

OHIO PERSON CENTERED CARE COALITION TELECONFERENCE
Reducing the Use of Alarms in the Nursing Home
November 6, 2007 1:00 - 3:00 p.m.

We're going to go ahead and get started at this time. Before we go any further, let me introduce myself. Most of you know me as a project leader on the nursing home team at Ohio KePRO. Today, however, I'm pleased to be representing the Ohio Person Centered Care Coalition and I will be moderating today's teleconference. So on behalf of the coalition, I would like to extend a warm welcome to each of you on the call, and let you know how excited the coalition is to be bringing you our first-ever educational teleconference.

Before we get started, I need to point out that we have 125 open phone lines on this call with over 500 people listening in and we want today's call to be the best experience for everybody, so with that in mind, we'd like to go over just a couple of housekeeping rules. If everybody would pay special attention for the next two minutes, I want to go over some of those housekeeping rules.

First, do not place your phone line on hold. If you do put your phone line on hold, all 500 of us will be able hear your "on hold" message until you return to the line. Needless to say, if this happens, it will disrupt our teleconference. If you feel that you must take another phone call while we are on today's conference, please be courteous and take the other phone call on a different telephone.

Secondly, we must ask each of you to mute your own phone lines. With this many people on one call, we really need to work hard to minimize any and all background noises. There is nothing more distracting for other callers and for the speakers than to hear such things as people talking in the background, overhead pages going off, telephones ringing, toilets flushing, dogs barking, babies crying or noises from video games or construction workers. If you have ever been on a teleconference with these kinds of noises in the background, you can certainly appreciate how important it is to mute your phone lines.

S1: Leasa? Excuse me just one minute. If Linda Smith or Dr. Savrin are on this line, please check your e-mail and go to the other line. Thank you.

LN: If your telephone has a mute button, then use your telephone's mute feature to mute your line or you can press "star, 6, star" to mute your line. Again, it is very important for everybody to do that because of the background noises that we are all hearing. Again, the instruction to mute your phone is to press "star, 6, star". I'll give everybody a few seconds to do that.



So if we do have any background noises as we continue through the call, I will interrupt our speakers and ask everybody to just double check and be sure that they are, in fact, muted, so we can have a good teleconference.

Before we introduce our topic and first speaker, I'd like to give a brief overview of the Ohio Person Centered Care Coalition for those of you who may not be familiar with the organization. The coalition formed over two years ago and has been meeting regularly over that time. In these two years, the group has sponsored two annual conferences, with over 300 people in attendance at this year's conference.

The mission of the coalition is to influence and support transformational culture changes in the long-term care environments, especially recognizing that every person has the ability to express preferences and to make choices and that a person's choices and preferences should always be considered. And finally, the coalition has been taking steps to become a formal entity, structured as a non-profit organization. If you would like to become a part of this dynamic and growing group, please feel free to join as a member on the coalition web site which is www.centeredcare.org. That's C-E-N-T-E-R-E-D-C-A-R-E dot O-R-G.

It sounds like someone has put our conference on hold so hopefully we will only hear music for just a minute. As I mentioned, this is the coalition's first-ever educational teleconference and since it is a first, we are very interested in getting some feedback about the call. We are asking then that you return to the coalition's web page after the call today and fill out an evaluation. All input about the call will be considered as the coalition plans future educational events. I will give a reminder about the evaluation at the end of the question and answer session. Also, please be aware that we will be making a written transcript of this call available on the coalition's web site. It will be posted later this month.

The title for today's teleconference is "reducing the use of alarms in nursing homes." This topic always brings up a few important questions: First, how effective are they? Does the use of bed or chair alarms actually prevent falls for our nursing home residents or do they just alert us that somebody is on the floor already? And secondly, do alarms cause unnecessary agitation and confusion for some of our residents and do they also make extra work for the staff? And do they make just too much environmental noise, considering that many nursing homes are trying to become less institutional?

Over the first hour of today's call, you'll be hearing from Carla Brumby and Diana Waugh about federal and state regulations that pertain to falls in the nursing home as well as some interventions that you can use to put into place to prevent recurring falls in your residents. And for the second hour, you'll hear from three different nursing homes that have found alarms were really not working to prevent falls and subsequently



eliminated their use. You'll be hearing about successful alternative measures they have put into place. I will introduce each speaker just before they are given the floor. Please save all of your questions for the final fifteen minutes of the call. I will let you know when the question and answer portion of the call will begin.

And now I'd like to introduce our first speaker. Carla Brumby is the Bureau Chief for the Division of Regulatory Compliance of the Ohio Department of Health. Many of you know Carla from your state surveys. She will be speaking about the regulations pertaining to falls and fall prevention. The coalition is very pleased to have Carla available to offer some guidance as to how to stay within the regulations as we make some person-centered changes in the way we care for our residents. Carla, would you like to go ahead?

CB: Thank you for having me today. As you all know, I am the chief for the Bureau of Long Term Care Quality and I would like to welcome you all to this conference call. You are well aware that there is no regulation that indicates each resident shall have an alarm. However, there are several regulations that do speak to the use of alarms in nursing homes. The main regulation that I am going to talk about today is data tag F323. Data tags F323 and F324 were collapsed into one regulation I believe in either July or August of this year. The regulation at F323 states that the facility must ensure that the resident's environment remains as free of accident hazards as is possible and each resident should receive adequate supervision and assistance devices to prevent accidents. The intent of the regulation is to ensure that facilities provide an environment free from hazards over which the facility has control and to provide supervision and assistance devices to each resident to prevent avoidable accidents.

In order to meet the intent of the regulation, there are several definitions that we must go through and discuss. The first one is the definition of the word "accident". CMS has defined an "accident" as an unexpected or unintended incident which may result in injury or illness and is not an adverse act outcome directly related to treatment and care, such as a side effect from some adverse drug reaction. CMS has also distinguished between "avoidable accidents" and "unavoidable accidents." An avoidable accident means that an accident occurred because the facility failed to: 1) identify environmental hazards or individual resident's risk of an accident; 2) provide necessary supervision to prevent the accident; 3) evaluate or analyze the hazard or the risk; 4) assess or implement interventions to prevent the accident; 5) monitor the effectiveness of the interventions; and/or 6) modify the interventions as necessary and follow current standards of practice. An "unavoidable accident" means an accident occurred despite the facility's effort to identify the risk, to analyze the risk, to implement their intervention, and to modify the interventions as necessary.



Although the regulations refer to "assistive device", CMS uses the term "assistive devices" interchangeably. So the regulation itself will say "assistance devices" but the guidelines refer to "assistive devices." A list of assistive devices includes, but is not limited to handrails, grab bars, transfer lifts, canes, and wheelchairs. Alarms are not even mentioned as an assistive device in the guidelines until you get into the falls portion. Other definitions that you must keep in your mind are the definition of "environment" which refers to the "resident's environment." The resident's environment is the physical surroundings to which the resident has access. That could be the room, the unit, any common areas, and the facility grounds. It is anywhere within the facility that the resident may have access. "Hazards" refer to the elements of the resident's environment that have the potential to cause the injury or illness. A "hazard over which the facility has control" are those hazards in the resident environment where reasonable efforts by the facility can influence the risk of resulting in injury or illness. So "free of accident hazards as possible" refers to being free of accident hazards over which the facility has control. "Risk" refers to any external factor or characteristic of an individual resident that influences the likelihood of an accident.

Facilities are obligated to provide adequate supervision to prevent accidents. "Adequate supervision" is defined by the type and frequency of supervision based on the individual resident's assessed needs and identified hazards in the resident's environment. Adequate supervision can vary from resident to resident and also from time to time for the same resident. Facilities may identify hazards and risks through these types of activities: 1) quality assurance activities; 2) environmental rounds; 3) MDS and the RAP data; 4) medical history and physical exams; and 5) individual observation. Once the hazards or risks are identified, facilities must evaluate potential causes for each of the hazards or risks and develop interventions to reduce the potential for accidents. Once the interventions are in place, facilities must implement their interventions, monitor to assure that the interventions are implemented correctly and consistently, modify and replace any intervention as needed, and evaluate the effectiveness of any new intervention. The use of personal alarms can help monitor a resident's activities but they do not eliminate the need for staff vigilance and are not to be utilized in lieu of supervision.

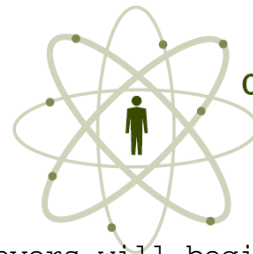
As stated earlier, supervision is an intervention and a means of mitigating accident risk. Adequate supervision is different from resident to resident and varies depending on the time of day. Resident falls may be due to environmental hazards as well as the resident's underlying disease processes, medication side effects and other individual risk factors such as lower extremity weakness, balance disorders, grip strength, and cognitive impairment.



The falls definition is the same as the definition found in the MDS user's manual. Falls are defined as unintentionally coming to rest on the ground, floor or other lower level, but not as a result of overwhelming external force. An episode of where a resident loses his or her balance and would have fallen, if not for staff intervention, is considered a fall. A fall without injury is still a fall. Proper actions by the facility following a fall include: 1) assessing for injuries and providing any necessary treatments; 2) looking at all of the factors that may have caused or contributed to the fall; 3) addressing factors that may have caused or contributed to the fall; 4) revising the resident's plan of care; and/or 5) changing the facility practice to reduce the likelihood of another fall. During a survey, surveyors will determine whether the facility identified hazards in their environment and whether they identified resident risks posed by those hazards. They will determine whether a resident's accident was avoidable or unavoidable. Surveyors must also determine whether the facility provided a safe environment and whether the facility provided adequate supervision and assistive devices to prevent an avoidable accident. If a resident is assessed as being at risk for falls, surveyors will determine if the facility provided the care and services, including assistive devices to prevent that avoidable accident and whether, again, proper and adequate supervision was provided. Surveyors will observe the type of assistive devices that are used in the facility. They will observe staff response to the resident's call for help will also observe the resident's and the staff's response to alarms.

