

# Improving Patient Safety in Long-Term Care Facilities: Training Modules



## **Module 1.**

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**Detecting Change  
in a Resident's  
Condition**

## **Module 2.**

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**Communicating  
Change in a  
Resident's  
Condition**

## **Module 3.**

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**Falls Prevention  
and Management**



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**Instructor  
Guide**

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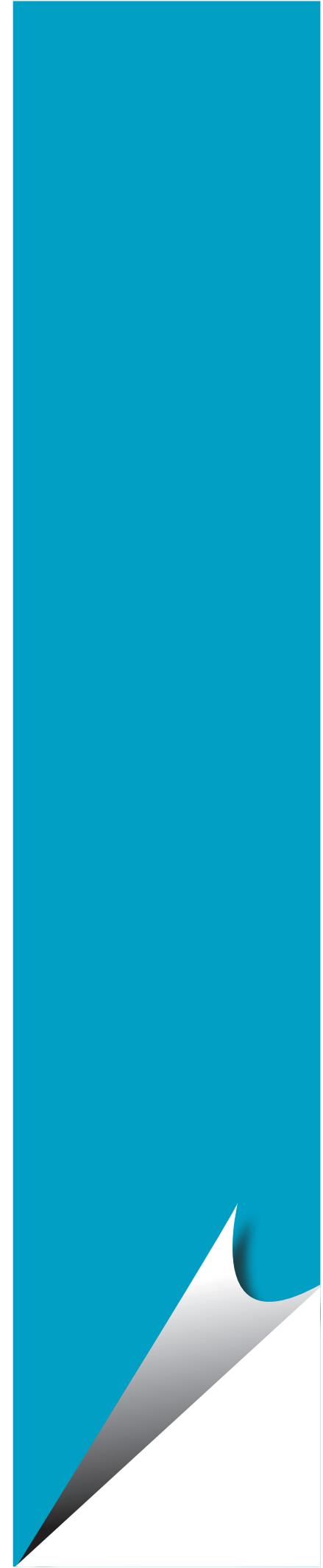
## **Instructor Guide**

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Please note: This instructor guide comprises three modules: Module 1. Detecting Change in a Resident's Condition; Module 2. Communicating Change in a Resident's Condition; and Module 3. Falls Prevention and Management. It is designed to be used along with the three student workbooks, one for each module. These training materials are intended for use in long-term-care facilities. The modules can be taught consecutively or independently.

For information on ordering additional copies of this instructor guide or other materials in this set, please contact the AHRQ Publications Clearinghouse at 800-358-9295 or [ahrqpubs@ahrq.hhs.gov](mailto:ahrqpubs@ahrq.hhs.gov). In addition, these materials may be downloaded from the AHRQ Web site, at [www.ahrq.gov](http://www.ahrq.gov).

The opinions presented in this guide are those of the authors, who are responsible for its content, and do not necessarily reflect the position of the U.S. Department of Health and Human Services or the Agency for Healthcare Research and Quality.

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# Improving Patient Safety in Long-Term Care Facilities: Training Modules

## Introduction

Since the Institute of Medicine issued its landmark report, *To Err is Human: Building a Safer Health System*,<sup>1</sup> in 1999, there have been tremendous strides toward improving patient safety and reducing medical errors in health care facilities. Substantial improvements have taken place in hospitals, in particular, yet progress on this front has been spotty in nursing homes and other long-term care facilities. Some of the reasons for this include differences in the patient populations served, the dual role of nursing homes as both health care and residential facilities, and staffing challenges that include high levels of turnover, wide variation in education levels, and varied cultural and language backgrounds.

Training nursing home staff – particularly nursing staff – to be on the lookout for changes in a nursing home resident’s condition and to effectively communicate those changes is one tool nursing home administrators can employ to improve patient safety, create a more resident-centered environment, and reduce the number of falls and fall-related injuries.

Detecting and promptly reporting changes in a nursing home resident’s condition are critical for ensuring the resident’s well-being and safety. Such changes may represent a patient safety problem, and they can be a signal that the resident is at increased risk for falling and other complications. All staff members share responsibility for noticing and reporting both physical changes (e.g., difficulty with balance, increased frailty or weakness, changes in urination and/or bowel patterns) and nonphysical changes (e.g., increased or decreased appetite, signs of withdrawal, confusion, or agitation) in a resident’s condition.

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<sup>1</sup> Institute of Medicine. *To err is human: Building a Safer Health System*. Washington, DC: National Academies Press; 1999.

These educational materials are intended for use in training front-line personnel in nursing homes and other long-term care facilities. The materials were developed by RAND Corporation, with support from the Agency for Healthcare Research and Quality (AHRQ). These training materials are organized into three modules:

Module 1. Detecting Change in a Resident's Condition

Module 2. Communicating Change in a Resident's Condition

Module 3. Falls Prevention and Management

This Instructor Guide presents training materials for all three modules, including suggested slides and pre- and post-tests to gauge the students' knowledge level before and after training. There is no need for instructors to flip from one section to another when using these modules, as some of the basic information (e.g., information on teaching methods) is repeated in each module, to ensure that each module is a complete teaching guide. Separate student workbooks are available for each module. Facilities can use the modules sequentially or independently, and the content can be tailored to fit the needs of individual facilities.

# Module 1. Detecting Change in a Resident's Condition

## Instructor Guide

This module focuses on detecting changes in a nursing home resident's condition. This Instructor's Guide describes how to use the materials in the companion Student Workbook as a teaching session and how to apply a quality improvement project for the topic of detecting change. Suggested slides are provided in Appendix 1-A.

### Principal Message

The single most important message your audience should come away with is that it is essential to notice and report change in a resident's condition, and it is everyone's responsibility to do so. Staff should know the signs of illness in older adults and other nursing center residents, and they should know how to watch for and report changes in a resident's condition.

Staff also should understand what it means to work in a safe environment. This means that nursing staff can work together as a team and share information openly. It also means they understand that keeping residents safe—and not worrying about who might be to blame when things go wrong—is the most important consideration. Participants should experience the setting of your teaching as an example of a safe environment, where information is freely shared and concerns are openly reported and supportively addressed.

### Principal Audiences

This training is geared towards licensed nurses (RNs/LPNs/LVNs), occupational and physical therapists, and nursing assistants. However, portions of the training are relevant for custodial and activities staff, who also are important for identifying change. The training is designed to be accessible and relevant to all these care providers. So you can teach your participants all together, mixing the professional roles.

The importance of teaching the different professions together is that it will, in and of itself, likely improve teamwork by allowing members of each profession to better understand the staff from other professions. For instance, anecdotal research suggests that nursing assistants feel that licensed nurses rarely read their notes. Learning together presents an opportunity for nursing assistants to understand more about what licensed nurses need to see in a nursing assistant's note, and it allows licensed nurses to understand that it is important to read the notes and to let nursing assistants know that they do so.

If the learning culture of your audience suggests they will have problems learning together, you can separate your participants into different sessions according to their professional roles. However, you should aim to get them comfortable learning together for the next module in this series, "Communicating Change in a Resident's Condition."

More abbreviated training might be appropriate for custodial and activities staff. This includes slides numbered 6, 8, 11-16, 18, 19, and 21 (see Appendix 1-A for suggested slides).

There is only one portion of this module that is targeted particularly to RNs, and that is the nursing assessment that is triggered by a change in the resident's condition. Note, however, that the specifics of how to conduct a nursing assessment are not within the scope of the module. Also, occupational and physical therapists and nursing assistants who might report a change all need to know that nursing assessments are an appropriate response to a potentially meaningful change in a resident. So, that section of the module can be included for all participants, even though its significance will differ depending on their professional roles.

