the staff each day.

Overcoming Barriers

Difficulty in getting people together and fitting huddles into the day to day workflow

- Keep doing it. Practice.
- Educate staff and help them to recognize the benefits of huddles. "Everyone needs to hear the same story."
- Point out situations where the huddle really made a difference in a resident outcome.

Hard for staff to break away from resident care and seen as an interruption

- Hold the huddle on the unit close to the point of care.
- Be flexible about when you do a huddle.
- Keep the huddle short. With practice, the huddle can last from 5–10 minutes.
- Provide coverage on the unit during the huddle time. Management can answer lights and respond to resident needs.

Resistance to a new way of doing things and personality conflicts

- Keep it positive. "Let's talk about our day today."

- Be encouraging and turn negative discussions into more positive ones through staff involvement in the problem-solving process.
- Take any blame out of the huddle. Focus on process, not individuals.
- Timing is everything. Schedule a huddle when staff have the best chance of participating.

Tardiness

- Be flexible with times.
- Hold huddles on the unit. Model being on time.

Confusion about roles

- Build a huddle team before the crisis arises. Be clear about who should attend.
- Form a hallway team that knows when to huddle.



Antipsychotic Medications

Antipsychotic medication use in nursing home residents who have dementia has limited effectiveness and causes severe side effects including orthostatic hypotension, over sedation, increased risk of falls and hip fractures, and increased mortality. Eliminating the off-label use of antipsychotic medications through individualized non-pharmacologic interventions that reduce residents' distressed behaviors by addressing their unmet needs is the key component of state and national initiatives to improve the care of residents with dementia.



ACE Tips for Success

1. Keep a focus on reducing antipsychotic medications. Go slow and select 1–2 residents at a time for gradual dose reduction (GDR).
2. Exchange information at weekly team meetings.
3. Be organized. Use a detailed spreadsheet or monitoring tool to track all antipsychotic medications, GDRs, and the results.
4. Use strong leadership and establish a gatekeeper who will monitor use and prevent new orders without an appropriate diagnosis. Remove the possibility of ordering an antipsychotic medication without going through a gatekeeper.
5. Don't allow a knee-jerk reaction of ordering an antipsychotic medication after an isolated behavior.
6. Be patient. Use trial and error when trying different non-pharmacologic interventions. Include everyone's ideas. Start with the easiest interventions first. Look for successes and share.
7. Train all staff regularly in dementia care. Use real case scenarios and the Centers for Medicare & Medicaid Services (CMS) Hand in Hand Toolkit as well as other training resources.

8. Develop a clinical champion with expert skills and dementia certification.
9. Listen to the resident. Know the resident well. Tune in to his/her communication style and needs.
10. Make sure communication from frontline staff is incorporated into the problem-solving process since they know the resident best. Acknowledge the value of their input.
11. Conduct an immediate review of medications for new admissions. Clarify medications and supporting diagnoses. Work with the hospital and admitting physicians to discontinue inappropriate medications.
12. Establish an automatic process for evaluation and GDR for newly admitted residents who are taking an antipsychotic medication.
13. Engage the medical director who will agree to educate all primary care providers and ask for their cooperation.
14. Work consistently with families.
15. Practice RCA and lead staff in critical thinking using non-pharmacologic interventions.
16. Be hands on with staff.
17. Make resources easily available.
18. Conduct additional activities through 1:1 interactions with the resident.
19. Place resident-specific boxes (e.g., memory box, activity box, life history or career related activity box) in resident rooms.

Interventions

Eliminating Off-label Use of Antipsychotic Medications

- Use a detailed, MS Excel spreadsheet to enter information and monitor residents on an antipsychotic medication. Include drug, dose, history, relevant diagnosis, and attempts at GDR. Monitor sedative/hypnotics for an increase.
- Check the diagnosis of each resident who is taking an antipsychotic medication to make sure there is a diagnosis to support use.
- Enter each resident on an antipsychotic medication into QI Psych Notes in your electronic health record (EHR) and use this system for weekly monitoring.