In addition to observation, surveyors will interview residents and resident's family regarding the staff intervention. They will ask staff about the assistive devices that are being used. They will interview residents and the resident's family about the staff's response to the assistive devices. So if you are using alarms, surveyors will also interview facility staff, mainly your nurse aides, about the resident risk factors, whether they have been identified and whether the aides are familiar with those risk factors. They will also ask them about the interventions that are on the care plans and about the training they received on the type of assistive device being used by the facility. Surveyors will conduct a record review where they will review the RAI and other documents such as the progress notes, physicians' orders, nurses' notes and consulting notes. Surveyors will be concentrating on the assessment and whether the facility's assessment is consistent with what is reflected in their observation of the resident, such as hearing, vision and sensory impairment, diagnosis of dementia or Alzheimer's, medication use and history of falls.

Also during the record review, surveyors will review the plan of care. If the resident has had an accident, they are going to look at what changes the facility has had to the plan of care and they are going to see if the facility investigated the cause of the accident, and implemented interventions to avoid further avoidable accidents. If any of the sampled

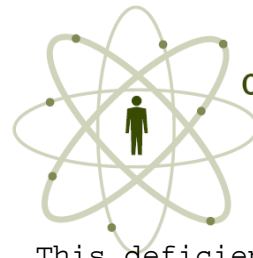


residents have a history of accidents, surveyors will begin to look into the facility practices or facility systems. Surveyors will begin to review policies and procedures, review staffing levels, look at past screenings, and interview your nursing supervisors to see how they identify risks and what systems are in place to prevent accidents.

LN: This is Leasa and I am going to interrupt you for just a moment. I am going to ask all of the callers to double check your phone lines and please make sure that you are muted. You can either use the mute function on your telephone or you can dial "star, 6, star" to mute your line. Can everyone please double-check that? Go ahead Carla.

CB: Okay. Once the surveyors have determined through their investigation that there may be a problem, they must determine whether or not the facility is in compliance with data tag, F323. Here it is very important for people to remember that not all accidents in a facility, regardless of the outcome of the resident, are necessarily due to a facility's non-compliance. A resident can sustain bodily injury as a result of an accident for which the facility had no control. In that case the surveyors would determine that it was an "unavoidable accident" and that the facility was in compliance with this regulation. Additionally, in order to determine that the accident was unavoidable, the facility's staff must be trained on the application and the use of assistive devices and equipment must be maintained in accordance with manufacturer's recommendations. So to determine compliance for a resident who has had an accident, the facility must identify the hazard, evaluate the hazards and the risks, implement the intervention, provide the assistive devices, provide the adequate supervision, monitor the effectiveness of the supervision and if needed, modify the interventions as necessary.

During the investigation, surveyors may have identified concerns related to other regulations, besides F323. Some examples of regulations that could affect supervision to prevent accidents are: 1) F272, resident's risk factors must be assessed; 2) F279, there must be a plan of care that will mitigate those risk factors; 3) when the care plan is not effective F280 will be reviewed to ensure there have been care plan revisions; 4) F281 will ensure that the plan of care is being implemented according to professional standards; 5) surveyors will review F353 to ensure there is sufficient staff to provide adequate supervision; and quality assessment and quality assurance will be reviewed at data tag F520. If and when the surveyors determine non-compliance at F323, the next step in the process is to determine the severity of the deficient practice. The severity of the deficient practice is based upon the presence of harm or potential for harm to the residents. The very first severity level that is ruled out by a survey team, of course, is severity level 4, which is an immediate jeopardy. An example of a severity level 4, immediate jeopardy may be a fall that results in a subdural hemorrhage or a fracture that requires surgical intervention and results in a significant decline in mental and/or physical functioning of a resident. Severity level 4 is the



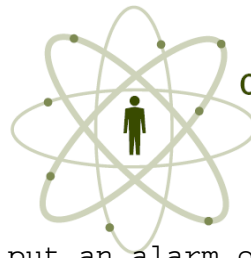
highest level of severity for an individual. This deficient practice must be corrected as soon as possible. Once a level 4 is eliminated, surveyors must determine whether or not a level 3 deficient practice has occurred. A level 3 is actual harm that is not immediate jeopardy. An example of this may be a fracture that required a surgical intervention but it did not result in a decrease in mental and/or physical functioning. Level 3 may be a fall that results in a treatment beyond first aid such as sutures. If a resident has a fall that has no actual harm, then surveyors would consider a level 2 deficient practice. A level 2 is a non-compliance which resulted in minimal discomfort to the resident, such as bruising or minor skin abrasions or pain that did not impair normal activities. CMS has determined that a fall can never ever result in a severity level 1 which is no harm or no potential for harm to a resident. Therefore, you will never see a severity level 1 deficiency or an A, B, or C deficiency regarding falls. We have reviewed data tag F323, the survey process, determination of compliance/non-compliance and severity of the deficient practice. I believe questions will be addressed at the end of the presentations.

LN: That's right, hold questions until the end of the call. Thank you Carla. It is always important to go back and look at the regulations and re-examine the interpretive guidelines before you make any changes to your policies. One of the important things that I think you brought up, Carla, was that alarms should not be used in lieu of staff supervision. It is always helpful to go back and look at those regulations. Thank you again for your informative presentation. We are going to go on with our next speaker now and I will introduce Diana Waugh. Diana Waugh has worked in long-term care for many years as a nurse consultant, researcher, and as a national speaker. She is very well known across the country for her work in reducing restraints and we are pleased to have her on the call to discuss fall prevention. Diana, you've got the floor for the next half hour.

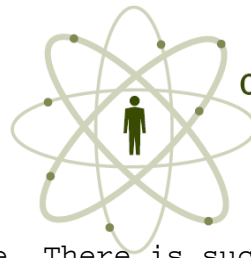
DW: Thanks Leasa. And I just want to say thanks for the folks who organized this. Amanda, you did a marvelous job. Leasa, this is a yeoman's task and what an important thing this is. Now, I heard some people ask as we began, "were there handouts" and I heard that we are going to be recording this and you will be able to pick up our words of advice on the Internet. The truth of the matter is, you don't need handouts. You see, we've been at this point before. We were at this very, very juncture 15, 20 years ago. What am I talking about? Well, anybody as old as me, and there aren't many of them left, will remember the days when we tied everyone up because we wanted to keep them from falling. Then we thought the federal government said we couldn't use restraints so we blamed them and we tried to get rid of restraints. So we've been through all of this once before. I guess my plea people, is let's not do it again. Let's look at where we stumbled trying to reduce restraints and those of you who know me know I'm pretty opinionated so you are going to get my opinions. Here's what happened. The federal government never said



we couldn't use restraints. Just as Carla has told us she is not saying, don't use alarms but by the time she got done with all the stuff I'm supposed to do, it's just too much work. The government is not saying, "don't use alarms", so please, please, please don't blame them. It is not a matter of blame, it's a matter of why and I guess, I hope that we can see this time around, our driver has got to be the resident. We're are sitting in a beautiful spot now because of all the resident centered, all the culture change, all the person centered, whatever words we want to use but what we're actually saying is let's start treating people like people. Okay? And that's what we said when we got rid of restraints but we got a little confused. And so what we did was we replaced one device for another. And the first thing I want to ask of you, from a challenge standpoint, is I want you to begin to track. Until you realize how many alarms you have, it is real hard to decide maybe you really don't want them. So I want you to begin to track the number of alarms you have in your building. When we began getting rid of restraints, nationally we were sitting at about 50%. About half of our folks were tied up, okay? And the federal government thought that was bad because we should have thought it was bad and we missed it. But at any rate, the federal government said "no, no, no" or so we thought and so we began to reduce them. I am going to submit to you that as I check this and I am the only person in the country looking at the percentage of alarms, because CMS doesn't ask it, it is not one of the survey questions, it is not on the MDS, so we are going to have to be proactive and begin to ask that question. It is running between 70 and 75% in many buildings. Wow! It's way above where we were with restraints. So what we did is we stopped tying folks up and we got confused and we thought that they wanted to buzz. I don't know about you but I'm really not interested in buzzing and I am going to spend a little time talking about what alarms I believe do to the resident. Not to us, we talk about are they effective and we know they're not but we thought surveyors wanted them and we just heard Carla say it won't probably fly if it's the thing you're doing for the surveyors, but we thought we were covered because we did something! We forgot to look at the fact that in America, bodily noises are not acceptable. Okay? Tried that out last night, stopped at *Cracker Barrel*, had a great meal, thought I was in Italy, burped real loud because that's what they do in Italy to say "thank you" and they asked if I could possibly leave the restaurant. Bodily noises just are not acceptable here. So why is it that we decided that at some age, bodily noises were going to be seen as a useful device? It came to me last November. Actually, I've hated alarms for a very long time because I felt they were inhumane and I knew they didn't work, I get that message all the time. And we're going to talk about that a little bit later on. When Carla starts talking about asking the staff if they work, that could get us into all kinds of trouble because the nursing assistants will say "of course they don't but I was told I had to put them back on." But at any rate, so I was thinking about the whole issue of alarms and this is not just an Ohio issue but I am so proud of us for doing this teleconference and really getting a look at this head on. But I was in another state and