## Workbook Content Overview

### Clinical Content

A change in a resident's condition may mean that he or she is at risk. Action can be taken only if changes are noticed and reported, the earlier the better. Changes that are not reported can lead to serious outcomes, including medical complications, transfer to a hospital, or even death.

In order to identify a change in condition and know when to report it, staff need to understand what is normal (baseline) for a particular resident's condition when he or she first comes into the nursing center, and over time after that. Armed with this information, staff will be able to identify changes and decide which ones need to be reported to others on the care team.

This module reviews ways to notice changes from the resident's normal condition. The more common of these changes are listed by their physical and non-physical categories.

The module also identifies ways the care team may best communicate with each other about such changes and use reporting tools. It notes the importance of logging shift-to-shift changes, and provides the Early Warning tool and the SBAR (Situation, Background, Assessment, and Recommendation) tool for the participants to get to know and use.

## Content by Session

This module is designed for presentation in two sessions. The first session introduces the importance of detecting change and describes how to detect change. The second session discusses the top 12 changes to watch for and describes how to use tools to document and get ready to communicate about the changes.

Your teaching goals for both sessions of the module are to:

Have participants understand what it means to be in a safe work environment with open reporting and to buy into that as something they want to be part of at their nursing center.

Develop participants' knowledge and skills in detecting changes in a resident's condition.

The module materials also can be used flexibly to fit a range of session lengths. Selecting materials to suit a 30-minute single session, for instance, is quite possible. However, this module is designed to be a 2-hour session.

## Objectives of the Session

Objectives are separated into knowledge and performance objectives. Suggested slides are provided in Appendix 1-A of this Instructor Guide, but they are not in the Student Workbook. You can use these at the start of the session and even have them up on a flip chart or screen that stays on the side of the room during the session. Alternatively, you can return to them at the end of the session to give participants a sense that they are following your road map. It is often best to select one, two, or three objectives and leave the others aside. In teaching material that you want participants to really take in and use in practice, "less is often more," so that participants can take in and integrate the new material in a usable way. You can remove unwanted items on the slides or highlight the information on which you will focus.

## Knowledge Objectives for Participants

For all:

- › Understand why detecting change is important.
- › Understand how to know a resident's normal (baseline) condition.
- › Understand how to watch for change.
- › Understand how the Early Warning tool and SBAR tool work.
- › Understand how to follow up at the first sign of change.

## Performance Objectives for Participants

For all:

- › Summarize a resident's normal (baseline) condition for other team members.
- › Identify whether changes in a resident's condition are important or not important.
- › Promote behaviors that improve change detection
- › Use the Early Warning tool and SBAR tool.
- › Decide when to report or when to ask for help when observing changes in a resident's condition.

## Preparing for a Session

### 1. Assess the Needs of Your Audience

These training materials are meant to be used as a complete package. However, you may tailor them to the needs of participants and current practice at their nursing center. To determine needs, you may use a survey or talk to individuals familiar with the nursing center. Whether you choose to use all or some of the material in the Student Workbook, decide on a focused goal for teaching. It is better for participants to learn and remember a few important pieces of new information than to feel overwhelmed by many new ideas.

Consider the language level that will best suit your audience. If you use technical medical terms, be sure to insert the meaning of the term. If your audience uses English as a second language, speak clearly and not too quickly.

## 2. Consider Your Teaching Method(s)

Most instructors find that a combination of methods – lecture and interactive – works best. Consider using a selection of these teaching methods:

- › Lecture with slides.
- › Whole group discussion.
- › Break-out group discussion.
- › Case discussion.
- › Role play.

Suggestions for ways to use these methods are in the “Recommended Teaching Methods” section of this module.

## 3. Presentation Timing

The suggested timing for each part of this 2-hour module is:

Introduction of Instructor, Topic, and Objectives .....	5 minutes
Pre-test .....	5 minutes
Case Discussion .....	10 minutes
Presentation 1, Interactive Lecture .....	20 minutes
Case and “Critical Reflection” Discussion .....	15 minutes
Break .....	5 minutes
Presentation 2, Interactive Lecture .....	18 minutes
Case Discussion and Role Play (2 scenarios) .....	20 minutes
Debrief on Teaching Methods .....	5 minutes
Key Take-Home points .....	5 minutes
Post-test .....	5 minutes
.....	Total: 115 minutes

Although this is a 2-hour module, you can teach it in two 1-hour blocks. You can also select material within the module to make a 30-minute or a 45-minute session or two 30-minute sessions within a 1-hour time slot. This flexibility is important, as some nursing centers might not have adequate nursing coverage for a 2-hour session.

## 4. Using the Slides

The Student Workbook is not meant to be used as a prepared speech. It assumes that you know the subject and offers material you may want to use. The suggested slides (Appendix 1-A) are meant to trigger your presentation. You will find it useful to practice speaking with them.

## 5. Preparing Your Presentation: Overview of Effective Instruction for Adult Learners

Adult learning involves changes in knowledge, behavior, and skills.

This module aims to help participants improve the way they notice, report, and keep track of changes in a resident's condition.

Adults are usually most motivated to learn when:

- › They see the subject as directly related to their own needs and goals.
- › They see ways for their learning to be applied to their own work settings.
- › They are responsible for their own learning.
- › Their own knowledge and skills are appreciated.
- › “Mistakes” are seen as chances to learn.
- › Practical, hands-on experience is part of the instruction.

Adults take in new information more quickly and remember it better when it relates to their own experience. Structure your session to draw on what participants already know and what they want to learn. Make sure everyone feels that they have something to contribute.

Teaching methods such as interactive lecture, case discussion, and role play help lead adults to make changes on the job. A good way to get your group moving in this direction is by starting with a case for discussion. If the case reflects a situation that's familiar to participants, with a problem they want to solve, you will have a “teachable moment.”

### **Interactive Lecture**

With this method you present the material, using questions-and-answers (Appendix 1-B) and slides (Appendix 1-A) or other visual aids.

## **Case Discussion**

The case tells a story. It involves situations similar to those faced by participants at work. You lead a discussion that brings in what they know and how they might handle the situation. You will want to be sure that different ideas are heard, and see if anyone changes his or her mind. You'll find a sample case in the "Making the Presentation" section, below.

## **Role Play**

"Learning through acting" gives participants a chance to use what they know and practice something new in a real-world setting. It can help them see a situation from different points of view. It also helps them develop communications skills.

## **Writing It Down**

With all these techniques, it's useful to note participants' ideas and questions – a flip chart works well. This helps keep participants thinking and engaged. You can keep a "parking lot" list of thoughts that may not be on point at the moment, but should be kept in mind when you're summing up the session.

More information on how to teach this material is, in the "Giving Your Presentation" section.

## **6. Preparing a Handout for Participants**

These training materials are meant to be used as a complete package. However, you should feel free to choose the parts you think are most relevant for your particular audience and their nursing center. The slides in Appendix 1-A may be reproduced and provided to participants. For this module, you will want to include the Early Warning and SBAR tools.<sup>2</sup> The case is presented in the Student Workbook.

## **7. Learning Settings that Work for this Module**

Think ahead about the kind of setting that will be available and best allows your targeted group to participate in the training. You'll also want to consider work shifts, and how your session can fit with in-service training requirements or other

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<sup>2</sup>Note: The Early Warning tool is available online at [http://www.in.gov/isdh/files/Doc\\_7\\_-\\_Interact\\_Stop\\_and\\_Watch\\_Tool.pdf](http://www.in.gov/isdh/files/Doc_7_-_Interact_Stop_and_Watch_Tool.pdf). The SBAR is available online at [http://www.interact2.net/docs/Communication%20Tools/SBAR\\_Communication\\_Tool\\_and\\_Progress\\_Notec.pdf](http://www.interact2.net/docs/Communication%20Tools/SBAR_Communication_Tool_and_Progress_Notec.pdf).

options. It helps if your session meets some of the nursing center's requirements for staff training. It's also good to provide refreshments if you can – that tends to increase attendance. Post announcements ahead of time so that people know when and where your session is going to happen. You might have a leader introduce the session to show that it's important.