- Use Behavioral Symptoms Monitoring Sheets to track behaviors and learn the “unmet need” being communicated. Review them with the nursing staff to check for accuracy and identify antecedents, early warning signs and effective interventions to reduce distress-induced behavioral symptoms.
- Collaborate with the pharmacy consultant who can be a valuable team member for reviewing medications with physicians and making recommendations about GDR schedules.
- Use geropsychiatric services on a regular basis to evaluate and monitor antipsychotic medication use. The geropsychiatrist can be a gatekeeper for making all changes. Individual physicians agree not to change or order new antipsychotic medications and to refer all cases to the geropsychiatrist.
- Educate physicians about the facility’s GDR program and use of non-pharmacologic interventions. Emphasize options other than antipsychotic medication use.
- Ask for a comprehensive medical assessment and diagnosis from the physician when needed.
- Meet weekly as an interdisciplinary team to review residents, behaviors, and medications. Continue to select 1–2 residents for GDR each week.
- Make the director of nursing (DON) or other nurse leader a gatekeeper for all antipsychotic medications. Structure it so that nurses must first check in with this nurse before contacting the physician for a new order or dose change. The gatekeeper assesses the situation and makes a decision about how to proceed. The nurse also models how to use non-pharmacologic interventions instead of medication.
- Review antipsychotic medication orders for all new admissions. Ask case managers or other hospital staff for a relevant diagnosis. If none is present, ask the physician to discontinue the medication. For new residents on an antipsychotic, observe and evaluate. Make GDR an automatic next step.

Non-pharmacologic Interventions

Interventions only work if they are individualized to each person. Here are some ideas for interventions that may work, as well as ways of communicating and problem solving to figure out the resident’s need.

- Share key information with CNAs about each resident’s behavioral symptoms, a guide to what is often being communicated, and specific interventions known to work. Put this information on the assignment sheet, share in huddles, and consider posting a care guide on the inside of the resident’s closet door. Include specific interventions for each behavior with suggestions about how to provide comfort and how to understand what the person may be seeking, so as not to thwart by redirecting.

- Allow residents to sleep until they awaken on their own in the morning.
- Use personalized music to engage residents with dementia. Purchase an iPod or MP3 player. Ask families for favorite songs. (<http://musicandmemory.org/>)
- Support residents to have long periods (at least four hours) of uninterrupted sleep so that they can complete REM cycles.
- Design a memory or activity box for individual residents. Keep it in the resident's room for easy staff access. Include items specific to the person's background, preferences, and work history.
- Create a notebook or toolbox of ideas and non-pharmacologic interventions for staff to use. Keep it handy and encourage regular use.
- Create a notebook or fact sheet with each resident's preferences. Review and update this at care plan meetings and post for easy access on the unit.
- Create a clipboard with resident names and space for the social worker to add information about the resident's social history, personal preferences, and life history. Review and update this monthly. Keep it on the unit for easy access.
- Ask CNAs to get additional information from families including helpful approaches to comfort and calm the resident. Record and share this with all unit staff.
- Use aroma and light therapy.
- Take the resident outside.
- Offer food and drink to the resident.
- Provide pain medications whenever you believe the resident may be experiencing discomfort or pain. Check the resident's diagnoses for those with pain as a symptom.

Problem Solving

- Conduct a stand-up meeting or huddle on the unit with frontline staff after a new distressed behavior occurs. Conduct RCA and develop interventions.
- Conduct a weekly interdisciplinary team meeting on the unit. Involve CNAs.

- Integrate distressed behaviors into the discussion at daily stand-up meetings. Involve CNAs.
- Improve the nurse's clinical assessment skills to determine underlying medical causes of distressed behaviors.
- Conduct deep RCA with staff to determine why the distressed behavior is occurring. Keep asking why to get to the underlying reasons and unmet needs.
- Observe and assess the resident's behavior over a 48-hour period. Do not use an isolated instance to determine your approach. Look for patterns, triggers, and unmet needs.

Staff and Family Education

- Ask a nurse, clinical champion, or other leader to become dementia care certified. In one facility the administrator became certified.
- Take sufficient time to educate and train staff in dementia care and the need to reduce antipsychotic medications. Work hard to get staff buy-in. Highlight successful elimination of off-label use of antipsychotic medications and any improvements noted in residents. Staff belief in the benefits is crucial for long-term success.
- Use the CMS Hand in Hand Toolkit to train staff. Use corporate materials to train staff. Send staff for training in dementia care. (<http://www.cms-handinhandtoolkit.info/>)
- Select a clinical champion and make sure he or she is well trained in non-pharmacologic interventions. Offer opportunities for dementia care certification.
- Begin dementia care training during orientation and make sure all staff are trained each year. Be sure to include housekeeping staff.
- Ensure that nurse leadership demonstrates expert dementia care skills for frontline staff. Lead by example.
- Meet with families of residents who are on an antipsychotic medication. Spend as much time as it takes to educate them about their dangers and the need to eliminate off-label use. Involve them in problem-solving. In some cases this takes multiple attempts.

