Quick tips
Taking Off Alarms and Supporting Safe Mobility

There has never been more support for re-thinking alarm use. There was a time that if a resident was determined to be at risk for falling an alarm was automatically put on. Now there is a realization that in many cases an alarm actually may cause the fall you are looking to avoid and as a result many homes have eliminated their use altogether. In fact, the survey guidelines now say about alarms:

- **Accidents: GUIDANCE §***483.25(***d***)* Facilities often implement position change alarms as a fall prevention strategy or in response to a resident fall. The alarms are designed to alert staff that the resident has changed position, increasing the risk for falling. However, the efficacy of alarms to prevent falls has not been proven and a study of hospitalized patients concluded these devices may only alert staff that a fall has already occurred. The same study also noted false alarms are a common problem leading to "alarm fatigue," where staff no longer respond to the sound of an alarm. A study on bed-exit alarms concluded the alarms are not a substitute for staff assisting residents and bed- exit alarms may not always function reliably for residents who weigh less than 100 pounds or who are restless. Individual facility efforts to reduce use of alarms have shown falls actually decrease when alarms are eliminated, and replaced with other interventions such as purposeful checks to proactively address resident needs, adjusting staff to cover times of day when most falls occur, assessing resident routines, and making individualized environmental or care changes that suit each resident. For example, brighter lighting might help a resident with macular degeneration ambulate more easily in his or her room but would cause glare and make walking more difficult for a resident with cataracts.

- **Determination of the use of position change alarms as restraints:** While position change alarms may be implemented to monitor a resident's movements, for some residents, the use of position change alarms that are audible to the resident(s) may have the unintended consequence of inhibiting freedom of movement. For example, a resident may be afraid to move to avoid setting off the alarm and creating noise that is a nuisance to the resident(s) and staff, or is embarrassing to the resident. For this resident, a position change alarm may have the potential effect of a physical restraint. Examples of negative potential or actual outcomes which may result from the use of position change alarms as a physical restraint, include:
  • *Loss of dignity;*
  • *Decreased mobility;*
  • *Bowel and bl*adder *incontinence;*
  • *Sleep disturbances due to the sound of the alarm or because the resident is afraid to move in bed thereby setting off the alarm; and*
  • *Confusion, fear, agitation, anxiety, or irritation in response to the sound of the alarm as residents may mistake the alarm as a warning or as something they need to get away from.*

Cathie Brady & Barbara Frank
Cbrady01@snet.net & bfrank1020@aol.com
www.BandFConsultingInc.com

Surveyors are now being given guidance to carefully evaluate the use of alarms. If you want to rethink your position and join the ranks of alarm free homes there are several ways to go about it that work. The best way involves carefully individualizing the care needed and informing and involving everyone in your building as well as families. We suggest starting small and in the easiest place. Have a plan, and stick to it.

Focus on three areas to promote safe mobility to reduce alarms and falls:

1. **Address risks:** Know how each person functions in their environment and identify external and internal risks. Consistently assigned CNAs' insights and observations related to fall risk are important contributions to the process.

2. **Individualize care:** Know each person's customary routines to anticipate and be proactive in meeting their needs. Use adaptive devices and mobility aids to maximize safe mobility. Base interventions on thoughtful, skilled assessment individualized to each person's risks, strengths, and circumstances.

3. **Build mobility into daily routines:** Standing for a few extra seconds and walking a few extra steps increase core strength, endurance and balance. Decrease use of wheel chairs when residents can walk. Add sitting areas that provide opportunities to rest along the way as needed.

Consider the following as key ingredients for successful elimination of alarms:

- Consistent staffing so that staff know residents well and work well with each other
- Daily meetings on the unit where you are changing practice to discuss what staff are doing, learning, and needing
- Consistent communication across shifts to share information, ideas, and experiences
- Interdepartmental communication so that all who are on the floor can be knowledgeable partners in the effort
- Coordination with care planning processes
- Inclusion of the physician
- Effective root cause analysis of falls and review of factors contributing to risk of falls (e.g. medications, diet, activity, footwear, etc.)
- On-going communication with resident and family throughout the process and full inclusion of their input into decision-making.