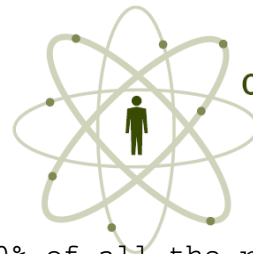


they told me that they have a lady and they put an alarm on her and she cries all the time now and it was one of those ones that has a remote voice where we actually make the family the scapegoat in hollering at the resident, but anyway the resident started getting depressed. And they said "why are you depressed" and guys I want you to listen with your heart. Listen with your person centered care heart. Listen with your culture change heart. Listen with your own heart because this could be you. Not your mom, but you. Resident said. "I don't understand it. I can hear that my daughter is in the building but I don't understand why she won't come see me". I heard that and it really upset me. And then I was in another state and I began to ask the question about what percentage of alarms were in place and the numbers started coming up so huge and a particular facility said "we are a 200-bed facility. We have 100 of those pieces of equipment" that I lovingly call remote screamers. One hundred. This is an industry that says we have no money. But look at it. They're \$400 apiece times - oooh! I said to her, "you personally have got to take responsibility for getting rid of these" and she said, "well let me tell you the message." She began to quote for me the marketing message that they leave on the alarms. Now this is December 2006. This is not dark history stuff. In May of this year I was in the New England states and I was saying I was certainly glad you don't do it here in Vermont. And the gentleman said we might not do it here in Vermont but I just moved here from New Hampshire and they are leaving the marketing message on the remote screamers there too. My sense is that if you do not begin to really see how very, very negative the use of alarms are, you are not going to be able to get rid of them and if you do, you will simply replace them with another device. It is not a matter of device. I think what we heard Carla tell us as she went through the regulation. That regulation, and by the way, Leasa maybe we can give them the reference so they can get the slides that Carla was going through because those are very, very helpful on F-tag 323. But if you read through there, and Carla hit it beautifully, what they are saying is, in all those pages, is it is no longer acceptable nor was it ever acceptable, for us to throw up our hands and go "look we're doing everything we can do". And as long as we stick to devices, we will always get short-circuited. There are only probably 10 useless devices that are out there and if we continue to use those, we are going to get stymied which is exactly where we are sitting right now with restraints. These are psychological restraints. That's how I see them. Because we should be looking at everything from the resident's perspective. All right. So I want to just beseech you, please, please, please. We are now in this country, allowed to treat elderly people worse than we are allowed to treat -- allowed to treat -- terror suspects in places like Guantanamo Bay and that prison, Abu Ghraib. That picture of that lady taking that gentleman for a walk was all psychological intimidation. And I know in my heart they didn't sign up to play that game. Okay? So, let's see if we can now move forward from that point. Carla said some wonderful things that got me all excited. I got all excited when I read it and I'm getting all excited listening to her say it. Here's words that she used. Reasonable. As possible. Not all



accidents are due to facility non-compliance. There is such a thing as an unavoidable accident. Guys this really gives us support to be able to show our mettle. The other thing that I heard Carla say that I'm in love with is this, if there is a need for modification. What I've heard for many, many years is the surveyors are saying "well if a person falls, you must come up with a new intervention." What Carla is saying is it's got to be based on what you found out with the resident. Maybe this particular fall was when the facility dog ran through - oh, that would be our fault because it's our dog. What about when the neighbor's dog runs through and knocks the resident down? Okay? Then should we really put them in a wheelchair and put an alarm on them. It makes no sense and I see us doing that. Making a modification that makes no sense, simply to be making a modification. So I get excited when I hear Carla saying, and you know, if Carla is saying it, it must be very important. Another word she used was mitigate. She used the word prevent as she began her conversation and that's how the law is written. But I heard her use the word "mitigate". In other words, fix it as much as you can. Fix it as much as you can. Be aware of what's going on, be able to speak to it. We'll talk to that as we go along.

One of the major issues, I think, with our whole falls prevention program is exactly the same one we had with the restraint freedom program and it's the same one we have in the behavior management program. The good news is that if we get this figured out, we're going to fix all these things at the same time. And that is, we are not looking at the resident's cognitive and functional ability. I want to spend a little time on this because without knowing this, we blow it. And we blow it like this. We ask a resident to take responsibility for their own actions at a level they can no longer understand or accomplish. We say to them, "Sit here, I'll be back in an hour". They say okay because they want to be compliant, if they're verbal but the idea that what they just agreed to goes out of their head in approximately two minutes. We know that folks with cognitive loss, generally speaking, have about a five-minute window to remember. Yet when they stand up 45 minutes from now, we go "didn't you remember? I told you to sit" and we holler at them. I know we don't raise our voice but it's the "what you're doing is wrong message" which makes them feel bad. Interesting to note, some day we ought to do some research on that. Folks with cognitive loss who can't remember good stuff sure can remember bad stuff. And I'm sure you're all shaking your heads. If you make the mistake of putting them down. "Sit down. Sit down. Sit down. Sit down. Sit down. Sit down. Sit down. Sit down." They will remember how it felt. They won't remember that they had originally agreed that they would not stand up. So it is my contention that until we begin to focus on cognitive levels, we are going to continue to miss our mark. You've got the data in your hands, however. So let's look at the data you already have in your hands. Don't believe a word I'm saying but when this is all over, I want you to go to your MDS person and I want you to run this report. I want you to run B2 A=1, short-term memory loss and/or B4 problems making decisions, greater than zero. I am going to bet you the

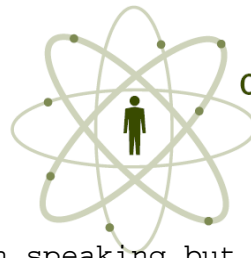


national number on that is between 75 and 80% of all the residents in long-term care facilities and we're not even talking about assisted living at this point, are ticking really high on cognitive loss. I'll bet your boots you do not have any one issue, like CHF, that affects as many residents as cognitive loss affects. Parkinson's, post-CVA, COPD all of these syndromes, symptoms and diseases that we deal with and there is not one that affects as many residents as cognitive loss affects. Yet we forget we have got to look at that as our major overlier. I doubt that you have a lot of alert, oriented residents alarmed. Sometimes I wish we could alarm the administrator. Then we could know when they were coming down the --- well anyway, that's another story altogether. But you are not alarming alert, oriented folks. You're alarming folks with cognitive impairment and we don't understand and we are not focusing on the whole issue of cognitive impairment. Okay? You've got to know it. There are two and I believe we can sure get them the reference if they're looking for this. There are two tests that I'm familiar with that are both standardized. They've both been researched, they've both been validated and all this other work that you need to do. One has been around about 20 years and it's Allen Cognitive Level. It's going to come to you through your occupational therapy department. You'll have to put it down there. Actually we're very fortunate here in Ohio, we happen to have one of the main trainers for that program in our state and could help us. Actually, Claudia Allen is in town in Ohio this weekend, working on the Allen Battery type of thing. Very important. It will tell you between six months of age and infinity how they're perceiving the information you give them which is where many of our interventions fail to meet their needs. Because we're giving them interventions beyond their ability to comprehend. The other is the Reality Comprehension Clock Test. That's been around about 10, 12 years now. I think they're equally good. It will also tell you between four and a half years and eight years perception and I can now level. The good news with either of those tests is it will also give you the information you need for the activities, the new activity guideline that says activities have to be selected at which the resident can succeed. It doesn't say take them to bingo so they can sleep while someone else plays the card for them. It says at which they can succeed and it's hard to know that unless I actually know their cognitive functional age. Assessment, assessment, assessment. I must understand how they understand what I tell them. One of the things that Carla said, and I almost laughed out loud. Well, I did laugh out loud but I was muted so you couldn't hear me and that was if the resident is at risk for falls, okay? Well what I would suggest you do is run that assessment on your staff first and you are going to find you're 100% at risk for falls in your staff. At that point I am not even talking about your residents yet. Falling is a part of nature. One of the things that we have done in the nursing home group/industry/service center, whatever we call ourselves, is somehow we've agreed that we can manage things that God is having trouble with and that is keeping everybody from falling. I think we look at the fact that every single one of them, I'm talking residents now, not staff having risk for falls. But if I'm really going to look at them as a

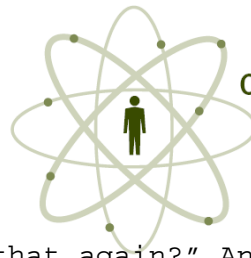


person and the interventions that I want to put in place really look at them as people, I'm not really doing it to keep them from falling, I'm doing it to keep them happy, engaged, involved, all that kind of thing. Okay? Well for all that as a background, it is interesting we're trying to do in an hour here what you can spend days and days and days but maybe if we can whet your interest enough maybe we can keep working with it because we're excited that you're excited. And I want to thank each and every one of you for joining this call. By the way, I forgot to say that up front and that wasn't nice of me. Okay, let's look at interventions. I've got to say it again what Carla said to us is that it is no longer acceptable, nor was it ever, to throw up our hands and say we've done everything we can, we don't know what else to do. Our problem is we said that because we were looking at external things to solve an internal motivation. So the first thing I want you to do is to really work with your staff and talk this over. Okay? Where does the answer to falls mitigation really lie? Is it in your ability to buy more devices or is it in your ability to look inside the resident's reality? Whatever the resident's reality is, is reality and I can think of the one interesting situation that we had. When you start doing this, it becomes so easy down the road. It's tough to get our heads wrapped around it but once our heads are wrapped around it, it's really interesting. We had a resident who was always, always getting up in the middle of the night. Her reason for getting up in the middle of the night was the dog needed to be let out. Remember we're dealing with people with cognitive loss and for some reason, whether it was the noise of the facility and I know in your place is probably all silent, but ours tended to be noisy. Whether it was the noise in the facility, something was triggering her that it was time to let the dog out. So she was getting up, getting up, getting up. So her intervention was we got a stuffed dog, this was a long time ago and we didn't have real dogs in the facility then. I'm sure most of you have real dogs, maybe even have her own dog, but we found a stuffed dog that looked like her dog and when it was time for her to go to bed, we would say to her "hmm, hmm, hmm, we can't go to bed until we let the dog out. Because you know what's going to happen. He's going to want to get up in the middle of the night." So we take the dog, I don't care whether it's snowing or raining or what it's doing, we took the dog outside and we waited. And we waited. And when the dog was done, we brought him back in, she got in bed, cuddled up with him and slept all night. So our intervention was a stuffed animal that we took outside. Our problem is again, unless I understand her cognitive level, you're going to say, "well that's cruel, you can't do that the surveyors are going to go..." No they won't. If I can show you that she functioned at the age of a four and a half-year-old and for a four and a half-year-old, it is hard for her to understand all the parts. All she knows is that dog needs to go out and she is going to accomplish it.