## 8. Using Pre- and Post-Tests

A series of pre/post-test questions and answers can be found in Appendix 1-B. These provide real-time feedback on how well the training session worked. The pre-test sets a baseline of what participants knew about the topic before the session; this can be compared to the results of the post-test to answer the questions, “What changed from the beginning of the session to the end? Did participants learn what we wanted them to learn?”

## 9. Equipment

You will need equipment that allows you to display slides and also record discussion points and questions from participants. You may use:

- › PowerPoint.
- › Slide projector and screen.
- › Flip chart.
- › Overhead projector with transparencies.

## Giving Your Presentation

- › Introduce yourself and your purpose in being there.
- › Hand out the pre-tests. Explain that pre- and post-tests help participants evaluate themselves and help you evaluate the course. Have participants complete the pre-test.
- › Introduce the topic and review session objectives (using slides).
- › Present the material.

## Recommended Teaching Methods

For this module, a mix of teaching methods may be the best – some interactive lecture, some case discussion, and some role play.

## Interactive Lecture

The “stand-up” lecture works well when it’s about something participants care about, and when the speaker is engaging. It’s best used when a large amount of information needs to be delivered to a silent audience.

In an “interactive lecture” you still speak most of the time and control the subject being addressed, but the audience participates in different ways – asking or answering questions, giving examples from their experience, and expressing opinions.

Like a story, any lecture – regardless of length – has a beginning (the introduction), a middle (the body), and an end (the summary). Each of these serves a different purpose.

**Introduction:** establishes the purpose of the lecture, including overall goals and specific objectives. It should include an overview of the whole lecture. You are aiming to get participants interested and make them aware of expectations for the session.

**Body:** includes the material needed to meet the objectives stated in the introduction. Your session will be most effective if you:

- › Grab participants’ attention in the first few minutes.
- › Involve them in fine-tuning the focus of learning.
- › Plan a change of pace every 8-10 minutes during a lecture.
- › Give participants a chance to reflect.
- › Use visual aids.

Give participants a chance to share experiences.

**Summary:** includes a recap of the material presented in the body of the lecture. It may also include an opportunity for participants’ questions and feedback.

## Case Discussion

Most instructors prefer to use the case provided in this module. A clinically experienced instructor who is also a seasoned teacher may also invite participants to contribute relevant cases in which they have been involved. But a new instructor may prefer to keep the focus on a familiar case.

### Case Study

Ms. A is a mentally intact 79-year-old frail (in a weakened condition) woman who arrived at the Manor Nursing Center following a hip fracture suffered at home. After a stay at an acute rehabilitation center, she is still not able to manage by herself. Ms. A walks with difficulty with a walker, and needs help with daily living activities. Ms. A also has several other medical problems, including high blood pressure, diabetes, and arthritis. She is also being treated for depression. Her family visits her regularly on weekends. She rarely participates in activities of the Manor Nursing Center; at mealtimes she tends to avoid conversation. Recently, she had diarrhea, was incontinent of liquid stool, was placed in adult briefs, and nursing assistants had to change her adult briefs once or twice per shift. She began taking meals in her room. Stool tests showed that she had a bowel infection with *Clostridium difficile*. An antibiotic was started. Even with the antibiotic, her bowel movements continued to be liquid and frequent over the next week, and she was eating less. Her blood pressure had been normal for her at 130/80, but her pulse rate was higher than her usual 70-75 at 90-100. Yesterday she had a fever of 102.5 and was transferred to the acute hospital, where she was admitted to the intensive care unit.

**How did Ms. A get so sick with only diarrhea? What changes might you have noticed about Ms. A? When might you have decided to do something about it? What could you have done?**

The case in the Student Workbook is the same. You may not need to use much or any of the clinical detail in your teaching; it is provided here in case it is relevant.

Once the case has been presented, pause and invite participants to comment.

Questions to get discussion going and draw on prior knowledge might be of the “survey” type:

- › Have any of you worked with a resident who had to be transferred to the intensive care unit?
- › How often would you say this happens in your nursing center?
- › Does your nursing center have procedures to follow when you see a change in a resident, such as Ms. A’s need for adult briefs?
- › Could you give an example of what you’re supposed to do when you see a change like this?

Questions you could ask to reinforce the knowledge you are sharing might be:

- › Could you give an example of a warning sign that Ms. A was becoming more ill?
- › Ordinarily, what is the result of treatment with an antibiotic for people with diarrhea?

You can then encourage critical thinking and communication with questions such as:

- › At what point would you think that the diarrhea might be a symptom of something more serious?
- › Who could you share these concerns with?
- › What do you think Ms. A's nursing team might have done differently that could have prevented her condition from getting worse?

You might ask participants to brainstorm ideas about ways to communicate that would prevent this situation.

Keep in mind that you are trying to get participants to think in terms of teamwork rather than blame.

Try to get them to talk with each other, not just to you. Have them discuss a topic in pairs or in groups of three. This method makes it easier for a shy person to be heard as the less shy member of the pair or team can speak up for both or all of them.

If the number of participants is small, you could lead the case discussion with the whole group. Larger groups may be broken up into smaller ones, with each taking one or two questions and then reporting out to the whole group. Or, you could divide the participants into groups according to what they do (i.e. licensed nurses, nursing assistants, occupational and physical therapists, etc.).

## Role Play

This technique has participants take on roles in a clinical interaction. There is no written script, and the “actors” don’t have to memorize anything.

There are five parts to this technique.

**Set-up:** Ask participants about their previous experiences with role play. Explain the goals of this exercise and relate them to the key learning objectives. Make sure everyone is familiar with the overview of the case. Only the “actors,” however, will know the details of their roles. It may be helpful to provide the description of the role play to those who are not participating as actors in the role play.

Then go over some guidelines:

- › Anything that comes up is confidential.
- › This is a safe place. Actors should not be afraid to take risks.
- › Feel free to be spontaneous.

**Assign the roles:** You may have actors play a role similar to the one they have in their real jobs, or you might encourage them to try out a new one. A licensed nurse, for example, could take the part of a resident, or a nursing assistant could act as a licensed nurse. Involve as many people as possible in the role play. Because role play requires participants to be somewhat emotionally open, they may feel anxious or resist being an actor. Your own positive attitude and a light touch will help. Any participants who are not assigned to a role should be asked to be observers.

**Conduct the role play:** Participants act out their roles in the “scenario” you provide (example below), based on the case. Try not to interrupt the role play while it is running; just let the interactions flow naturally.

Before the scenario, explain how much time it will take, and that it will be followed by discussion. It should take only 2-3 minutes, followed by perhaps 5 minutes of discussion.

Don't let the role play go on for too long – most of the learning happens in the first few minutes. If actors seem too carried away by their roles, remind them to keep it simple.

Scenario 1. Two roles: Mary and Marli. Mary is worried about how depressed Ms. A seems. She has tried unsuccessfully to get Ms. A to talk. Marli is concerned about there not being enough people on the floor to get all the work done, and thinks Mary is spending too much time with Ms. A. Marli has had the experience of bringing concerns to the RN and nothing being done. They talk about whether they should mention anything about Ms. A to anyone else.

Tell the role players to simulate the interaction between the nursing assistant and the licensed nurse, making it clear when the interaction is happening and in what setting (e.g. on the phone as soon as possible, at change of shift, etc.). Tell them their goals are to: (1) get all the information across, (2) communicate about the situation in a timely fashion, and (3) be able to push if the message does not seem to be getting across. You can also tell the role players that the purpose of this role play is to discuss barriers to communication and how to effectively overcome the barriers.