Overcoming Barriers

Families' concerns about changing a medication

- Educate family members and involve them in the resident's care.
- Know the family history. Involve families in finding appropriate non-pharmacologic interventions and communication methods.
- Arrange for the geropsychiatrist to provide an educational session for families.

Train nurses to conduct RCA and use critical thinking skills

- Review cases regularly with frontline staff to discuss resident behaviors and alternative interventions.
- Discuss details of the behavior and look for underlying causes. Be specific and go deep. Then discuss different interventions.

Antipsychotic medication use is a knee-jerk reaction by many nurses

- It takes time to change the mind set of nurses and CNAs.
- Educate staff about the serious side effects and need to reduce this class of medications.
- Educate staff about non-pharmacologic interventions and engage staff in thinking through how to use them case-by-case situations.

CNAs hesitant to be involved

- Regularly ask for input from frontline staff
- Model problem-solving using CNA input
- Give praise and show an appreciation for ideas from the frontline staff.
- Follow through on suggestions and then let staff know you have done so.

Lack of physician awareness regarding the impact of antipsychotic medication use and an unwillingness to change antipsychotic medication orders

- Educate physicians and nurses about national and state initiatives to reduce antipsychotic medications and improve dementia care. Explain your facility program. (<http://www.youtube.com/watch?v=FEFTCtyWPGA>)

- Redirect physicians to non-pharmacologic interventions.
- Encourage the medical director to discuss reduction efforts with all prescribers.
- Don't be afraid to be direct about the standard of practice and hold firm with the physician as you explain the need to eliminate off-label use of antipsychotic medications.
- Ask the family to agree to a trial reduction before approaching the physician.
- Recognize that when sedation ends, residents' unmet needs will once again be communicated through their behavioral symptoms. Be prepared to learn how to address these needs.

Incoming patients from the hospital with antipsychotic medication orders

- Call the hospital case manager to ask for an appropriate diagnosis. If there is none, ask for discontinuation of the antipsychotic medication before the resident is admitted to the facility.

Insufficient or old style activities that do not meet the needs of residents with dementia

- Create individualized boxes of activities for residents based on life experience and personal interests. Keep this in the resident's room.
- Develop 1:1 activities and small group activities for those with dementia.
- Get CNAs involved.

Increased behaviors after GDR

- Huddle regularly to problem-solve.
- Learn as much as you can about the resident's preferred routines.
- Recognize early warning signs and share interventions that work best.
- Make sure to have consistent staff assignments.
- Check in with family and friends about how to reduce the resident's distress.
- Increase staffing.
- Assign two staff members to assist during care.

- Conduct 1:1 activities.
- Create an individualized schedule for the resident.

Staff anxiety after GDR when behaviors re-emerge

- Hold steady.
- Use trial and error.
- Be patient.
- Continually problem solve together.



Hospital Readmissions

Older adults with complex acute and chronic care needs are especially vulnerable during transitions from the hospital to the nursing home as well as into the community. The capacity of a nursing home to produce positive outcomes for these vulnerable patients while avoiding unnecessary re-hospitalization is a key indicator of quality that will drive future market share when hospitals select discharge sites for their patients. In addition, a system-wide quality improvement program to reduce hospital transfers will protect nursing homes when penalties for high readmission rates goes into effect for nursing homes in 2018.



ACE Tips for Success

1. Be realistic in planning and developing a timeline for the implementation of INTERACT (Interventions to Reduce Acute Care Transfers).
2. Always conduct an after-action review of all unplanned hospital transfers including those to the emergency department, readmissions, and observation stays. Make recommendations on actions to improve and discuss at the QAPI meeting.
3. Conduct monthly meetings with the medical director and staff to share data, discuss trends, and develop actions.
4. Build good relations with the hospital and select a joint project to work on together to reduce readmissions. For example, develop a new transfer form.
5. Consistent staff assignment is essential to catching early changes in the resident's condition.
6. Involve all employees of the nursing home in recognizing and reporting any change in condition to the nurse.
7. Identify and assess resident risk for potential readmission. Closely monitor residents.