So, the ultimate falls reduction belief has got to be answer to falls mitigation lies in your ability to look inside the resident's reality, not at external things. I know you're going to say, you said that now

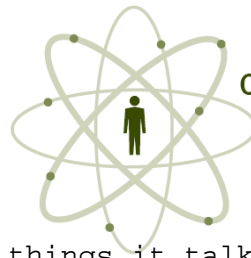


four times in the twenty minutes you've been speaking but I can't say it enough because we keep expecting pommel cushions, I have to make a comment about pommel cushions. I just have to say this out loud. Personal. I read a pillow that said this once and I want to share it with you. Pommel cushions. Those are the cushions that have the horn, looks like a cowboy saddle, you know, horn towards the middle. Here's what the pillow said and I am just going to give this to you for your own edification. And it said this, "if the world were logical, men would ride side saddle". Yet it is an intervention we use for all kinds of folks. Okay, moving right along. So, if that is our ultimate belief, I've got to figure out what the resident's reality is here and why the resident thinks they're moving then my goal has got to be to determine the resident's goal for moving or getting up and helping them meet that goal. If we are to be resident centered, if we are to change our culture, we need to stop saying "no don't", all those things that we need to say from our root cause analysis, which is what Carla was telling us they're going to ask us for, what are they trying to do? And tell me what you're doing to help them get it done. Not stop them from doing it. And that is probably my biggest issue with alarms. Alarms don't help me do anything. They embarrass me when I try to do what it is I wanted to do. One of the interesting things that I have done, is that I will take an alarm. I stole this idea. I can't be, I can't lie to you, I stole it. A facility was trying to get rid of alarms so I took four staff members and put them around a table. Did it with a different group of staff members. Put an alarm on one of them. Real short little cord. Because you see if the cord is long enough so they could lean forward, they could also fall out. We wouldn't want that to happen. So they got the cord real short and they're having the meeting. Then they decided to play pick-up sticks. You have to reach forward to get the darn sticks. I talked to some of the people that played and they say, you know, I think I'm very alert and very oriented but you know, within three rounds, I found I did this. I passed. I said go ahead. Because, she said, I kept leaning forward and buzzing and I was so embarrassed. Yet she even knew that the game was that they were going to play, to try to feel against the alarm. I was in a facility not very long ago and I ran into, unfortunately, I say this unfortunately, a very young nurse. I guess I would expect the young folks would see it differently and us old staid people who got in trouble for not pulling the side rails are the ones who are going to want to be putting on alarms. We got in a bit of a disagreement about alarms. She was in the special care unit and a resident kind of hooked up with me. We were on our way to the meeting. I said to the resident, want to go to the meeting? Sure, she said. So she came along, extremely demented. Extremely short, less than a minute attention span. We go into the minutes. I put the alarm on the nurse. She was sitting next to me, then the resident and her. Okay? Time ran along and I asked her to get me a Kleenex. There was a Kleenex box on the other side of the table. She leans forward to get the box and of course the alarm goes off. The resident, I wish I had had a video camera. The resident looked at her and she looked at me and the nurse got it and said, "did you like that?" She went, "well, no, as a



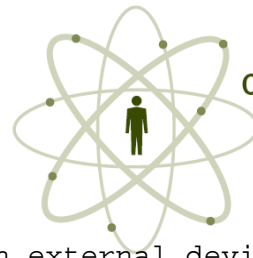
matter of fact, I didn't. Could you not do that again?" And it was beautiful. Because the resident said how she felt because it wasn't ringing on her. She was probably one of the residents who was taking it off of other folks. Okay? Whenever you look at an intervention, okay? We heard this again, we heard this before. I'm going to say it again. Whenever you look at interventions, it must be based on some sort of root cause. Are you going to be right 100% of the time? Probably not but even a bad decision is okay because it's a decision you know you shouldn't make again. Okay? So learn something from it. Base it on a root cause analysis and there are millions of reasons why people move. Okay? But this is the test that I think. Whatever intervention you select, can you or your staff stand in front of the Supreme Court of the United States, not the surveyors and not Carla's group. I don't care about those. I want you to go to the big boys. I want you and your staff to be able to in front of the Supreme Court of the United States, support the use of the alarm, explain the resident's response, explain the effectiveness and why you think you need to use it. I think it was a year or so ago one of our major categories of IJs was alarms, well it wasn't alarms but what it was falls. And we had a fall, we put the alarm on and the resident took it off, we put the alarm on, the resident took it off, we put the alarm on and the resident took it off, fell. Went to the hospital. Broke his hip. He came back, we put the alarm on. Slam-dunk. I think we ought to make the surveyors work a little harder than that. Don't just give it to them, okay? My goodness. It didn't make any sense. If you can't stand in front of the Supreme Court of the United States, draw yourself way up tall and explain why you're using, why did you select an alarm. You're going to have trouble with it. With families. With Carla. With anybody who might be asking. Okay.

Now then. Having said all that, there are some assessment questions that I think lead to interventions that make sense. That are supportable. That will work sometimes as well as alarms, probably better if we begin to combine them. And any of you who have heard me are going to go "here she goes again". Yep. There is a social issue. If we could determine two things, just two things that the resident likes to see, smell, taste or hear. Just them. See, smell, taste or hear. Two of each of those. Their favorite chair. We've got them in wheelchairs and some day we'll get together and talk about how silly that one is. Okay? People, wheelchairs are for transportation from A to B, not to be used as a stationary chair. They're uncomfortable. So if they're uncomfortable for long term use, I go to stand up and when I go to stand up someone yells at me and then the next thing I know they have an alarm on me. So we have two devices fighting with each other. Okay? Where have they been sleeping? Before they came to you, I'm sure in the culture change person centered world we all do preadmission visits. You never would bring someone to live with you until you know where they lived. So we know where their bed is and what their favorite chair is and three stories that make them happy. No matter what intervention I put into place, I want them to be happy people. Guess who can gather that data? Anybody. Because it is social



information. Social information. One of the things it talks about in F323 is the commitment to safety and it talks about what they are going to look at as a commitment to safety is that all staff is involved. Actually, Carla mentioned that. In this particular case, all staff can be involved and when we're using social interventions. I'm not any good at math but I can tell you the permutations of what I just mentioned is thousands. Thousands. And let me see if I can explain it. If it's me, I want you to know that I love, I love seeing mountains, I love seeing beach scenes. That's two, that's all I'm going to do. I love smelling eucalyptus and I love smelling cinnamon apple. Okay? I love tasting chocolate chip cookies and lemonade. I love touching soft, fuzzy things. I like, you know those new kids' toys that are real soft? And I love touching animals. I love hearing Yanni. No don't anybody be making fun of me. And I love country and western. Okay? I can tell you three stories that make me happy. With that information, you would have so many interventions, you're not going to be limited to the ten devices that didn't work anyway. You're going to be saying, "we're giving her that real fuzzy blanket and a chocolate chip cookie". That's one. Chocolate chip cookie alone, no that's one. The lemonade alone, that's one. The lemonade and the Yanni music. That's the second one. The Yanni music, the lemonade and eucalyptus is one. We just keep building.

We need - Carla says what? There are unavoidable accidents. But when she defines what that is, she says that you better have identified the risk, evaluated the risk. You better have interventions that make sense. She doesn't use the phrase "make sense", but I added that. And you have to monitor and modify. Those four words show up in F23 about nine hundred times I think. So I think they are serious about that. But if I am using pieces of the resident's past history, I'm meeting many, many, many goals. One, it's person centered. Two, I helps with activities of daily living and I don't mean brushing their teeth. I'm talking about communication. I'm talking about social involvement. I'm talking about, I don't go to bingo because I can't handle that, but I went to the, they bring me my box of coupons and I'm responsible. They asked me if I would find any mushroom soup coupons in there. We don't care about product, we're looking for process. And my nursing colleagues always want the mushroom soup coupon to be found. Probably won't be, but I want to capture the person's attention because when I'm working on the coupons, hunting for that mushroom soup stuff? I'm not getting up and I'm not falling. Interventions are as simple as that. We've made it way, way, way, way, way too difficult. If I'm using what the resident can see, smell, taste and hear - I've always said too there's millions. Think of yourself. Write your own list. And think how we can involve the family. Now the family is on our team, okay? As we try to prevent falls. They are really an integral part of what we're doing and why we're doing what we're doing. It is possible to not use alarms and now we've got three folks who are going to tell us that because they're proof in the pudding. But put the person back in the picture. Utilize interventions that drive who that person is as a person and what are things that they like? What

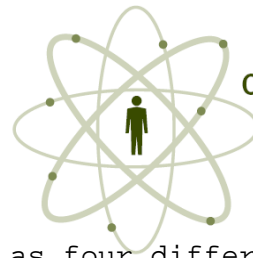


are their root causes? And stop expecting an external device to change my mind as to why I wanted to move. Okay? Thanks Leasa.

LN: Thank you Diana. It's always great to hear your interesting perspective and your insights. I just want to take a moment to remind everybody to please double check that your phone line is muted. If you don't have a mute button on you phone, you can use star, six, star. Let me give everybody a second to check that they are, in fact, muted. Okay, somebody out there still needs to mute their phone. Okay, we're going to go ahead and introduce our next speaker. We're going to be hearing from representatives from three different nursing homes across the state on how they've been able to successfully eliminate alarms in their buildings. We're going to begin with Chapel Hill Community, which is located in Canal Fulton, Ohio. On the line we have the director of nursing, Gayle Dettman, the assistant director of nursing, Kay Flanagan, and the activities director, Amy Ringly. Gayle? Would you like to start?

GD: I sure would. And good afternoon to everybody. I thank you very much for this opportunity that allows us to share our success with everyone. To begin with, our observations indicated to us that there may have been some complacency with our staff. The alarms were noisy and it was determined through a QA process and many other things that they really did not prevent falls or any injuries at all. Actually, we did have one resident who fell because when she bent over, the alarm went off and she actually thought it was the fire alarm. There was also a question of dignity with the use of these alarms. One of our residents, who I'll call Betty, just because, had fallen when she went into her own bathroom. The nurse, her intervention was to immediately put an alarm on her wheelchair. This nurse thought that it would prevent Betty from going into the bathroom by herself. Betty was very alert. She was oriented to all three spheres and was quite an independent lady. Once the alarm was placed on Betty's chair, we noticed a very significant change in her behaviors and her actions. She would no longer go to the main dining room for her meals. She would not leave her room for any activities. She was becoming depressed and not eating well. Being a diabetic, this was affecting her other medical issues. As we investigated, we found that Betty had told the nurse who initially put the alarm on that she was embarrassed by it. When she tried to move the alarm, it rang and everybody was looking at her. It was certainly a dignity issue to us. This was certainly one example of our facility -- we decided to go ahead and take action with these alarms. It took us all about nine months to reduce the alarms to nothing. Right now we have none. Right now I'm going to pass this on to Kay Flanagan, the assistant director of nursing. She is going to give a little more detail on how we did this.