**Discuss the role play:** Discuss the issues that came up in the role play. Everyone's input should be included. After each scenario is played out, ask the actors: What went well? What did not go well? What would they do differently next time? How did it feel to say \_\_\_\_? How did it feel to hear \_\_\_\_? Ask observers for their opinions about what the desired outcome was in each situation and how they might have handled the situation differently.

**Conclude the role play:** Encourage a round of applause as the participants transition "out of role." Summarize the major themes and issues. Consider with the group how to apply the role play to real life clinical situations. Emphasize what was learned during the role play.

## Debrief About the Teaching Method

- › Ask participants what methods they think you used. Get their thoughts on what worked and what could be done better.
- › Listen and thank them for their thoughts.

## Review Key Take-Home Points

- › Promote a safe environment based on teamwork and thinking about how the system of care works and how it can be improved, rather than thinking about blame.
- › Educate the entire staff about the importance of falls, risk factors for residents, and methods of prevention.
- › Use appropriate risk-assessment and reporting tools.

## Post-Test

Thank your participants for attending. Let them know that you enjoyed being with them. Hand out the post-tests. Emphasize how important it is to complete the post-tests because they can get feedback on what they've learned (based on their answers to the pre- and post-tests). Tell participants that you will provide the correct answers and rationales for the tests after they are done.

Also, you should stress that the post-test is anonymous.

## Translating the Teaching into Practice

It is often hard to get what is taught in a classroom or in-service learning session translated into action as part of resident care. Even if the teaching has gone well

and the learning was taken in and appreciated, it can be hard to put the new learning into practice. There are many possible barriers. For instance, the system of care may not accommodate the new practice, or the culture of care may not accept the change, or the leadership may not be aware of the new learning and so may not make room for it.

Following up after a teaching session with a quality improvement project in which the new learning is put into practice by the whole team can help a lot. Quality improvement projects use a step-by-step approach to improving care by taking a long, hard look at what needs to be done; starting out with a small change, watching it, adding to it, and continuing in this fashion until the job is done. There is a method at work here, and the method is described in the next section, “Quality Improvement.”

Quality improvement methods often include a teaching step. This module can be the teaching material for that step. If the quality improvement project is to improve the way nursing assistants and licensed nurses detect and communicate changes in a resident’s condition, then this module is perfect for the teaching portion of the project.

## Quality Improvement

“Quality Improvement” (QI) is an approach that may be used by nursing staff and managers to improve quality and safety in patient care. The three main components are to:

- › Gain knowledge and skills to understand systems of care and minimize adverse outcomes.
- › Apply methods to identify, measure, and analyze problems with care delivery.
- › Act on the results of data collection and analysis to improve both individual care delivery and systems of care delivery.

QI is a team approach that involves everyone in thinking about innovation and recognizing that the key to improvement is the people who care for patients. It is not about individual rewards and punishments, but rather QI relies on measurement to improve the center’s performance as a whole.

At the core of QI is the “Plan-Do-Study-Act (PDSA) Cycle,” based on trial and error over time.

- › Plan: Identify a problem and design a change to address it.
- › Do: Implement a small change.

- › Study: Measure and analyze the effects of the change.
- › Act: Take action based on the results of analysis, such as trying another change, formally implementing a change, or extending implementation more broadly.

When you engage in a QI project you will be using information/data that you have on current practices at your site to develop goals based on both best practices and realistic expectations.

The five phases of the QI process are outlined here.

For more detailed information on QI and measurement tools, please see “The Patient Safety Education Project (PSEP), Module 9: Methods for Improving Safety,” which can be found at <http://patientsafetyeducationproject.org>.

## 1. Project Initiation Phase

### **Decide on the Area of Work that Needs Improvement**

In this example we focus on detection of changes in a resident’s condition. Most likely, a process to get to this point is already in place at the center. Still, it is helpful when starting the project to make sure everyone believes in its importance. Collect data to support your assumption that there is a problem and establish a baseline for measuring improvement.

### **Form Teams**

Leadership teams must include one or a few people with enough institutional authority to help get the resources that the project team needs

For this project, the Director of Nursing, the Quality Improvement Officer, the center’s overall Director, or the Chief Operating Officer are potentially good choices.

Project teams must:

- › Have basic knowledge of the problem.
- › Represent all parts of the process and different levels of the organization.
- › Have at least one member trained in QI.
- › Recognize that good ideas can come from anyone.

The ideal team size is five to nine members. Additional temporary members with special areas of expertise can be invited to particular meetings as needed.

For a “detection of changes” improvement project, the following project team members are one example of a good team.

- › Registered nurse.
- › Two nursing assistants.
- › Director of nursing.
- › Education director.
- › Geriatrician.

#### **Write an Aim or Mission Statement that is “SMART”**

- › **S**pecific.
- › **M**easurable.
- › **A**ppropriate.
- › **R**esult-oriented.
- › **T**ime-scheduled.

The aim should include a “stretch” goal that may be hard to reach but is achievable—for example: Decrease the rate of resident falls by 50 percent in 12 months.

#### **Consider Appropriate Measures**

Examples of measurement (data) include a “process measure” like compliance rates for use of the Early Warning Tool or SBAR, or documented nursing notes in a resident’s chart on reports of change.

To show improvement, you should be able to plot the variable being measured on a run chart (a graph that displays observed data in a time sequence).

## **2. Identifying the Problem**

### **Identify the Problem**

At the outset, you need to identify:

- › The problem and the extent of the problem—that is, what are the barriers to detecting changes and how poor is detection of change now?
- › Changes that can be made that are expected to result in improvement—that is, what might improve the detection of changes in a resident’s condition by overcoming those barriers and how?

- › How the effects of the changes will be measured—that is, select the measures that you will use to assess change over time in detection of changes in a resident’s condition.

### **Plan for Data Collection and Analysis**

Tools that you can use to collect and analyze data include process flow charts, brainstorming, cause and effect diagrams, and consumer focus groups. These are readily accessible at: [www.health.nsw.gov.au/resources/quality/cpi\\_easyguide\\_pdf.asp](http://www.health.nsw.gov.au/resources/quality/cpi_easyguide_pdf.asp) (Easy Guide to Clinical Practice Improvement: A Guide for Healthcare Professionals. New South Wales Department of Health).

## **3. Intervention Phase**

### **Get Consensus**

Get team consensus on priorities and changes most likely to result in improvement and then decide on an intervention.

### **Remember Culture and Teaching, as well as Protocols**

Many interventions focus on what is done—for instance, changing or adding a protocol. These are good, but they often don’t work as well as they could unless they go along with changing the culture to appreciate the importance of the new protocol. The best interventions tend to address culture with team meetings and other educational or inspirational materials at the same time that the new protocol is added. Usually, culture change includes implementing and disseminating some core teaching.

### **Conduct PDSA (Plan, Do, Study, Act) Cycles**

The cycle begins with a plan and ends with an action based on learning gained. It should specify who, what, when, and where. The end of one cycle leads directly to the start of the next one.

- › Try a change; for example, conduct a 1-hour, online educational session for nurses on a specific ward.
- › Observe consequences by using the selected measures.

- › Learn from consequences—for example, some people used SBAR and the Early Warning Tool, but others did not, and you discover that those who used the tools had taken the online learning and the others had not.
- › Try a change—for example, in-service time is given for all staff to complete the online education. Then run another PDSA cycle.

The way you document observations may be simple, such as counting and recording on a tally sheet, or it may be more complex, such as using sophisticated tools for data analysis.

If the data do not support the intervention, they may not be appropriate. Look at the data for clues about what to change, and run another PDSA cycle. When you have finally arrived at a sustained change of the kind you intended, that final version of the intervention may be implemented on a larger scale.