Interventions

Implementing Best Practice

- Use the INTERACT curriculum and access all tools online. (<http://www.interact2.net/>)
- Begin by using the INTERACT Quality Improvement Tools to track and analyze all hospital transfers. Record and graph 6–12 months of data for 30-day hospital readmissions. Look for patterns and trends. Identify your strengths and weaknesses. Why do residents transfer back to the hospital from your facility?
- Begin with one INTERACT topic at a time and implement the program on a small scale. Use a Plan-Do-Study-Act (PDSA) cycle to start with one tool on one unit.
- Train staff in the use of the INTERACT program and the tools.
- Train frontline staff to be part of the process and use their input when designing how the program will flow. Ask staff to lead implementation on a unit. Give staff ownership of the process.
- Measure the progress of each topic implemented and share data with the staff. Show graphs and keep staff informed of hospital transfers each month.

Improving Communication about Acute Changes in Condition

- Use the INTERACT Stop and Watch tool. Enlist participation of all staff with direct resident contact.
- Develop a specific, structured shift report process for all units that includes acute changes in condition and residents at high risk for hospital readmission.
- Encourage walking reports and viewing the resident together.
- Have staff participate in developing an end of shift report checklist.
- Review incident reports and assess which residents are most at risk and why. Be sure this information is included in the shift report.

- To report and respond to early acute changes in condition, frontline staff should huddle at least once a shift. Make an outline or script the huddle so that the right information is discussed each time. Be consistent across all shifts and units.
- Educate and role play with staff so that they can see how a huddle works and the process for communicating about high risk residents.
- Explain the importance of huddles and share stories of when a huddle prevented a hospital transfer.
- Make sure the huddle is noted on the charge nurse shift report as a reminder.

Creating a Transitional Care Unit

- Develop a business plan. Determine the cost allocation and potential return on investment.
- Determine the scope of service you would need to provide by analyzing the data collected through a retrospective readmission audit as well as the primary diagnosis-related groups (DRGs).
- Assess the current gaps in your services.
- Create a steering committee with the referring hospital, physicians, and all division leadership who would support the service (including a resident and family advisor).
- Determine additional equipment needs for the unit.
- Sketch out a timeline for the project and create a step-by-step implementation plan.
- Provide training to all staff, residents, and families.
- Hire and train permanent staff for the new unit.

Physician Involvement

- Review all readmissions and observation stays from the past year with the physicians, nurse practitioners, and physician assistants. Make the case for their involvement and adequate rounding in the facility on a regular basis.

- Create a business case for your corporate office to increase medical care in the facility.
- Discuss a strategy with your referring hospital chief executive office (CEO) to gain endorsement and build the case for increased medical presence in the facility. Hospital readmission is a poor outcome and means that hospitals will discharge fewer patients to your facility.
- Work with the medical director to target high risk residents for additional medical supervision and care.
- Assess the communication between nurses and physicians. Determine if it is consistent across all providers and all nurses. Identify gaps. Consider using the INTERACT SBAR tool to ensure consistent and thorough nurse assessment prior to physician contact.
- Provide a daily list of any high risk residents to the rounding physician.
- Encourage physician dialogue with the family to suggest treatment options that the nursing home can provide in the facility and the advantages of avoiding a hospital transfer.
- Ensure that the rounding physician has regular discussions with residents about advanced care planning and end of life care when appropriate.

Working with Hospitals

- Engage in early discussions with the hospital about information technology (IT) capacity and available equipment. Determine the cost of an IT interface with the hospital to share or at least view electronic health records (EHRs).
- Be proactive in your communication with the hospital, home health agency, and other community partners to maintain referrals to your facility.
- Use the INTERACT Nursing Home Capability List to outline your facility's capacity and services. Share with your referring hospitals.
- Discuss frequent risk factors and the challenges of providing good transitional care with the hospital and other partners.
- Standardize communication that is essential to the hospital and nursing home receiving the resident.
- Consider using the INTERACT Transfer forms.
- Form a multidisciplinary clinical team from both the hospital and nursing home to design a transfer form.
- Include the emergency medical services (EMS) staff in the final discussion of the transfer form.

- Educate all staff involved in using the transfer form.
- Track the use of the transfer form weekly and follow-up with non-compliant staff until compliance is at least 90 percent and then audit quarterly.

Planning and Post-discharge Follow Up

- At least three days ahead of expected discharge, use the morning stand-up meeting to plan ahead in order to prevent resident discharges from being rushed and disorganized. Ensure all disciplines are present. Use a white board to determine what the resident will need at home so that equipment, prescriptions, therapy orders, discharge summaries, and appointments are in place at the time the resident leaves the facility.
- Assign the responsibility of post-discharge follow up to a clinician who can make the calls consistently such as the ADON, staff development nurse, MDS coordinator, or social worker.
- Script the post-discharge call to ensure that the same content is used each time.
- Consider calling within 48–72 hours post-discharge and also at day 30 after discharge home.
- Collect data on common issues that residents report during the calls. Summarize the data and look for trends. Consider what changes your team needs to make to the discharge planning process to address the issues. Make a report to the QAPI committee.