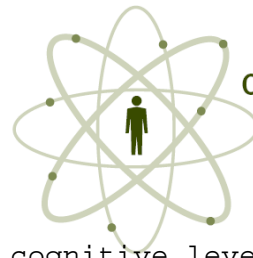
KF: Our process. Initially we set a goal date to have no new alarms to be initiated. The goal was that our alarms would be eliminated all together. The managers, prior to this date assessed the current alarms that were in place with the goal to eliminate any alarms that had been placed. We



actually had some residents who had as many as four different alarms on. They could have a chair pad, a bed pad, a motion and a sentinel alarm. They were alarmed for sound and all the alarms may no longer be needed due to a change in a resident's condition. As some of our alarms were being discontinued we found that families began requesting alarms. They were writing letters to the administrator, to the director of nursing and they were coming to the plan of care meetings and demanding that alarms be put on their loved ones. We then realized that more education was needed. All of the staff including the activities, food service people, maintenance, nursing, as well as the families. The families were educated by letters that were sent out with our billing statement, also at our care conference meetings. Alarm reduction continued by using alarm tracking to find out the time frames when resident alarms were sounding as well as why they were attempting to get up could be initiated. We have daily falls committee meetings and we added to our stand up meetings a social service representative as well as activities. We found that frequently the STNAs were not aware of these fall interventions. So we created a procedure to help with that. We made bright pink tabs to put in their flow books with the new intervention on the tab. At the beginning of each shift, nursing assistants can look at these tabs to see if anything new has been added to that resident's plan of care. As soon as the intervention is added to their work sheet, that tab can be removed.

(Change tape)

AR: Glad to hear Diana mention the Allen Cognitive scale. I first heard about the Allen cognition screen through a conference that was hosted by members from Hennis Care Center and we were really impressed with the way they presented the Allen cognition levels of function. We needed to get our staff on board with new ways to look at interventions for falls and behaviors for residents. We began studying the Allen cognition screen. We have a group of staff here at Chapel Hill that are members of what is called "career ladders" group. They actually want to go above and beyond their normal job descriptions so to speak. They take extra care and time in presenting new educational information to care partners here at Chapel Hill Community. They got on board with the Allen cognition screen and presented an Allen's cognition fair day here at Chapel Hill where they highlighted the different levels of Allen cognition and all the staff were in-serviced. If staff were not here, we in-serviced them one on one about what the Allen cognition screen was and how we were going to present it to be used for further interventions for residents. Currently we have biographies for all of our skilled nursing residents. The biographies are on their door. A little overview of their interests, past life interests, pursuits here at Chapel Hill. At the top of that biography, there is a color code. The color code represents the Allen cognition level that they fall into. The care partners can access the Allen book and what interventions can be used. We have had a great success with one of our female residents who presented with both falls and behavior and that really fascinated, to look at the approaches. This

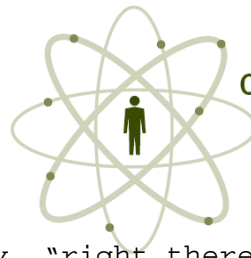


particular resident fell into a category of cognitive level of a six-year-old and so it gave the staff a whole new way of communicating with that resident and helping them to see there were better ways to intervene for falls and behavior. If you need any information on the Allen cognitive levels, you can go under <http://allen-cognitive-network.org>

Pretty much, that's all we have right now from Chapel Hill.

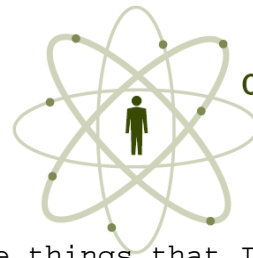
LN: Okay! Thank you for sharing your experiences with us. Just want to remind everybody once again to please double check that you are, in fact, muted. We are getting a lot of background noises so if you could please double-check that you are muted. You can do that by using the mute button on your phone or dialing star, six, star. At this time we are going to hear from our next nursing home presenter. In the room with us today we have, from the Eliza Jennings Home in Cleveland, the director of nursing Pam Riter and the Restorative nurse, Pam Ehren. Pam, I'll let you go ahead.

PR: I would also like to thank you all for allowing us to be here today. First, a little bit about Eliza Jennings so that people know what our facility is like. We do have 150 beds, 14 of which are considered short-term skilled. All of our beds are dually certified. Our STNA ratio, which I'd like to mention, is generally 1:10 to 1:12. It depends on the household because I think facilities need to realize that you don't have to have very low ratios to be successful in eliminating alarms. We actually did totally eliminate alarms approximately two and a half to three years ago. What started us on the process was our administrator at that time. When he would be out on the floors and he would hear our alarms going off, he himself would become annoyed with them. We at that time had already eliminated overhead paging so that was just another noisy thing in the facility that could be distracting to everybody. So he was asking about the possibility of attempting to eliminate alarms. We started to look also and question whether they were, in fact, effective in preventing falls. So what we started to do was at that time, we had, Pam Ehren, our restorative nurse, who is here today. She became our point person. I think it is very important in a facility that is looking to eliminate alarms does need one person who is going to champion the cause. One person that everybody can go to. Another thing that is very important and was very important in our facility is everyone, from management on down needs to be on board. You can't have an administrator or DON or someone who isn't on board with the idea. You have to have everybody's cooperation and everybody working toward the common goal. So, as I said, Pam was our point person at Eliza. She is also the head of our falls prevention committee so she knows all the issues and the concerns that had to be addressed. Pam, at the time we started the process, and as we remain alarm-free, starts by looking at all new admissions. As new admissions come in, obviously nurses are doing their admission assessment, falls risk assessment and we are identifying those residents who are at risk for falling. The nurses are busy and frequently they



would look at an alarm as being a nice, easy, "right there" intervention for a fall. You can't fault nurses for that. As I said, they're very busy and they have a lot going on so this would be what they would turn to very frequently as an intervention. This is where our point person started her education and education is also very vital to this. You need to educate your nurses, you need to educate your families, the residents themselves and all the staff. Busy nurses, as I said, will look to a quick easy fix. Families will ask for alarms, maybe in the hospital or in another facility they were used elsewhere on their loved ones and families aren't always aware of alternatives so that's where your education with them will come in. Another area that maybe people haven't thought about as far as education is also with the surveyors. We did have an incident during one of our surveys where Pam and myself were questioned as to why we did not use an alarm on a specific resident who had a number of falls and we educated that surveyor that in fact alarms do not prevent falls. We did learn, as I said, that they do not prevent falls. They can, in fact, and I think that this has been mentioned already, increase both tension and anxiety in the resident. Not only those residents who have them on, but residents in the area. It also does that with staff too. We found frequently that when we had alarms that even if residents were confused, they would remove those alarms. They were annoyed by them, so they would be taking them off if they could. They didn't know that they were removing an alarm, just that they were taking off whatever this thing was. And I think, I'm not sure who mentioned it, if it was Diana, but somebody mentioned that staff becomes complacent about them. And they do, unfortunately. You know, that's just Mrs. So-and-so, she's probably just turning in bed and, in fact by the time they get in there, maybe she is on the floor. You really have to look at other alternatives to alarms and Pam is going to talk about how some alternatives that she came up with and a little bit more about how she started eliminating alarms in our facility.

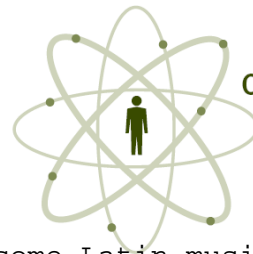
PE: Thank you. We do work very closely with our PT and OT staff. I refer to them on a several times a week basis if I see someone that is either falling or has the potential for falls and we do have a nurse practitioner that can do any acute assessment when something is going on. We have had quite a few new residents on our skilled facility that will come in with the words, I'm sure you've seen them, "falls precautions" as a new order. I think every single person in our facility is automatically on fall precautions. They're in a new environment. They need orientation to their surroundings and it was already mentioned, sometimes every five minutes they're going to need orientation to their surroundings. The one thing that we do when "fall precautions" are ordered, is we have some things such as perimeter mattresses. Sometimes at night they may just need that small reminder, the little lip on the edge of the mattress, to say "oh that's right, I'm in a little bit of a different bed than I was in in the hospital." We will use a low bed and sometimes mats. If someone is a getter-upper at night, I don't really want a mat in there that they can trip over but we can consider a low bed. A night-light just so they



can see their way around the room. Those are things that I'll automatically put in place when a new resident comes in skilled and has that fall precautions order. I did find just as recently as last week that the one gentleman didn't end up needing the low bed nor the perimeter mattress the next day. We found some other interventions that made him happy. Checked out his shoes and the other things that you are probably already doing. I'm also proud that we are side rail-free. Many of you may already be that but I'd like to mention that we use enabler bars and that's something else that I'm the point person for. I work with therapy. Do they really need them for bed mobility and transfers in and out of bed. So an enabler bar can help them prevent falls because they have that little armrest they can count on but it is also not used as a restraint or anything to keep them in bed.

Another thing that I look at with new skilled people is, of course, their diagnosis. We're looking so much at diagnoses in relationship to the medications that the doctor's orders, etc, and I want to look at their weight bearing status and what their diagnoses are. That will also help me take a look at what they need as far as those fall precautions. Again, the low bed and that kind of thing. When someone has had a fall, during my working hours, we're on it, right away. We have lots of processes but the one I felt you should know about right away is that at each one of our household nurse station, we have a clipboard that I brainstorm right away with the aides, the nurse and anyone else that's in the household. What we can do right away to help that person. And it's written on the clipboard and then the STNA and the nurse for three days post-fall not only are doing their post-fall assessment, the vital signs, and that kind of thing but the aides are able to know when they fell, what they were doing and what new thing we're putting in place to keep that fall from happening.

