Making Chair Alarms Extinct

Presented at NADONA 2013

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Agenda

• Review the federal regs
• Alarm fatigue
• Replacement strategies
• Removing alarms from beds and chairs

Chair Alarms

• A class of personal alarm devices designed to alert staff with a warning signal when a person moves in a way perceived to put them at risk, usually for a fall
• Many different types, but all with the same purpose and providing a ‘false sense of security’ that we are preventing falls

The Rise and Fall of the Use of Chair Alarms

• Replaced physical restraints in care plan process
  - In 1991, approximately 60% of residents were restrained
  - In 2011, approximately 3% of residents were restrained and it is still trending downward
  - In the late 1990’s, as restraint use decreased or eliminated, the use of monitoring devices increased
  - As alarm devices replaced restraints, we hoped they would assist in falls reduction and prevention, but without the serious side effects
Making Chair Alarms Extinct

The Rise and Fall of the Use of Chair Alarms

• But... do they work?
• Have falls decreased related to alarm use?
• How do they prevent falls?
• Why are we still using chair (and bed) alarms?
• Does the chair alarm rise to the level of a physical restraint?

Can You Justify?

• What are your reasons for an alarm that is currently in use on one of your residents?
• Describe how that is working for you?
• Describe how that is working for your resident?
• What could you do instead?
• What do your observations tell you?

When I Was a Child...

• No one wore a helmet when riding a bike
• Didn’t know what a seat belt was!
• The adults in my family all smoked in the house and workplace
• We didn’t know any better, now we do

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QUICK GLANCE AT REGULATION

**F155 Right to Refuse Medical Treatment**

- §483.10(b)(4) – The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section; and
- This would include alarms!

**F221 Restraints**

- §483.13(a) Restraints
  - The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident’s medical symptoms.
Physical Restraints Definition

- "Physical Restraints" are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.
- Does this include alarms?

Convenience Definition

- "Convenience" is defined as any action taken by the facility to control a resident's behavior or manage a resident's behavior with a lesser amount of effort by the facility and not in the resident's best interest.

F241 Dignity

- § 483.15(a) – Dignity
  - The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.
F248 Accommodation of Needs

- A resident has the right to — §483.15(e)(1) — Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered; and
- The facility’s physical environment and staff behaviors should be directed toward assisting the resident in maintaining and/or achieving independent functioning, dignity, and well-being to the extent possible in accordance with the resident’s own needs and preferences.

F252 Environment

- §483.15(h)(1) – A safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible;
- A “homelike environment” is one that de-emphasizes the institutional character of the setting, to the extent possible, and allows the resident to use those personal belongings that support a homelike environment.

F252 ‘Homelike’ Environment

- Some good practices that serve to decrease the institutional character of the environment include the elimination of:
  - The widespread and long-term use of audible (to the resident) chair and bed alarms, instead of their limited use for selected residents for diagnostic purposes or according to their care planned needs
  - These devices can startle the resident and constrain the resident from normal repositioning movements, which can be problematic

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Resident Assessment and Care Plan

- F272 Resident Assessment
- F279 Comprehensive Care Plan
- F353 Sufficient Staff

F309 Quality of Care

- Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care
- Also review
  - F315 Continence
  - F323 Accidents

Possible Substandard Quality of Care (SQC)

- F level deficiency in any quality of care, quality of life, or resident behavior grouping
- Alarm use is widespread problem
- No actual harm
- Potential for more than minimal harm that is not an IJ

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Evidence of Justification for Use of Alarms

- There isn’t any to support the usefulness of chair alarms in preventing falls and injuries

  Falls continue to occur

The Back Story on Chair Alarms

- Serious ramifications have been documented
- Personal alarms are alerting devices not prevention devices
- Empira, in MN, was able to link time of falls to noise levels and determined that there is significant ‘noise contribution’ to falls. (Sue Ann Guilderman, RN, BA, MA)
- Embracing person-centered care ensures you know your residents needs (so why do you need an alarm!)

Alarm Fatigue Anyone?!!
Observe Patient Responses to Alarms

- Learned alarm avoidance
- Ingrained alarm response
- Agitation
- Afraid to reposition
- Potential for deterioration in overall condition
- Embarrassment
- May act as a passive restraint
- “Behavioral symptoms”

Observe Staff Responses to Alarms

- “Sit down!”
- Irritation with noise that may be perceived to be irritation with the resident
- Irritation with resident
- Failure to ascertain what the resident needed
- Four P’s:
  - Position
  - Personal Needs
  - Pain
  - Placement

Investigating Unassisted Transfers

- Root cause analysis
- What is the resident trying to accomplish
- What are the resident’s usual habits related to unassisted transfers
- Consider:
  - Toileting
  - Fatigue
  - Curiosity
  - Discomfort
  - Repositioning
  - Different activity
Fall Assessments

- Which of your residents is at risk for sustaining a fall?
- Why? (Specific risk factors)
- What interventions did you select?
  - Why?
  - Directed at risk level or their personal risk factors?

Investigating Falls

- Root cause analysis
- Why did the resident fall?
- What was the resident doing just prior to fall?
- What did the resident need?
- Was their an alarm going off?
  - Why? – Movement?
- QA + PI techniques

Our ability to change is limited only by the script in our heads and the fear in our hearts

My friend and colleague, Lou Burgess

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Methods of Change

• One unit
• Selected residents
• New patients
• Cold turkey

Approaches to Elimination

• Establish timeframes
• Goals
• PDSA: plan, do, study, act

Plan

• Review your statistics:
  - Quality measures
  - Falls and interventions
  - Improvement or lack of improvement with chair alarm use
  - Correlation between falls and noise levels in the facility and time of day
• Engage staff
• Engage residents and/or significant others

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Plan

- Design alternate strategies with staff
- Educate and elicit ‘buy-in’ from staff
- Educate residents and families
- Test to make sure you’ve covered the bases
  - Make sure you know how you will implement
  - Progress intervals (1 shift, 1 day, etc)
  - Acuity staffing
  - Implement alternate strategies

Strategies to Consider Implementing

- Rounding techniques
- Creating communication tool for special needs
- Patient preferences and habits
- Know medication regimen
- Prompted toileting versus habit toileting
- Checklist for making sure resident has all their devices in easy reach
- Boredom relief

Strategies to Consider Implementing

- Differentiate your strategies for:
  - Short-Stay patients with acute and post acute conditions
  - Long-term patients with acute and chronic diseases
  - Dementia patients
  - Staff training and sensitization practices
**Do**
- Implement with your specified time interval
- Fix any 'bugs' that will inevitably pop up

**Study**
- After implementation has proceeded and been adopted by staff
- Re-monitor to determine impact:
  - Falls
  - Noise levels
  - Behaviors
  - Incontinence
  - Pain
  - ADL declines
  - Activities

**Act**
- Incorporate QAPI techniques in an ongoing way and update your strategies as needed

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Are You Ready?

- Changing perspectives
- Give staff the support and encouragement they need to accomplish this change
- Continue to involve management in the process
- Share your success stories!

Presented By:

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