Advanced Care Planning

- Assess when advanced care planning begins at your facility. Is the timing appropriate and consistent? Define the steps in your process.
- After the initial conversation about advanced care planning, consider follow-up within the first 30 days after the resident and family have had time to adjust to the nursing home environment.
- Use the Medical Orders for Scope of Treatment (MOST) form. Provide education to physicians and staff about its purpose and use. Implement facility-wide. (<http://www.ncdhhs.gov/dhsr/ems/pdf/ncmostform.pdf>)
- Use trained providers such as hospice and palliative care staff to provide education on end-of-life care.

- Collect data on the completion and adherence of advanced care planning in the facility. Identify gaps and provide training to ensure a consistent process.
- Reassess the resident's end-of-life care when there is an unfavorable change in condition.
- Ensure that the resident's DNR status is posted in the chart and is communicated consistently to all staff.

Residents and Families

- Develop a script and educate the staff about how to inform and communicate confidently about the resident's change in condition and plan of care to the family.
- Round on high risk residents every shift. Provide early interventions and communicate these to families in a timely manner.
- Check in with concerned families at least twice a week. Do not wait until there is a serious event. Be proactive.

Overcoming Barriers

Staff who are uncommitted and do not use tools or support the initiative

- Have a 1:1 discussion with staff to educate them and to secure their commitment.
- Encourage resistant staff to take a lead role during implementation of INTERACT.
- Offer different times for the training sessions to assure all staff have a chance to attend.

Staff lack critical thinking and advanced clinical assessment skills

- Increase the nurse practitioner coverage.
- Provide ongoing training in clinical assessment and mentoring to nurses.
- Demonstrate RCA.
- Send nurses offsite for training in geriatric clinical assessment skills. For example, attend a hospital based NICHE program used to train geriatric resource nurses. (www.nicheprogram.org)

Staff resistance

- Assign staff roles during program development. Get staff input when deciding how to roll out the program.
- Reinforce the importance of good strategic communication and how it can prevent a hospital transfer.

Staff resistance to early shift huddles

- Allow each shift to decide the best time for their huddle.
- Reward and praise those staff members who catch issues early and prevent readmissions. Highlight how a huddle impacted a resident outcome.

On call physicians still sending residents to the hospital

- Incorporate all physicians in the readmissions monthly meeting.
- Have the medical director discuss the facility goal on preventing avoidable readmissions with all physicians.
- Provide individual provider readmission reports on a quarterly basis. Use graphs to illustrate patterns of high readmission rates for individual physicians.

Insufficient revenue generated to offset additional cost of expanded services

- Consider a financial partnership with the hospital to offset negative revenue.

Costly IT interface and limited facility funds

- Consider getting corporate staff involved early in the discussions with the hospital.

Closed or disorganized hospital-based communication

- Use the INTERACT communication tools to help quantify data and information that needs to be shared between the nursing home and hospital.
- Consider 1:1 conversations with selected providers first before moving into a larger community partnership with all providers.
- Offer to participate in a hospital readmission reduction project.

Difficult resident transitions to home and need for high level of community assistance

- Develop an internal decision support tree that can align resources to help resolve some of the issues once the resident returns to the community.

- Contact the necessary local community-based services for needs as identified prior to discharge.

Staff inability to locate the transfer form

- Standardize the location of the transfer form.
- Consider mounting the form on a colored envelope.
- Assign the unit secretary to maintain the form inventory.

Inconsistent use of the transfer form by staff

- Monitor and share data about the form's use at every monthly meeting.
- Use break room posters to communicate changes, the procedure, and degree of staff compliance.
- Meet weekly with the hospital lead to share the data results and address issues.

Family's insistence that the resident needs to be sent to the hospital

- Engage the resident's physician in the conversation.
- Limit staff communication with the family to one or two senior staff members who are confident and comfortable handling family conversations.

Staff uncomfortable with advanced directive care planning conversations

- Provide education to all staff about advanced care planning.
- Select champions among the team to support other staff and to be family advocates.
- Involve the medical director. Enlist his or her support to empower other physicians, nurse practitioners, and physician assistants to have conversations with families before the resident is in crisis.