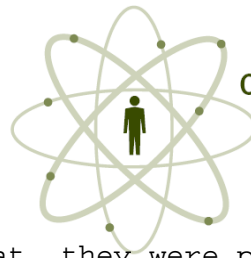
Going back historically to when we did eliminate all of our alarms, to be totally honest, we had two holdouts. They were on the memory support unit. We had one bed alarm that the daughter absolutely would not allow us to get rid of. So I want you to realize we are in the real world and that does happen and it wasn't until that lady went to heaven that she no longer had her alarm. That daughter was quite the holdout. The other one on the memory support. It was again what Pam had mentioned educating the family. We were all in plan of care, we talked about some of the other things that we would try in place of the alarm and once the daughter saw that, that we of course cared about her mom, we had some other things and the perimeter mattress was the big one that enabled her to say no more alarms. Because then mom would know that little lip was there and she'd know that when she got out of bed that maybe she should rethink that or hopefully get some help. Another thing, it was already mentioned but I think it's worth mentioning yet again, is looking at that whole person. I got lots of ideas from Diana on how we can take this even further so I'm very excited to get back and get started on that. But we have totally been using music therapy. We have two very frequent fallers. One is



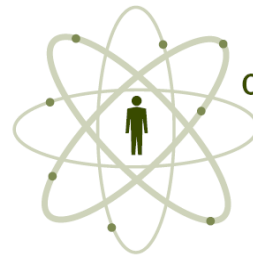
Spanish-speaking and we just got a hold of some Latin music that his son actually composed when his son was younger. We got that playing for that resident and then another gentleman who is from the south who is very ornery. He was very tough to come up some interventions and we found out he is a big Johnny Cash fan. So we got him and maybe Johnny Cash isn't calming but it will take this gentleman home to a time and maybe to a time that makes him feel more comfortable. And again, the whole thing with our environment is homelike so it does bring him back. So I think that the other gentleman, the music of his son may be calm and soothing and remind him of another time as well. And don't be afraid when you're eliminating your alarms that your fall numbers are going to increase. I think you may be pleasantly surprised that that will not happen and I think everyone will enjoy work a little bit more. I think staff and residents, just because of that homelike atmosphere that you have without all the beeping and the buzzing.

LN: Thank you for sharing your experiences with us. I wanted to point out that I have had the opportunity to visit both Eliza Jennings and Chapel Hill Community and just from the environmental perspective, it's so nice to be able to walk through the halls and not hear that buzzing and beeping and all those other distractions that lend itself to a very institutional feel. Okay, next we are going to hear from our final nursing home presenters, who come from SEM Haven Community in Milford, Ohio. On the line we have the director of nursing, Helen Canfield. Helen, are you ready?

HC: Yes, I'm ready. Thank you very much for inviting us to share our journey because it certainly has been a journey for us. Boy the last two presenters were very good, it's very hard to top what they've done because we've done a lot of things very similarly. SEM Haven, we're 100 beds, not for profit and about six years ago we became a registered Eden facility and then we also began the journey to resident-centered care. We haven't used alarms as the device to prevent falls since about 2005 but prior to that we thought that alarms were the answer to our prayer, they were going to stop all of our falls, and slowly we became disenchanted. We found that the residents hated them. They would damage them, turn them off, throw them across the room. We actually had one person try to flush one of the boxes down the toilet. They were annoying to hear, the buzzing, and with our resident-centered care, we were striving for noise reduction. We found that the aides were sometimes complacent, didn't always answer them, exactly what everyone else said. Our administrator also wanted to eliminate alarms. She really thought that they were a violation of resident rights. I have to admit that I was a little bit reluctant in the beginning because I thought that probably they did stop some residents from falling. But, I think that the straw that broke the camel's back was when we were cited because we had an alarm listed as an intervention and when the surveyors came in, lo and behold, the resident had turned it off. So, we decided that we were going to make this commitment. The first thing we did was talk to the staff and since we had



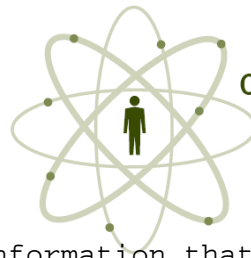
eliminated restraints a few years before that, they were pretty open to trying this. They were becoming a little tired of the alarms too and saw that they were weren't preventing falls. So that was the first big thing. To make sure that everybody was on the same page, that everybody saw the benefit to the residents and to convince them that we didn't have to use them, there were other ways we could prevent falls. We started to look back at why the alarm had been applied. Sometimes, just as with restraints application, residents had alarms and no real attempt was made to remove them. For some residents, if you stopped to think why we used the alarm, nobody could really remember. It was just they knew that that was what they always did for the person. So, we looked at reasons for the alarm. Were they were trying to go to the bathroom? Was it because they were trying to go to bed? What exactly were they doing? We involved the restorative department to look at the toileting program. Were we really toileting them at the time of day that they needed to be toileted. We looked back at their fall patterns. If someone was falling at night between 2 and 3 in the morning, we needed to toilet them at 1:30. If someone wanted to go to bed right after a meal and there wasn't anybody there to put them to bed and they would attempt to self-transfer themselves, we enlisted the office help, the dietary department, and the maintenance staff and we set up a schedule where everyone participated in at least one meal twice a week. They were providing support for the nursing assistants. They could pass trays. They could go and get things that needed to be gotten from the kitchen. And then if a resident decided that they were going back to their room, it freed up one of the nursing assistants to go back and to meet the needs of the resident and not worry about the fact that he was going to try to self-transfer himself into bed and no one was going to hear the alarm because everyone was in the dining room. That works well for us. I think the whole thing is knowing your residents and what your residents need. The activities department helped us by providing some activity equipment on the household so that now we don't have to go to the activity room for supplies. We have activities right on our household. We have permanent staffing so that the staff and residents can build a relationship. The staff know what they like to do. They are encouraged to go and visit with the residents and sit down and discuss things with them. We had one man, he wanted a lot of attention so he would throw himself out of his wheelchair all of the time. If he was in bed, he would throw himself out of bed. Fortunately, we found out that he had been in the Navy and so had our chaplain. The chaplain visits and has formed a relationship with him. Now he's the chaplain's assistant. He goes to all of the Bible studies and church activities. He goes and talks to other residents. He still demands a lot of attention but now the staff knows what his needs are and they're encouraged when they finish their assignment, to go down to his room and talk to him. This works out pretty well. He hasn't thrown himself out of bed in a long, long time. So that was an intervention that was effective and he doesn't have an alarm anymore. In fact we don't even have any alarms in the building. Once we really got into this, we threw them all out. So there is no way that anyone uses an alarm.



We also have low beds and mats and perimeter mattresses to remind residents not to get up or if they should make an attempt, hopefully they won't become injured. We found that a lot of times it's really the simple things that the resident's will enjoy doing and preoccupy their time. We have some residents that just like looking at books. They like the colored flowers or they like magazines that have pictures of beaches. It reminds them maybe of vacations that they took and we get them talking about it. Because we're a member of the Eden alternative, we have learning circles. The household staff actually conducts them. They'll get the residents in the circle and they'll come up with the topic, such as, what did you like to do at Christmas time and it just amazes us that even the most confused residents will contribute to the conversation. It may take them a while, you may have to be patient with them, but you know, they're engaged in activity that is appropriate on the calendar. We tried to find things for the residents to enjoy, that they want to do. We ask them what they want to do and then we plan a day around what they're suggesting. We have people that like to go and do things and we have people that like to do crafts. Even the most confused resident, we find if we include them in the group, they will observe. They may not necessarily participate in the same way, but they will observe. As I said, we encourage the staff to build a relationship with the resident.

We did have a small rise in our falls when we took the alarms away but it was only for the following month and then after that, our falls remained what they were prior to using personal alarms. In fact when we were getting together to talk about alarm reduction, it's been a couple of years, people were having a hard time remembering what it was like to have alarms here because we haven't had them for a while and it's not something that our staff even thinks about. They know that they need to come up something different. If we do have a fall on the household, we have electronic charting, and it's programmed to automatically print out a copy of the care plan and one of the things that the staff has to do is to review the care plan to see what interventions are already listed and they need to either modify the intervention or add a new intervention. So this way, every time somebody falls, you are evaluating the previous interventions. I think that by listening to Diana it has really reinforced, you know, we know we did the right thing. I love what she called the psychological restraints because that's what we were beginning to think that they were and we've learned something in this too because we had not been using the Allen, I'm sorry what's the name again? The cognitive scale and we are going to start instituting that. We have a dementia household and we have instituted part of the Montessori program at SEM with folding the clothes and sorting different pieces of clothing and things like that, but we want to take that even a step further.

That's about all I can think of right now. Do you want us to give our web site now or do you want us to do that later?



LN: If our speakers have personal contact information that you'd like to share with everybody on the call today, we can go ahead and do that now. Helen, if you'd like to begin.

HC: okay, well, my e-mail is hcanfield@semcommunities.org. I'd be glad to speak to anyone and invite anyone that would like to come and see our facility.

LN: Okay. Thank you Helen for your presentation. Would the presenters from the other nursing homes like to share their contact information? Go ahead Pam.

PR: My E-mail address is priter@elizajen.org.

LN: Just a quick reminder to double check that your phones are muted. We're again getting some background noise and again the instructions are star, six, star.

Then if someone from Chapel Hill Community would like to give your contact information.

KF: Yes, mine is kflanagan@uchinc.org.

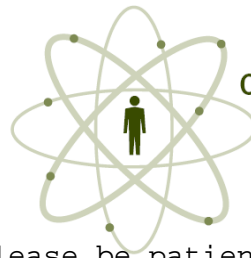
LN: And Diana, how about you? Would you like to have your e-mail address out there for everybody?

DW: Sure. It's dwaugh@accesstoledo.com.

LN: okay. And Carla?

CB: My e-mail cbrumby@odh.ohio.gov.

LN: Thank you everybody, for those of you who didn't quite catch all of the e-mail addresses, we will have them in the transcript when we get that posted. At this time, I would like to thank all of our speakers for sharing your experiences and your insights with us on the topic. We'd now like to open up the floor to our callers for their questions and we actually have two ways you can submit a question. The first way to submit a question is to ask your question now while we have our presenters on the phone. The second way is to ask your questions by E-mail. Any questions that are E-mailed will be answered by our presenters and then posted to the coalition web site in a few weeks. You can E-mail your questions to this address: amanda@fvcolumbus.com. Once again, that's amanda@fvcolumbus.com. If you want to E-mail a question, you can go ahead and E-mail. We can do it that way or we can take your live questions now over the phone. If you have a question that you'd like to ask of any of our presenters, you may go ahead and un-mute your lines now. Since we don't have an operator to assist us, we need to be careful not to speak over each other as we go through the questions. So if you have a



question, go ahead and un-mute your line. Please be patient with this process if we have a lot of questions; we will do our best to get everybody's questions answered. Again, if you've got a question, feel free to go ahead and speak up.

S2: Hi. I do have a couple of questions, actually. The first one, I was hoping that the representative from Eliza Jennings could clarify what she means by an enabler bar as opposed to a half side rail or something like that. The second question is for all three speakers.