## 4. Implementation and Impact

### **Implement the Change**

This means making it a permanent part of normal business throughout the unit or setting. It may mean applying the intervention throughout the nursing center, for instance. In this case, it would probably mean ensuring that all nurses and nursing assistants take the online teaching and demonstrate their familiarity with SBAR and Early Warning Tool.

Relevant support processes have to be implemented at the same time. For instance, the rollout of education will need to be supported with suitable in-service learning time.

### **Measure the Impact of the Change**

To provide evidence that the intervention resulted in improvement in all places where it was implemented, you will need to collect, analyze, and display the data. For example, you might create an annotated run chart showing changes in reported use rates for SBAR, unit by unit in the whole nursing center, after nursing assistants started using a new form to document changes in a resident's condition. You will be able to choose your measure from the experience you gained in the Intervention Phase (as described previously).

## 5. Sustaining Improvement

The QI step that fails most often is sustaining the improvement. When the project is done, even if it has been successful, if it is not monitored and no one is assigned to make sure the new standards are kept up, it will probably fade away.

Mechanisms for sustaining change include:

- › Standardization—that is, ensuring that new methods are implemented consistently over time.
- › Documentation of the project from planning through testing, implementation, and followup.
- › Indefinite periodic measurement—for example, of reported use rates of SBAR and the Early Warning Tool—and review to ensure that the change becomes routine practice. The measure chosen for this is called a quality indicator, and usually, it is easy to establish (for instance, something that is part of the Minimum Data Set or some other set of data that is always collected) and part of what a senior person reviews regularly.
- › Staff training and education, geared to the type of change proposed, the people who will be asked to implement it, and the skill level and work experience of the target group.

## Applying QI to Improving Detection of Change in a Resident's Condition

### Starting the Improvement Effort

First, you will generate and look at relevant data on detecting resident change in your area, probably with some of your lead team members. For instance, you might survey staff about how long they think it usually takes between the onset of a behavior change and getting a nurse or physician evaluation. Then you will ask questions and discuss how this state of affairs stacks up against other institutional priorities. When you have decided that this is the area you want to work on, you will form your teams; you will have a leadership team of one or a few people and a project team of five to nine. The project team will write a mission statement and select measures that the leadership team will review, adjust as needed, and approve.

Next, the project team will decide which problem to address in order to help detect change. Whatever the intervention, it will likely be essential to enhance the culture of awareness and the importance placed on the topic. That is usually where the teaching module comes into play. The project team will decide what area to work in first and will identify what process to change. Then the people in that unit will be educated about the topic area.

### **The Intervention**

In the case of detecting change, the primary intervention may be teaching this module, but it is likely that there will be a corresponding change in standard operations. For instance, daily rounds may add a specific question for every resident: Did you notice anything new about Mr. Jones? Or it may add this question to the format used by nursing assistants in their change-of-shift verbal and written reports. Each QI effort may have its own intervention to enhance detection of change.

### **Including Teaching for Culture Change in the Effort**

Finding the right person to teach the module is important. It is essential to find someone that the participants will look up to and respect for their knowledge of the area. A person who teaches well is also very important and not always easy to find. The person can be a lead nurse or other clinician, a QI officer, or a special guest teacher.

### **Plan-Do-Study-Act (PDSA) Cycles**

When the teaching is done and the new protocol is starting, the project team will assign someone to collect and review the data. That person will look at it, decide what seems to be working and what seems to not be working, adjust the protocol, let the staff know, and try again. He or she will continue until things seem to be where they should be for a sustained period of time.

### **Implementation and Impact**

Next, the protocol and education will be rolled out throughout the relevant area—say, the whole nursing center. A small number of key measures will be collected that the center can monitor to know how well the implementation worked.

## Concluding the Improvement Effort

Finally, a routine measure—such as the rates of documented nursing assistant reports of change, documented communications from nursing assistants to licensed nurses about change, or reported SBAR or CUS use rates—should be chosen as a quality indicator. The leadership team then needs to ensure that the quality indicator is routinely collected and reviewed by a responsible member of the center in order to ensure that the improvement is sustained over time and, if it falls off over time, that attention to the problem is renewed.

## Appendix 1-A. Suggested Slides for Module 1

Slide 1

### Knowledge objectives

Participants will be able to understand:

- › Why detecting change is important.
- › How to know a resident's normal (baseline) condition.
- › How to watch for change.
- › How the Early Warning tool and SBAR tool work.
- › How to communicate about change.

Slide 2

### Performance objectives

Participants will be able to:

- › Summarize a resident's normal (baseline) condition for other team members.
- › Identify whether changes in a resident's condition are important or not important.
- › Promote behaviors that improve change detection.

Slide 3

### Performance objectives (continued)

Participants will be able to:

- › Use the Early Warning tool and SBAR tool.
- › Decide when to report or when to ask for help when observing changes in a resident's condition.

Slide 4

### Case Study: Ms. A

- › 79-year-old frail woman.
- › Admitted after hip fracture, followed by hospital and rehabilitation stays.
- › Walks with a walker.
- › Daughters visit on weekends.
- › Liquid diarrhea.
- › Falling blood pressure, rising heart rate.
- › Fever of 102° F.
- › Transferred to the hospital intensive care unit.

Slide 5

### Case Study: Ms. A

- › How did Ms. A get so sick with only diarrhea?
- › When might you have decided to report it?
- › What would you have reported and to whom?

Slide 6

### Key Lessons

- › Learn to notice a change early.
- › Not reporting a change can lead to other things going wrong.
- › The sooner something is done, the better.

Slide 7

## Role of Nursing Assistants and Licensed Nurses

- › Your role in a long-term nursing center is important.
- › Nursing assistants see the residents most often.
- › Residents in long-term care depend on nursing assistants to notice changes.
- › Nursing assistants are the eyes, ears, and hands of the care team.

Slide 8

## Detecting Change

- › Know the resident's normal (baseline) condition.
- › Note the resident's ability to move around.
- › Know how the resident does with activities of daily living.
- › Know the resident's preferences for activities, eating, and dressing.

**Changes from the resident's normal condition can signal a medical change.**

Slide 9

## Recognizing Changes

- › Do a shift-to-shift comparison.
- › Make sure the needed equipment is available.
- › See if a change occurred in any of the resident's other vital signs.
- › Check the resident's records of urination and bowel movements.

Slide 10

### Registered Nurse's Assessment

- › Ask the resident how he or she feels, even if the resident is confused or seems to be “out of it.”
- › Ask the resident how and when the symptoms began.
- › Take the resident's vital signs again.
- › Perform a general exam; assess level of consciousness and cognitive and physical function.
- › After the assessment, organize the information and report it to the resident's nurse practitioner or doctor, if warranted.
- › Several tools to help with evaluating mental status can be found in the MDS.

Slide 11

### Top 12 Changes in Residents

#### Physical Changes

- Walking
- Urination and bowel patterns
- Skin
- Level of weakness
- Falls
- Vital sign

#### Non-Physical Changes

- Demeanor
- Appetite
- Sleeping
- Speech
- Confusion or agitation
- Resident complaints of pain

Slide 12

### Watch for Physical Changes

- › Walking – e.g., how much assistance the resident needs with walking.
- › Urination and bowel patterns – e.g., the resident is urinating less frequently.
- › Skin – e.g., the resident's skin is puffy.
- › Level of weakness – e.g., the resident is having difficulty lifting his or her arm.
- › Falls – e.g., the resident reaches for objects when in a wheelchair.
- › Vital signs – e.g., the resident is breathing faster than normal.