Falls, Alarms, and Mobility

The majority of nursing home residents have a very high fall risk. As a result, falls and related injuries are major safety concerns for staff, residents, and their families. Often in the past, these concerns have prompted staff to immobilize residents through the use of physical and chemical restraints, alarms, and extended wheelchair use.

Within a person-centered care approach, alarm use, once a “go-to” intervention for falls, is now replaced by care strategies to address individual resident needs and specific fall risk factors. Instead of immobilizing residents to improve their safety, staff integrate opportunities for safe movement throughout the day to maximize the resident’s ability to participate in self-care, as well as improve their physical and psychological well-being. Reducing alarm use and improving the resident’s balance, strength, endurance, and flexibility through exercise and mobility are key components of a broader approach to manage fall risk and reduce the risk of a serious fall related injury.



ACE Tips for Success

1. Use an interdisciplinary falls team, to include frontline workers and non-clinical staff such as housekeeping to collect more complete information and ideas about interventions. Different perspectives help. Including direct care workers in the problem-solving process helps them feel valued and to function as a team.
2. CNA involvement is key. They know the residents best.
3. Individualize interventions instead of using the same intervention for all residents after a fall. Provide individualized interventions with frequent rounding in place of the alarm.

4. Replacing antipsychotic medication use with meaningful activities helps to reduce negative behaviors and increases supervision of residents with unsafe behaviors.
5. Consistent assignment helps staff to get to know residents and facilitates RCA and the process of targeting interventions.
6. Address staff buy-in by providing inservices from professional trainers.
7. Educate physicians regarding antipsychotic medication changes to reduce falls.
8. Ask to change medication schedules to allow for flexibility and to avoid waking the resident up to administer medication during the night.
9. Huddle with frontline staff at change of shift. Have the director of nursing provide updates regarding the resident and his or her fall risk factors.
10. Once staff see the success of alarm reduction, they understand it just creates “more noise” without a positive benefit.
11. Add housekeeping staff to the team during the post-fall investigation process.
12. Address buy-in by talking through and educating staff.
13. Make education fun and rewarding. Make fall reduction a challenge and increase incentives for improvement to increase staff buy-in.
14. Get families involved in reducing the resident’s fall risk. Ask them for information about the resident’s personal history and preferences before trying a new intervention.
15. Educate families within three days after the resident first arrives at the facility about how staff plan to address fall risk and alarm use.
16. The structure of Wii games work as a way to improve the resident’s activity and improve mobility.
17. Make physical exercises a part of daily activities so that mobility is integrated into the resident’s daily routines.
18. Have a clinical champion for mobility who can serve as a point person for promotion, education, and questions that crop up along the way.
19. Integrate therapy into the mobility process. For example, screen residents so that aides understand what level of participation is safe.
20. Provide education and empower all staff to assist with mobility programs.
21. If a program is not embedded into the system it will not last. Embed systems for mobility into your day to day structures such as a Get Up and Move Program and Walk to Dine Program.

Interventions

Interventions to Reduce Falls and Alarm Use

- Implement interventions specific to the needs of each resident based on determining the root cause of a fall versus using an alarm as the standard intervention for every resident after their first fall.
- In addition to regular activities staff, appoint other staff members (CNA, RN, housekeeping staff) to conduct activities on nights/weekends.
- Modify scheduling for activities staff to cover hours when more assistance is needed from 3:00 p.m. to 11:00 p.m. Empower aides to assist with activities during this time when a high number of falls occur.
- Promote and expand activities during the day shift to increase supervision.
- Use Wii games to provide an opportunity for supervised exercise and mobility. Exercises to improve balance, strength, endurance, and flexibility reduce the risk of a fall-related serious injury.
- Teach frontline staff to use the 4 Ps of Rounding (pain, potty, personal items, position) on a regular basis. Round frequently enough to anticipate the resident's needs before unsafe behavior occurs especially with toileting needs.
- Add a fifth element to the 4 Ps Rounding for P.O. (oral medication) or food.
- Assign two aides the sole responsibility of toileting all residents throughout the day shift.
- Use a toileting program based on voiding diaries and specific resident needs. Round proactively to toilet residents.
- Allow enough time for toileting. Do not rush the resident. Adjust the staff to resident ratio to accommodate for this approach.
- Use dietary staff for regular hydration rounds.
- Use a gradual dose reduction for residents who are on an antipsychotic medication in order to eliminate serious side effects that increase the resident's risk of falls and hip fracture.
- Train staff in behavior management skills to reduce the need for antipsychotic medications and to minimize unsafe behaviors which put the resident at fall risk.