Assessment: Assess why each alarmed resident is at risk for a fall**.** Go right to the resident's room to assess their normal movement in their living space. This bed-side assessment is more useful than an assessment in the therapy room because it allows the team to see how the resident is functioning and where assistive devices are needed to maintain independent function.

Examine the site of the fall for clues and options. There are many helpful resources on fall prevention assessments that note many risk factors including, medication, environmental factors (e.g. lighting, noise, seating, footwear) and clinical factors (e.g. pain, multiple medications, nutritional status). A contributing factor is often the resident's own lack of core strength and balance.

Figure out how you want to proceed: Decide on a process for alarm reduction and meet regularly as you undertake it. Start small. Pilot test on one unit before rolling this out everywhere. Options include removing a few alarms each week starting with the easiest to remove. Start with residents who are disconnecting them themselves. If you have it in your care plan that alarms are your fall prevention intervention, and the resident is disconnecting the alarm, then you have a care plan you are not following, and that is not effective. Another good group to start with is residents who haven't fallen in a long time.

Find out what the resident needed: Find out the "antecedent" – what happened just prior to the fall. Sue Ann Guildermann, RN, from Empira, suggests asking, "*What was the resident doing just before they fell and what did the resident need that set them into motion?"* She focuses on 4 P's: *Position, Personal Needs*, *Pain*, and *Placement of Possessions*. These provide information on what a resident needed that set the resident into motion. The key is to know residents' customary routines and signals. For example, do they need to get away from loud noises? Are they in pain? Do they need help to the bathroom?

Keys to success:

- **Effective interventions address both the root cause and the resident's needs.** *The root cause of the fall combines what makes a resident at risk for a fall with the details of what a resident needed at the time of the fall.* For example, a resident may fall because she has slippery footwear or poor balance. Her reason for getting up might have been to go to the bathroom or adjust to a more comfortable position. In this case, an effective intervention provides better footwear or strengthens balance, and also uses individualized knowledge of the resident's customary routines to know the time of day she usually needs a trip to the bathroom so staff can be proactive in assisting her at that time. Note that noisy routines such as taking the garbage out at night or buffing the floor early in the morning can contribute to falls by waking residents up. Lack of staff availability at shift change, gaps in recharging the sit-to-stand machine battery, and other factors may contribute to a resident's fall. Knowing residents' rhythms of life will aid in preventing falls.

- **Use "Out of the Box" therapy.** The physical therapist, nurse and CNA function as a team to assess the residents' room and other areas where they are at risk of falling, To help residents maintain and increase their mobility, use adaptive equipment, such as assist bars positioned to support the resident's natural movements, skid strips, and seat cushions that help them stand more easily. Make changes to the residents' environment such as turning the bed around to the resident's strong side or lowering the closet bar and shelves so that items are easier to reach. Use visual cues (for example a colored toilet seat or a blue line that glows

at night and leads to the bathroom). Teach CNAs techniques that build core strength and balance in everyday transfers and walking. Explore coding evaluations, assistive devices, and therapy to determine if the cost for these interventions can be covered by insurance.

- **Partner with families.** Families have been taught that alarms prevent falls. Help families learn as you are learning about the unintended negative consequences of alarms in restricting mobility and socialization, and about the better practices that promote instead of restrict mobility. Enlist their knowledge, help, and advice and invite their participation in problem-solving. Keep them fully informed as you discover causes of falls and determine effective interventions.

- **Communication is key.** Use huddles for communication within and across shifts and with other departments so that staff can share what they are learning about residents' customary routines and needs as well as effective methods for building strength and supporting safe mobility. Tools such as **INTERACT^{II}** ***Stop and Watch*** can help staff know what changes to note that might be contributing to increased risk of falls. Note new interventions in communication books, care plans, and CNA assignment sheets.

- **Incorporate practices into the care plan**. Shift goals from preventing movement to promoting mobility. Be agile: change plans on the spot as you learn what will work best for individual residents. Document your rationale for your strategies. Know and follow residents' customary routines to anticipate when they will be getting up or needing to rest. Take a holistic approach not just a clinical approach: look at mood, behaviors, functional ability, and customary routines together to understand what a resident needs.

- **Involve medical staff.** Share your approach with your medical director and other providers so they are an educated and active part of this process. Medical Directors can take the lead in communicating the goals of mobility promotion and alarm elimination with other physicians, and with families.