Slide 13

### Watch for Non-physical Changes

- › Demeanor – e.g., the resident is socializing less than normal.
- › Appetite – e.g., the resident is not interested in his or her food.
- › Sleeping – e.g., the resident falls asleep in unusual places.
- › Speech – e.g., the resident's speech is slurred.
- › Confusion or agitation – e.g., the resident is talking a lot more than usual.
- › Resident complaints of pain – e.g., the resident grimaces or winces when moving.

Slide 14

### Watching for Change

- › The key is to always be watching.
- › Residents should be watched wherever they are, all the time.
- › Check in with residents often.
- › Talk with others who provide care for your residents.

Slide 15

### All Members of the Interdisciplinary Team Must Watch for Changes

#### Physical Changes

- Walking
- Urination and bowel patterns
- Skin
- Level of weakness
- Falls
- Vital sign

#### Non-Physical Changes

- Demeanor
- Appetite
- Sleeping
- Speech
- Confusion or agitation
- Resident complaints of pain

Slide 16

### What is important enough to report?

- › For about every three to five reports, one full assessment is done.
- › It is more important to report anything that might matter than to get the amount of reported information perfect.

Slide 17

### How to Follow Up on the First Sign of Changes

- › Shift-to-shift comparisons.
- › Are there any changes that should be watched for or reported?
- › Early Warning tool.
  - o Form that nursing assistants can use to write down what they have noticed about a resident's condition.
  - o Use the tool anytime a resident has had a change.
- › SBAR tool.
  - o An abbreviation that helps you to remember how to communicate change.
  - o SBAR stands for Situation, Background, Assessment, Recommendation.

Slide 18

### Observing and Reporting

- › Who is responsible?
- › Front-line providers are the eyes and ears of the team.
- › Part of helping the team perform best is sharing information.
- › Receptionists, occupational therapists, chaplains, volunteers, housekeeping staff, other staff members, and visitors are important observers.

Slide 19

### A Safe Environment

- › Reporting changes helps keep residents as safe as possible.
- › Learning and experience help providers to keep residents safe.
- › Open communication among team members helps to keep residents safe.
- › Team members must move beyond blaming someone.
- › Those who care will speak up.

Slide 20

### Summing Up:

- › Detecting changes can prevent illness from getting worse.
- › Nursing staff know the resident best.
- › Nursing staff must be alert to watching for changes.
- › The need to share observations and respond to changes is very important.
- › Staff must know what's normal for the resident so it can be used for comparison when there is a change.
- › Staff must know the different changes they need to watch for.

Slide 21

### Pearls

- › The best way to detect a change in a nursing center resident is to get to know what is normal for that resident.
- › You can learn to be observant and to make a habit of being “tuned in” to residents.
- › Older people tend to respond less to change and may exhibit symptoms of illness that are different from those seen in younger people.
- › A safe environment supports open reporting of resident changes and does not find fault with reporters.
- › When in doubt, report a change.

Slide 22

### Pitfalls

- › Feeling that it is hard to report a change due to fear of blame is a barrier to safe care.
- › Forgetting to use reporting tools makes it harder to alert the care team to changes in a resident's condition.
- › Expecting someone else to take action when change is detected does not help residents stay safe.
- › Assuming someone else knows the resident better or knows more than you can get in the way of your desire to report what you think might be a change.

## Appendix 1-B. Pre/Post-Test Questions and Answers for Module 1

### Part 1. Pre/Post-Test Questions

1. What is the best environment that allows you to pick up on a change in a resident's condition?
  - a. An environment where providers are 'tuned in' to the residents.
  - b. One where staff are punished for reporting safety concerns.
  - c. One where people only feel comfortable to report anonymously.
  - d. One in which only supervisors/leadership may address concerns about residents.
  
2. Mr. L has been in the [LTC facility] for a month. He has a pressure ulcer that developed weeks ago and measurements are about the same as last week. The nurse should:
  - a. Make no mention of it at report.
  - b. Mention it at report, noting that it is unchanged, and when the nurse/doctor will next review the situation.
  - c. Tell Mr. L to 'eat more and fatten up a bit!'
  - d. Talk critically about the resident's care privately to coworkers.
  
- 3 Which of the following are part of gauging a resident's normal patterns:
  - a. Talking with the resident about things that are important to the resident.
  - b. Assessment of consciousness and function.
  - c. Reviewing the resident's health record.
  - d. All of above.
  
4. You notice that another nurse's resident, who is in the room near where you are to see to your resident, is angrily demanding his lunch. You are surprised because he is usually quiet and patient. Which of the following is the best next step?
  - a. You ask the licensed nurse if she has noticed any change in his mood or behavior, and if she has asked him how he is feeling.
  - b. You go to the resident and ask how he is feeling.

- c. You ask the resident what is wrong, telling him you will check on his lunch, and then notify the licensed nurse responsible for the resident about the possible change in condition.
  - d. You do nothing, as this is the first time it has occurred.
5. The Early Warning tool reminds you to do the following things, except?
- a. Notice whether the resident seems different than usual.
  - b. Check whether the resident ate less than usual.
  - c. Assess the resident's capacity to make a decision.
  - d. Notice whether the resident seems more agitated or nervous than usual.
6. What protocol does the SBAR tool ask you to follow?
- a. Situation-Blame-Argue-Resolve.
  - b. Situation-Background-Assessment-Recommendation.
  - c. Situation-Background-Alleviate-Resolve.
  - d. Solve-No Blame-Assessment-Resolve.
7. If you notice a sudden change in a resident's condition, what should the nursing assistant do?
- a. Notify a supervisor.
  - b. Document it in the resident's record.
  - c. Check with a co-worker about any previous history of similar events.
  - d. All of the above.

## Part 2. Pre/Post-Test Questions with Answers

- a. What is the best environment that allows you to pick up on a change in a resident's condition?
- a. An environment where providers are "tuned in" to the residents.
  - b. One where staff are punished for reporting safety concerns.
  - c. One where people only feel comfortable to report anonymously.
  - d. One in which only supervisors/leadership may address concerns about residents.

Answer: a

2. Mr. L has been in the [LTC facility] for a month. He has a pressure ulcer that developed weeks ago and measurements are about the same as last week. The nurse should:

- a. Make no mention of it at report.
- b. Mention it at report, noting that it is unchanged, and when the nurse/ doctor will next review the situation.
- c. Tell Mr. L to 'eat more and fatten up a bit!'
- d. Talk critically about the resident's care privately to coworkers.

Answer: b

3. Which of the following are part of gauging a resident's normal patterns:

- a. Talking with the resident about things that are important to the resident.
- b. Assessment of consciousness and function.
- c. Reviewing the resident's health record.
- d. All of above.
- e. Answer: d

4. You notice that another nurse's resident, who is in the room near where you are to see to your resident, is angrily demanding his lunch. You are surprised because he is usually quiet and patient. Which of the following is the best next step?

- a. You ask the licensed nurse if she has noticed any change in his mood or behavior, and if she has asked him how he is feeling.
- b. You go to the resident and ask how he is feeling.
- c. You ask the resident what is wrong, telling him you will check on his lunch, and then notify the licensed nurse responsible for the resident about the possible change in condition.
- d. You do nothing, as this is the first time it has occurred.

Answer: c

5. The Early Warning tool reminds you to do the following things except?

- a. Notice whether the resident seems different than usual.
- b. Check whether the resident ate less than usual.
- c. Assess the resident's capacity to make a decision.
- d. Notice whether the resident seems more agitated or nervous than usual.

Answer: c

6. What protocol does the SBAR tool ask you to follow?

- a. Situation-Blame-Argue-Resolve.
- b. Situation-Background-Assessment-Recommendation.
- c. Situation-Background-Alleviate-Resolve.
- d. Solve-No Blame-Assessment-Resolve.