- Increase fall risk awareness of all staff to build a larger capacity to supervise residents with unsafe behaviors. Add fall risk strategies to the job descriptions of staff in all departments so that everyone shoulders the responsibility of preventing falls. For example, housekeeping staff can look in on residents and report safety concerns as they remove trash from a room.

Embedding Problem-Solving into the System

- Use an immediate post-falls huddle for real time problem solving by an interdisciplinary team.
- Use Empira's 10 Questions for the post-fall huddle to help guide the discussion during RCA and not omit any key information. (<http://ccmemedicare.org/default.aspx?pn=ClinicalTopicResources#Falls>)
- Measure the distance between the bed, chair, or toilet and the location of the fall. This helps staff determine possible causes and guides the development of an intervention. For example, if the resident fell immediately from the original surface such as a bed or chair, orthostatic hypotension is more likely to be a factor. If the resident fell five feet or more from the original surface, poor balance or lack of strength may be a factor.
- Use a falls scene investigation process where the first staff member (not just nursing) who is on the scene of a fall investigates what is seen, what the resident was trying to do, and searches for key risk factors.
- Use the IPRO Falls Tracking Tool to monitor falls data and key variables such as time of day and day of the week. Patterns begin to emerge so that you can pinpoint system wide issues impacting falls. (<http://www.ccmemedicare.org/default.aspx?pn=ProcessTopicResources>)
- Plot falls by time of day in a graph to show staff the data and determine any patterns. This reduces defensiveness of staff about a "fall happening on their shift."
- Form a falls Performance Improvement Project (PIP) team. Make it interdisciplinary. Conduct RCA. Meet monthly to review outcomes and keep members accountable for their action items.
- Implement a falls huddle on the unit to problem solve around fall risk factors and interventions.
- Conduct a weekly falls committee meeting to track falls data and identify areas for improvement. Make it interdisciplinary.

Environmental Modifications

- Install motion sensor lights to help the staff know when a resident rises at night. Staff can determine patterns and then proactively respond to needs.

- Install contrasting colored toilet seats and call lights.
- Reduce excessive fluid intake at night to reduce the need for frequent urination.
- In order to improve sleep, stop nightly medications by either moving them to a daytime schedule or eliminating their use.
- Reduce medications with side effects that contribute to confusion and drowsiness.
- Reduce noise at night to promote uninterrupted sleep and reduce unsafe behaviors due to confusion and fatigue.

Mobility

- Add Wii gaming to the activities roster as a way to integrate movement into the daily routines of residents and as a way to increase supervised exercise.
- Begin a walking program at 10:00 a.m. and 2:00 p.m. each day. All staff are asked to find their assigned resident to assist during ambulation. (<https://www.nhqualitycampaign.org/goalDetail.aspx?g=mob>)
- Promote and increase the number of activities during the day and make sure that mobility is integrated into these activities. For example, ask residents to stand periodically by the table during a cooking activity.
- Provide an in room exercise before each meal for bariatric residents in wheelchairs.
- Implement a Get Up and Move Program everyday at 2:00 p.m. music is played on the intercom and all staff help a resident participate in line dancing. Include residents in wheelchairs so that they can move to the degree possible.
- Implement a Walk to Dine Program where restorative staff assist each resident to the dining area to integrate mobility into the day's routine. (<https://www.nhqualitycampaign.org/goalDetail.aspx?g=mob>)
- Adapt the program, A Matter of Balance, for use with residents to improve their balance. Appoint a staff member to become a certified instructor. (http://www.mmc.org/mh_body.cfm?id=432)
- Use a rehab flow sheet by therapy for CNAs to use as a guide about the resident's level of mobility and degree of assistance. Include exercises that frontline staff can do with the resident to improve strength, balance, endurance, and flexibility.

- Change your culture from an environment where everyone sits in a wheelchair for much of the day to a place where no one sits in a wheelchair unless they are being transported.
- Provide seating options at stations along the hallway to facilitate resting when residents walk through the halls.
- Have therapy assess the resident's seating devices such as wheelchairs, chairs, raised toilet seats, and bed height. Individualize the fit to maximize safe transfer and enhance mobility. (<http://www.ccmemedicare.org/default.aspx?pn=ProcessTopicResources>)
- Make sure assistive devices like walkers are available to the resident. For example, keep the walker at the edge of the bed, not across the room.
- Remove clutter and all unused items in resident rooms and common areas to promote safe mobility.
- Encourage mobility by providing areas of interest such as a working garden, courtyard, outside benches, and sunroom.