LN: If I could have everyone's attention, there is way too much background noise and we can't hear the callers as they're asking questions.

S2: Thanks. The second part is I was wondering if any of the three facilities have decided to go without Wander Guard or Secure Care System to get rid of those alarms as well and if not, what's the outcome of that been.

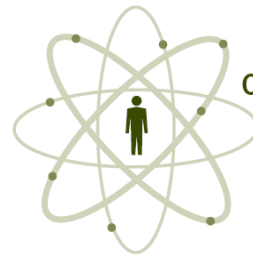
PE: This is Pam Ehren from Eliza Jennings in regards to the enabler bars. A year ago in July our beds were such that we could take metal half side rails, maintenance did this, not me. They took them completely off of the bed. So there was none of those apparatus on our beds. Then we, the facility purchased the enabler bar which some people do call them transfer handles, but it a very small diameter, I'd say 8-10 inches in diameter, handle that doesn't have all the safety concerns as the side rails did as far as entrapment issues but it is still something secured to the bed with a board under it. So again, maintenance does that.

PR: This is Pam Riter from Eliza Jennings. Pam Ehren and I had actually attended a seminar at another Cleveland facility where the seminar was about the safety of side rails and about the measurements how big it shouldn't be in order so that someone's head could not be entrapped and that sort of thing. It was after that seminar that we started researching and looking into enabler bars for our facility. Our facility has never used Wander Guards or any alarm systems such as that. Our doorways are key padded for anyone who might try to exit out a doorway, but again, we have never used Wander Guards in our facility.

HC: This is Helen Canfield from SEM Haven. We took our Wander Guards off when we opened our dementia unit. However, we had one woman in one of our households that she did wander and the family really did not want her moved to another bed. So we have a Wander Guard on the doorway to that household only. It was to enable this woman to stay on the household where she lived.

S2: Thank you.

LN: Okay. Do we have any other questions?



S3: Are the surveyors being educated?

PR: You may have to do that. Get together and educate them one by one. That's what Pam did when we were specifically questioned as to why the man did not have an alarm. I honestly don't know if all the surveyors have been educated but don't hesitate for the one on one. Thank you.

CB: I can tell you that all surveyors have been educated already on the new guidelines put out by CMS for data tag F323 and last week we had our conference, our division conference and one of the speakers was Courtney Lighter which you may know that Courtney wrote the CMS guidelines for data tag F314, pressure ulcers. He spoke about restraints and the surveyors were asking Courtney about alarms. I won't give you his direct quote but his quote was something like "they stink" and I believe surveyors heard that message loud and clear.

S4: I just think you have to be confident in your interventions that you put in place instead of alarms and you have to be able to have a discussion with the surveyor as to why your interventions are appropriate and be confident in the decisions you're making.

LN: Thanks. Do we have any other questions?

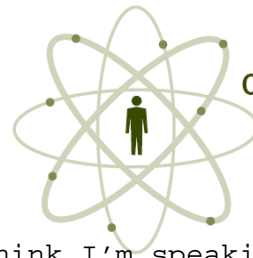
S5: I agree with that last comment. I believe that the facilities need to be able to articulate to the surveyors why the interventions that they have in place are the best interventions for residents.

S6: Yes, I have a question.

LN: Go ahead.

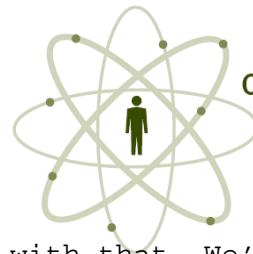
S6: We have been told that no matter what you do whenever it comes to an intervention, that you've got to come up with another one and you've got to come up with another one and there's no stopping the intervention that you put in place for falls and you find that very frustrating. You've got the barrier mattresses. You've got low beds. Of course you've got the alarms which you know, you said are no good and we try as far as toileting and resident needs and their seeking behavior, but we just find it very frustrating to try to figure out another intervention when we've covered them all. Then when you're seeing level 4 for immediate jeopardy because you know if the person has a surgical intervention for a fracture, you know there's going to be some decline in their condition as far as their ADLs. That's almost an absolute there. So, where do we go from here?

LN: Who would like to address that?



DW: I'll give it a shot. This is Diana. I think I'm speaking clearly and Carla, please correct me if I'm not. It's not that you have to put in another intervention. You need to look at what the root cause was and make sure you're addressing that. Remember when I mentioned the person who falls over the neighbor's dog, putting them in their wheelchair with an alarm, it doesn't fit. Actually, I can't remember which one of you, I can't remember who said it. You had a lady and your intervention to keep her from falling in the bathroom was to put her in a wheelchair with an alarm. It doesn't make any sense. So, I think if you go for the root cause, maybe it is as simple as, somebody mentioned a dog book. Somebody mentioned singing. I loved that story about the Mexican music, the Spanish music. That's beautiful. Those are the kind of interventions. Don't look for that external device. It's not going to work for you.

The second thing I wanted to speak to and I'm glad you brought this up, is when you have, as Carla was talking about, severity level 4. I think that is the place where we can really show our mettle. It talks about, there was a fracture or an injury, surgical intervention, with decline but the decline they're talking about is physical, mental, and psychosocial. They're talking about physical functioning and mental functioning. So I think we need to look very carefully. Remember, if it was unavoidable, we're not even talking about this level business. So if we were diligent and got all our ducks in a row back here, this isn't an issue. But let's assume that it wasn't avoidable and we slipped a cog. Alrighty. Now, I don't want a level 4 so I want to make sure is when that person is in therapy, which they'll be in therapy, and we understand that and that's very important and we are not neglecting them mentally and that we are not neglecting their arms, assuming for a second that it was a broken leg. That we are doing some restorative work with their arms. Because you and I both know that if you allow a resident to sit and do nothing for three days with their arms, they'll start to lose their mobility. So we'll see a decline and that's what the surveyors are going to be looking for. But more than that is fitting into the whole psychosocial business that came out last year that said, dear surveyor, if you see something happening and then in addition to that, there is an psychosocial impact, then that is another problem for us. So, I want to make sure that if Mary was looking for the mushroom soup coupon, she could still look for the mushroom soup coupon with her broken leg. My mother-in-law is 98. She broke her hip when she was 97 and she is now back running circles around me. And I said why do you think you did so well? And she said, "well, you've got to keep your mind going. You can't just be sitting around like that." But because of the cognitive loss piece, sometimes we miss the business about keeping them going mentally and keeping the other pieces of them going so they don't have physical decline. So if I miss the unavoidable, if I had a little problem there, I want to make sure that I don't, while they're in therapy, let them sit in terms of all the other activities of their body and their mind.

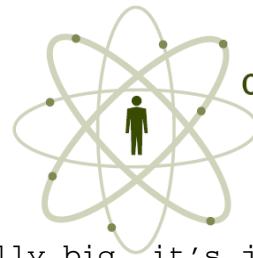


S6: I have another question that goes along with that. We've been working on person centered care forever it seems, since 1971, actually, but how do you get everyone on board with activities? Self-directed activities and you know, how do you get everybody on board with that? Because this sounds like it's mostly trying to provide activities of every count and how do you get people on board with that?

PR: This is Pam Riter from Eliza Jennings and I kind of wanted to go back to your first question, about you know you've come up with all sorts of interventions and you're kind of running out of ideas and I just want to say to you and anybody else who might be feeling that way, I think we can all empathize with you. I've said if somebody can write a book with a million and one interventions, they'll become a millionaire. Because you do run out of interventions. You've done 20 different things for one person but I think everybody needs to remember it is a team effort and by team, it's not just nursing. It's everybody in that building. Your housekeeper might see a resident who they might have an idea for an intervention so you really need to get everybody that you possibly can and talk to them and any ideas that anybody might have and don't disregard any idea that a housekeeper or someone might offer to you. And in activities, I don't really have a lot to say to that but I think it goes along with getting activities involved with interventions and how can we all, and again it's everybody in the facility that needs to work together to help with the falls reduction and eliminating your alarms.

DW: Maybe if we didn't use the word activities. Maybe that's our stumbling block. Because making my day worthwhile is what it's all about. I'm the resident. Making my day worthwhile. So the maintenance man can very easily understand to stop by me and we read just one verse out of my Bible. I love that and he knows I love that. And so that's good. Or he knows about the fish I caught. If we stop, I think maybe our problem is, I've a problem with it forever because most activities I see are therapeutic and we were kind of missing that one and so I kind of try to figure out how to say it without saying activities and its really, I'm doing it for the resident, it's really not an activity like we think of in the old days. I don't know if that helps at all.

HC: This is Helen and we find that somebody will always pick up the gauntlet when somebody else drops it. For example, when you were talking about someone coming in and reading. We had several of our residents wanted to have a garden. So we took them out on the bus and they picked out what they wanted and then we had someone from maintenance went out and dug up the yard and then some of the aides got into it and went out and helped to plant them and then the gal from activities went out and did the watering it and the residents watched it and they loved it. They just loved the idea that they had their own zucchini and they made zucchini bread. At Christmas time, they wanted a Christmas tree. So we had one donated and we put lights on it. It's right outside the dining room so they can see it at night when they were eating their evening



meal. So it doesn't have to be anything really big, it's just every day things that you do in your own life.

AR: This is Amy from Chapel Hill Community and that's a great point. So many people have talents that they could share. As the activity director here, the activity staff is always asking staff from other departments things that they would like to share with the residents. We take for granted that people should just step in and help out but they need an invitation as well. We found that asking, we kind of watch the things that they like to do, take an interest survey from your staff, hobbies maybe that they have and invite them to tap into a program. Maybe it can just be a brief 30-40 minute program where the activity staff can kind of watch the floor while the nursing or nursing assistants are doing a program in a common area. You can alert - you have to help each other out. You have to help each other out. We're starting to divide our living areas into neighborhoods and a lot of our nursing staff are starting to take the initiative and lead programs. They're contacting the activity department for maybe supplies that they need. Recognize them. You know, publicly recognize them. We have "catch someone shining" board where we can write down what we are observing other staff taking the initiative to do. I think asking them for help and recognizing them for what they're doing above and beyond goes a great way when they're interacting with the residents on any level that they can.