Answer: b

7. If you notice a sudden change in a resident's condition, what should the nursing assistant do?

- a. Notify a supervisor.
- b. Document it in the resident's record.
- c. Check with a co-worker about any previous history of similar events.
- d. All of the above.

Answer: d



# Module 2. Communicating Change in a Resident's Condition

## Instructor Guide

Communicating Change in a Resident's Condition is intended for use in training staff in nursing homes and other long-term care facilities. This Instructor's Guide describes how to use the materials in the companion Student Workbook as a teaching session and also how to apply a quality improvement project for the topic of communicating change.

### Principal Message

The single most important message your audience should come away with is that communicating about changes in a resident's condition is essential and is everyone's responsibility. When procedures for team communication are in place, the number of "adverse events" (negative effects on residents' health) can be reduced. Staff should know how to keep track of and report changes in a resident's condition.

Staff should understand the concept of working in a safe environment. This means that nursing staff can work together as a team and share information openly. It also means they understand that keeping residents safe (not worrying about who might be to blame when things go wrong) is the most important thing. Participants should experience the setting of your teaching as an example of a safe environment, where information is freely shared and concerns are openly reported and supportively addressed.

### Principal Audiences

This training is geared towards licensed nurses (RNs/LPNs/LVNs), occupational and physical therapists, nursing assistants, and custodial and activities staff. It is designed to be accessible and relevant to all these care providers. So you can teach your participants all together, mixing the professional roles.

The importance of teaching the different professions together is that it will, in and of itself, likely improve teamwork by allowing each profession to understand

the other better. For instance, anecdotal research suggests that nursing assistants feel that licensed nurses rarely read their notes. Learning together presents an opportunity for nursing assistants to understand more about what licensed nurses need to see in a nursing assistant's note, and it allows licensed nurses to understand that it is important to read the notes and to let nursing assistants know that they do so.

## Workbook Content Overview

### Clinical Content

A change in a resident's condition may mean that he or she is at risk. Action can be taken only if changes are noticed and reported, the earlier the better. Changes that are not reported can lead to serious outcomes including medical complications, transfer to a hospital, or even death.

This module reviews ways for care teams to communicate about changes in a resident's condition, and it offers tools for reporting and following up after the report.

### Content by Session

This module is designed for presentation in two sessions. The first session introduces some of the art and science of communication. The second session provides tools of communication and discusses how to use them.

Your teaching goals for the module are to:

Ensure that participants understand a safe work environment and buy into that as something they want to be part of at their nursing center.

Develop participants' knowledge and skills in communicating resident change.

The module materials can also be used flexibly to fit a range of session lengths. Selecting materials to suit a 30-minute single session, for instance, is quite possible. However, this module is designed to be a 2-hour session.

### Objectives of the Session

Objectives are separated into knowledge and corresponding performance objectives. Suggested slides are provided in Appendix 2-A; they can be modified to suit your facility's needs. You can present these at the start of the session and even have them up on a flip chart or screen that stays on the side of the room

during the session. Or, you can return to them at the end of the session to give participants a sense that they are following your road map. It is often best to select one, two, or three objectives and leave the others aside. In teaching things that you want participants to really take in and use in practice, often ‘less is more’ – people can take in and integrate the new material in a useable way. You can remove unwanted objectives on the slides or highlight the ones on which you will focus.

## Knowledge Objectives for Participants

At the completion of this training, all participants should understand:

- › Why communicating changes in a resident’s condition is an important safety issue.
- › Why communication lapses are a major risk factor for resident safety.
- › The key principles of effective communication.
- › Typical obstacles to effective communication and how to overcome them.
- › What to communicate about changes in a resident’s condition.
- › How to communicate a resident’s change in condition using the SBAR (Situation – Background – Assessment – Recommendation) and CUS (Concerned – Uncomfortable – Safety) tools.

## Performance Objectives for Participants

At the completion of this training, all participants should be able to:

- › Demonstrate good communication techniques.
- › Use good communication skills.
- › Know how to communicate a change in a resident’s condition.
- › Use some simple tools to improve communication.

## Preparing for a Session

### 1. Assess the Needs of Your Audience

These training materials are meant to be used as a complete package. However, you may tailor them to the needs of participants and current practice at your nursing center. To determine needs, you can use a survey or talk to individuals

familiar with the nursing center. Whether you choose to use all or some of the material in the Student Workbook, decide on a focused goal for teaching. It is better for participants to learn and remember a few important pieces of new information than to feel overwhelmed by many new ideas.

Consider the language level that will best suit your audience. If you use technical medical terms, be sure to explain the meaning of the term. If your audience uses English as a second language, speak clearly and not too quickly.

## 2. Consider Your Teaching Method(s)

Most instructors find that a combination of methods – lecture and interactive – works best. Consider using a selection of these teaching methods:

- › Lecture with slides.
- › Whole group discussion.
- › Break-out group discussion.
- › Case discussion.
- › Role play.

Suggestions for ways to use these are in the “Recommended Teaching Methods” section of this module.

## 3. Presentation Timing

The suggested timing for each portion of this 2-hour module is:

Introduction of Instructor, Topic, and Objectives .....	5 minutes
Pre-test .....	5 minutes
Case Discussion .....	10 minutes
Presentation 1, Interactive Lecture .....	20 minutes
Case and “Critical Reflection” Discussion .....	15 minutes
Break .....	5 minutes
Presentation 2, Interactive Lecture .....	18 minutes
Case Discussion and Role Play (2 scenarios) .....	20 minutes
Debrief on Teaching Methods .....	5 minutes
Key Take-Home points .....	5 minutes
Post-test .....	5 minutes
.....	Total: 115 minutes

Although this is a 2-hour module, you can teach it in two 1-hour blocks. You can also select material within the module to make a 30-minute or a 45-minute session, or two 30-minute sessions within a 1-hour slot. This flexibility is important, as some nursing centers might not have adequate nursing coverage for a 2-hour session.

#### 4. Suggested Slides

The Student Workbook is not meant to be used as a prepared speech. It assumes that you know the subject and offers material you may want to use. The suggested slides found in Appendix 2-A and the text boxes shown in the Student Workbook are meant to trigger your presentation. You can pick and choose the slides to suit your students and your facility; it would be useful to practice speaking with them.

#### 5. Preparing Your Presentation: Overview of Effective Instruction for Adult Learners

Adult learning involves change – in knowledge, behavior, and skills.

This module aims to help participants improve the way they notice, report, and keep track of changes in a resident's condition.

Adults are usually most motivated to learn when:

- › They see the subject as directly related to their own needs and goals.
- › They see ways for their learning to be applied to their own work settings.
- › They are responsible for their own learning.
- › Their own knowledge and skills are appreciated.
- › “Mistakes” are seen as chances to learn.
- › Practical, hands-on experience is part of the instruction.

Adults take in new information more quickly and remember it better when it relates to their own experience. Structure your session to draw on what participants already know and what they want to learn. Make sure everyone feels that they have something to contribute.

Teaching methods such as interactive lecture, case discussion, and role play help lead adults to make changes on the job. A good way to get your group moving in this direction is to start with a case for discussion. If the case reflects a situation that's familiar to participants, with a problem they want to solve, you'll have a “teachable moment.”

### **Interactive Lecture**

With this method you present the material, using questions and answers and slides or other visual aids.

### **Case Discussion**

The case tells a story. It involves situations like those participants face at work. You lead a discussion that brings in what they know and how they might handle the situation. You will want to be sure that different ideas are heard, and see if anyone changes their mind. You will find a sample case in the “Making the Presentation” section that follows.

### **Role Play**

“Learning through acting” gives participants a chance to use what they know and practice something new in a real-world setting. It can help them see a situation from different points of view. It also helps to develop communications skills.