Overcoming Barriers

Non-activities staff uncomfortable with role of leading activities

- Train non-activities staff to lead activities on nights and weekends. Accompany them in the beginning and provide support as long as needed.
- Help staff become a certified instructor in an exercise program for older adults.

Fear of new methods not working and reliance on old ways of doing things

- Provide targeted training for CNAs on falls and alarm reduction.
- Explain the importance of changing from a culture of immobility to one of mobility.
- Educate all staff and families on the benefits of antipsychotic medication reduction, alarm reduction, mobility, and falls management programs.
- Showcase successes and improved resident outcomes to increase staff buy-in.

Frontline staff not empowered to give information about a fall or resident

- Train staff.
- Ask for their input and show them how their knowledge can prevent falls. Value their opinion and knowledge of the resident. Stress that they know the resident best.

- Model how to think critically in a huddle. Ask the right questions.
- Get frontline staff involved in RCA.
- Close the loop. Let them know when their information about a fall or resident resulted in a good outcome.

Difficulty getting buy-in from staff

- Arrange a competition between different halls to determine which hall can reduce falls by the largest number.
- Use a phrase like, “Your Aide is Your Quarterback,” to show the value of feedback and that input from a person working on the frontline made a difference

Frontline staff not at the PIP team meeting and unaware of recent changes in care strategies

- One team member is responsible for taking minutes at each PIP team meeting. Share minutes at unit and facility meetings to let all staff know the outcomes of the discussion, any changes, and all new interventions.
- Communicate content from the PIP Team in shift huddles.

Amount of time needed to start new methods such as a post-falls huddle or completing a new post-fall report

- Be consistent in using these programs. It takes time to make this part of the new routine.
- Model the use of new methods.
- Use a dummy and an attached fall scenario as a way to train staff on the unit during a shift. Using the simulated falls scenario, instruct staff to conduct a post-fall huddle and RCA to practice good critical thinking skills.

Family push back on alarm reduction

- Educate families in the first three days after resident admission on policies and programs to reduce antipsychotic medications, reduce alarm use, and manage falls.
- Educate the family before an incident occurs when families are more open and receptive to listening. This prevents defensiveness if an event occurs because the family understood facility policy beforehand.
- Conduct a family night education program. Place an alarm on a family member during the education (keeping it fun, not punitive) to get the point across about how restrictive and frightening an alarm can be for a resident.

Staff on one shift blaming another shift when a fall occurs

- Implement a checklist for the CNA to complete at the end of each shift to document the resident's status. This reduces blaming.

Orthostatic hypotension occurring during participation in Wii gaming

- Monitor the resident for orthostatic hypotension and take precautions during participation.

Aides not always comfortable being asked to assist with walking or other aspects of promoting mobility

- Conduct targeted training and group staff education using consistent messaging.
- Assign a point person or clinical champion for questions along the way.

Challenge of changing culture to focus on mobility

- Shift from residents staying in wheelchairs in rooms alone during mornings and evenings to residents participating in more activities, participating in movement times, and being more engaged.
- It takes strong, consistent leadership, consistent messaging, modeling, and making change positive and fun with contests between halls and recognition.
- Strong leadership engagement should include the administrator, director of nursing, and medical director.

Aides thinking there would be no time to integrate mobility into daily schedule

- Assistance from restorative aides helps to share tasks during activities of daily living.
- Use all nursing home staff for Walk to Dine program spreads out responsibility.
- Reallocate staff to work during times when more staff is needed such as late afternoon.

Difficulty keeping bed height in correct setting or correct equipment with the resident

- Color code resident's items with colored or patterned duct tape.
- Place tape on the wall next to the bed for a visual cue to set the correct height.

Old buildings that do not allow for ease of movement in rooms or in common areas

- Apply for civil money penalty grants to purchase equipment or to improve spaces. (<http://www.ltcenthance.com/>)

Lack of resources to purchase additional seating or individualized options for positioning

- Use a business case for purchasing positioning equipment. (<http://www.ccmemedicare.org/default.aspx?pn=ClinicalTopicResources>)
- Get leadership buy-in for these purchases by showing improved outcomes of individual residents. For example, showcase a reduction in falls following improved changes to the bed and wheelchair.



**100 Regency Forest Drive, Suite 200, Cary, NC 27518
800-682-2650**

**246 Stoneridge Drive, Suite 200, Columbia, SC 29210
800-922-3089**

www.ccmemedicare.org