S?: You know, I think it's contagious. When someone else starts doing something, somebody else thinks of something else that they can do. For example, we have the same dietary staff on our households and they're noticing if a resident doesn't eat. I mean, without even being asked, they went and made up a food tray with cut cheese and different kinds of fruits and when they found that the residents liked them, then they would make up two or three of them. This is getting to know the resident and take and interest. It just amazes me sometimes what the staff will come up with.

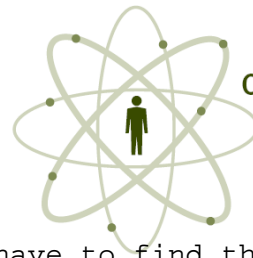
DW: Have any of you three facilities done any correlation between the time you stopped using alarms and your staff retention?

HC: We haven't really done that.

DW: I've got to believe there's a connection.

Kim: I have a question. This is Kim from Heartland. Could you give us another definition of what a fall actually is? We were debating on whether it's a fall. We have a question about the fall definition.

LN: Would somebody like to address that?



CB: Yeah, I'm going to be just a minute. I have to find that part so I can make sure I am correct. The definition actually comes right out of the MDS manual. You can go on with another question while I look.

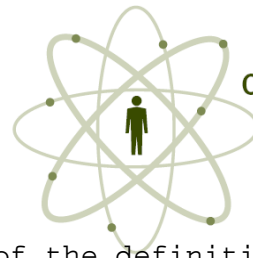
LN: Okay, we'll come back to that. Are there any other questions?

S8: I have a question. Regarding educating your staff. You know, as with any other policy or procedural type things that we make in nursing homes, there is often a few staff members that are kind of reticent to, you know, changing the way they carry out their duties. Did any of our three homes have any particular challenges with any resistant staff members when it came to not being able to not putting an alarm on somebody?

Pam: I think at Eliza Jennings since the time that we totally eliminated the alarms, I think periodically Pam will find a nurse who, as I think I mentioned when we did our session, that periodically a nurse will still want to put that as an intervention. And that is where Pam Ehren, our restorative nurse, does go to that nurse and re-educates. But it's rare that they actually try that anymore because they know that they are not going to get an alarm in our facility. But every once in a while they try to sneak that one in and so Pam does go back and re-educates. Okay?

DW: One of the things I've seen facilities do in that case is pick someone who is really, really on board with getting rid of the alarms and in order to put an alarm on someone, I must communicate with that person even if it's 3:00 in the morning that I have to call them and many times I'll decide maybe it would be easier to come up with an intervention rather than calling that person that is going to question me. I think we need to look at why nurses do that and I'm a nurse. We do that because, way back in the old days, historically we were chastised for not doing tasks. And that's a task. We're very task oriented. How can we get them to see, one of the problems too, and I don't know how you guys address this or not and that is if your incident report contains a list of things to do, you know, pommel cushion, mat, alarm, you know, if they have a list, then I have a bigger tendency to pick something off that list. I think it makes me think a little more if that incident report really is pretty wide open and says, "what are you going to do" and I really have to answer that question. So help me and teach me how to answer that question. But don't give me an alarm as a choice or a whole list of pieces of equipment as choices. I feel bound.

CB: Okay, the definition of a fall, and this is the same definition that's in your MDS User Manual. Falls are defined as unintentionally coming to rest on the ground, floor or other lower levels but not as a result of overwhelming external force. That means, I do believe, that somebody does not push a resident. The manual goes on to say that a fall is an episode where a resident loses his or her balance and would have fallen if not for staff intervention. That means if a resident loses his balance and probably would have fallen but a staff member caught them. It



is still considered a fall. The last part of the definition is that a fall can be with or without injury. So a fall without injury is still classified as a fall.

Kim: But there is no requirement that they had to have landed on the floor with that staff intervention, it's not that the staff helped them to the floor, it's that they probably would have hit the floor if someone hadn't intervened at all. Even if they just propped them back up and they went on walking.

CB: That's correct.

Kim: Okay, thank you.

LN: Okay, do we have any other questions?

Elise: From the time that you made the decision to go alarm free and you did staff education, how long was that process, on the average, for your very last alarm to come off? Beginning to the end.

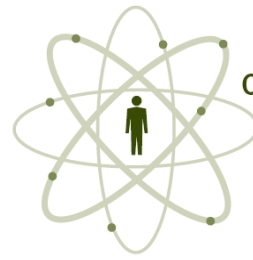
GD: This is Gayle from Chapel Hill. Approximately nine months from the beginning. Recognizing, researching, looking at the different people, Allen cognitive, education. It took us about nine months to be completely alarm free.

Pam: At Eliza Jennings, I'm really not positive the exact time frame. I'd say probably anywhere from six months to a year. Our biggest holdout as Pam mentioned was the daughter who was just adamant that we could not remove that alarm on her and until she did, in fact, pass away, we had that one alarm still in our building but I would say probably about six months to a year total.

S9: I think one of the important things to keep in mind is to have as many successes and goals as you can. So if you try to eliminate the alarms in maybe one unit, you can show that great success and it will spread throughout the rest of the facility. Or if there is an alarm to eliminate, you can show great success and have a party or have recognition of look what we've accomplished, now let's go to the next level. So, as opposed to looking at all the alarms that we have and trying to eliminate all of them at once, that could sometimes be overwhelming and sometimes somewhat disastrous if we don't take baby steps and do it in a planned approach.

LN: It is so important to get that positive momentum going.

HC: What we did at SEM is to look at the people that it looked like they would be easiest to remove the alarm. We came up with interventions a lot quicker and we were successful and then we just took it day by day and I'd say it took us about six months.



LN: Do we have other questions?

S10: I do have a question. What kind of objections would there be to having a bed alarm that was turned off at the site but actually cut on the call light so that someone would know during the night that a resident was up?

S11: Well, it's an alarm. Even though it is not in a certain place but it is in another place and this and that. I really felt like we had 100% support from everyone that we were going to be alarm free. I think that you could split hairs on any alarm if you want to but it's that commitment and what Diana said, standing up in front of the Supreme Court and saying why you have that alarm. If you have that much passion for it, you know, whatever you want to do in your facility. But the commitment of absolutely no alarms is a big one when you're ready to make it.

S12: I agree with Pam. At our facility we've been actually restraint free for a good ten years. At the time we started moving to become restraint free, the time of the Poseys and the lap buddies and the Geri-chairs with the trays, I was still a floor nurse at Eliza and I was like, "we're going to do what?" But now that we are restraint free and alarm free and side rail free I wouldn't want to go back and if I were a resident in any facility, I wouldn't want any of that stuff placed on me either. And you have to look at that. You have to look at the person and really try to identify their likes, dislikes and put your interventions and think outside the box for them.

HC: One of the things we found at SEM when you were talking about night shift was that we had to get the staff away from the nurse's station after they made rounds and everybody congregated there and encourage them to spend some time down in the hallways outside somebody's room who got up a lot during the night and also to get them away from the idea that people went to bed at 7 o'clock at night and didn't get up until 7 o'clock in the morning. That residents might want to get up, they might be hungry. We had people who used to work nights. They don't sleep at night, they tried to get up. So just to educate night shift that they're part of this too and they had to change their behavior.

DW: I think it's interesting, one of the very first restraint deaths that I ever dealt with was a night nurse who was doing nothing that she hadn't done forever and that was working all night but with her restraint in place. I always say that to night people, "you're awake" the folks that are awake these hours, it's hard to see but if you look at them as people, it makes it a little bit more real.

LN: Do we have more questions?



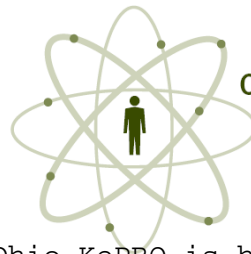
Amanda: Hi, this is Amanda at Friendship Village in Columbus. When we went to reduce side rails we utilized some brochures and information that explained the negatives about side rails and so forth. Has anybody come across any information explaining the negative of alarms that could be used for staff and families?

Pam: This is Pam from Eliza. I have not seen information like that. We did it like on a family-by-family basis. I called them at home. Keep in mind we only had like 10 or 12. It wasn't a huge number. If you're talking about 100, that would be, you know, very hard, but it was more an individual education with each family and with each nurse on that team, so we didn't use a hand out.

DW: I think our problem is we don't have any handouts because we don't have any collection that it's a problem yet. With side rails, the FDA began really looking at them very specifically in 1995. I think we can probably use a lot of the same information we used on restraints. Because it is a kind of a restraint. A different kind of restraint.

LN: We are at the top of the hour, 3 o'clock. We will continue with questions if there are more questions that people have. We will not cut the call off until everybody's questions are answered but I do want to state that if you have prior commitments or obligations, we will have a transcript posted with all the questions and answers posted included in that on the web site. So at this time I'll ask once more if there are other questions, and if not, we'll end the call. If you have a question please feel free to ask now. ... Okay, well I'm not hearing any other questions coming forward so at this time, I would like to go ahead and thank all of our speakers today for a wonderfully informative presentation. We'd also like to thank all of our nursing home providers who joined us for the call today. We know that care for our nursing home residents continues to improve because of people like you who are willing to take a couple of hours out of your day to learn from the people who have paved the road and are willing to share their experiences.

I have a couple of reminders in closing. Again, I mentioned the transcript of the call will be posted on the coalition web site which once again is www.centeredcare.org. Give us a couple of weeks to get that posted. Also please remember to go to the web site to fill out an evaluation for today's call. We'd like to get your feedback so that we can make future educational opportunities that much more rewarding for you. Also, check the coalition web site about any upcoming events. If you have not yet joined the discussion group for the coalition, we encourage you to do that as well. More than 300 people use the e-mail group as a communication tool and there is often very extremely insightful discussion that takes place on the e-mail group. You can sign up for the e-mail group on the coalition web site. From the home page, click on Discussion group, then enter your e-mail address and click on submit.



I would like to make one announcement that Ohio KePRO is hosting another teleconference this week. The call will be on Thursday November 8 from 1 o'clock to 3 o'clock. The topic is restraints. We'll have Carla Brumby on the call discussing restraint regulations and we will also have Patsy Strouse who will be discussing the MDS coding considerations. No pre-registration is necessary for that call. The call in number is 866-256-9239. Once again, the call is Thursday, November 8 from 1-3. The dial-in number is 866-256-8239. We'd love to have you on that call.

That concludes today's presentation. Thanks again for joining us and have a great day.