### **Writing It Down**

With all these techniques, it is useful to note participants’ ideas and questions – a flip chart works well. This helps keep participants thinking and engaged. You can keep a “parking lot” list of thoughts that may not be on point at the moment, but should be kept in mind when you’re summing up the session.

More information on how to teach this material is presented in the “Giving Your Presentation” section.

## **6. Preparing a Handout for Participants**

These training materials are meant to be used as a complete package. However, you should feel free to choose the parts you think are most relevant for your particular audience and nursing center. The slides provided in this Instructor Guide (Appendix 2-A) may be reproduced and provided to participants. For this module, you may also want to distribute the case.

## **7. Learning Settings that Work for this Module**

Think ahead about the kind of setting that will be available and will best allow your targeted group to participate in the training. You also should consider work shifts and how your session can fit with in-service training requirements or other options. It helps if your session meets some of the nursing center’s requirements

for staff training. It is also good to provide refreshments if you can – that tends to increase attendance. Post announcements ahead of time so that people know when and where your session is going to happen. You might have a leader introduce the session to show that it is important.

## 8. Using Pre- and Post-Tests

Pre- and post-tests provide real-time feedback on how well the training session worked. The pre-test sets a baseline of what participants knew about the topic before the session; this can be compared with the results of the post-test to answer the questions, “What changed from the beginning of the session to the end? Did participants learn what we wanted them to learn?” The tests can be found in Appendix 2-B.

## 9. Equipment

You will need equipment that allows you to display slides, and also record discussion points and questions from participants. You may use one or more of the following:

- › Slide projector and screen, along with PowerPoint slides.
- › Flip chart.
- › Overhead projector with transparencies.

## Giving Your Presentation

- › Introduce yourself and explain the reason for the training.
- › Hand out the pre-tests. Explain that pre- and post-tests help participants evaluate themselves and help you evaluate the course. Have participants complete the pre-test.
- › Introduce the topic and review session objectives (using slides – see Appendix 2-A).
- › Present the material.

## Recommended Teaching Methods

For this module, a mix of teaching methods may be the best – some interactive lecture, some case discussion, and some role play.

## Interactive Lecture

The “stand-up” lecture works well when the topic is something participants care about and when the speaker is engaging. It is best used when a large amount of information needs to be delivered to a silent audience.

In an “interactive lecture” you still speak most of the time and control the subject being addressed, but the audience participates in different ways – asking or answering questions, giving examples from their experience, and/or expressing opinions.

Like a story, any lecture – regardless of length – has a beginning (the introduction), a middle (the body), and an end (the summary). Each of these serves a different purpose.

**Introduction:** establishes the purpose of the lecture. The overall goals and specific objectives are stated. The introduction should include an overview of the whole lecture. Your aim is to get participants interested and make them aware of expectations for the session.

**Body:** includes the material needed to meet the objectives stated in the introduction. Your session will be most effective if you:

- › Capture participants’ attention in the first few minutes.
- › Involve them in fine-tuning the focus of learning.
- › Plan a change of pace every 8-10 minutes during a lecture.
- › Give participants a chance to reflect.
- › Use visual aids.
- › Give participants a chance to share experiences.

**Summary:** includes a recap of the material presented in the body of the lecture. It may also include an opportunity for participants’ questions and feedback.

## Case Discussion

Most instructors prefer to use the case provided in this module. A clinically experienced instructor who is also a seasoned teacher may also invite participants to contribute relevant cases they have been involved in, while a new instructor may prefer to keep the focus on a familiar case.

### Case Study

Mrs. C is 85 years old; she has lived at the Manor Nursing Center for about a year. Lisa and Anne are the nursing assistants on duty on Mrs. C's unit today on the evening shift, and Linda is the licensed nurse. Lisa and Anne know that Mrs. C has recently learned that her daughter, who lives in another State, is seriously ill. After the evening meal, Lisa notices that Mrs. C is not her normal self. Usually talkative, she is suddenly not talking much. She is also limping for an unknown reason, and seems very upset and angry. Lisa tries to talk to Mrs. C but doesn't get much response. When she arrives to help Mrs. C prepare for bed, she finds Mrs. C already asleep on her bed, still in her clothes. When she wakes Mrs. C up to help her change and wash before bed, Mrs. C seems disoriented and says something rude to her.

**What needs to be communicated? By and to whom? How? When? Where?  
How do you know when the communication has worked or not?**

In answering these questions, think about specific things that specific people should do: What should Lisa do next? What can Anne do? What can Linda the nurse do? Should Linda call Mrs. C's attending doctor? What should they tell the night shift licensed nurse and nursing assistant when they come on duty?

Once the case has been presented, pause and invite participants to comment.

Questions to get discussion going and draw on prior knowledge might be of the "survey" type:

- › Have any of you ever had to work with a new resident without having been told anything about them?
- › How often would you say this happens in your nursing center?
- › Does your nursing center have rules to follow when you see a change in a resident, such as Mrs. C's sleeping at a time when she's usually up and dressed?
- › Who are you supposed to talk to if you have a concern about a patient?

Questions you could ask to reinforce the knowledge you are sharing might be:

- › When would you use SBAR?
- › When would you use CUS?

You can encourage critical thinking and communication with questions like these:

- › What should each person on the care team know about Mrs. C?
- › When should a member of the team ask for help? Who should it be?
- › When should a report be made about the change in Mrs. C's condition?
- › What kind of report should be made, and who should receive the report?

You might ask participants to brainstorm ideas about ways to communicate that would prevent this situation.

Keep in mind that you are trying to get participants to think in terms of teamwork rather than blame.

Try to get them to talk with each other, not just to you. Have them discuss a topic in pairs or in groups of three. This method makes it easier for a shy person to be heard, as the less shy member of the pair or team can speak up for both or all of them.

If the number of participants is small, case discussion may be led with the whole group. Larger groups may be broken up into smaller ones, with each taking one or two questions and then reporting out to the whole group. You may also wish to divide participants into groups according to what they do (i.e. licensed nurses, nursing assistants, occupational and physical therapists, etc.)

## Role Play

This technique has participants take on roles in a clinical interaction. There is no written script, and the “actors” don't have to memorize anything.

There are five parts to this technique.

**Set-up:** Ask participants about their previous experiences with role play. Explain the goals of this exercise and relate them to the key learning objectives. Make sure everyone is familiar with the overview of the case. Only the “actors,” however, will know the details of their roles. It may be helpful to provide the description of the role play to those who are not participating as actors in the role play.

Then go over some guidelines:

- › Anything that comes up is confidential.
- › This is a safe place. Actors should not be afraid to take risks.
- › Feel free to be spontaneous!

**Assign the roles:** You may have actors play a role similar to the one they have in their actual jobs; or you might encourage them to try out a new one. A licensed nurse, for example, could take the part of a resident, or a nursing assistant could act as a licensed nurse. Involve as many people as possible in the role play. Because role play requires participants to be somewhat emotionally open, they may feel anxious, or they may resist being an actor. Your own positive attitude and a light touch will help. Any participants who are not assigned to a role should be asked to be observers.

**Conduct the role play:** Participants act out their roles in the “scenarios” you will provide (examples below), based on the case. Try not to interrupt the role play while it is running; just let the interactions flow naturally.

Before each scenario, explain how much time it will take and that it will be followed by discussion. It should take only 2-3 minutes, followed by perhaps 5 minutes of discussion.

Don't let the role play go on for too long – most of the learning happens in the first few minutes. If actors seem too carried away by their roles, remind them to keep it simple.

**Scenario 1.** Two roles: Pamela and Peter. Peter gets paged while taking a report from Pamela and has to leave to deal with a situation on another floor. Pamela had just begun telling him about Mrs. C. Pamela switches to a rapid SBAR communication so that Peter can act on it before going to the other floor.

Tell the role players to simulate the interaction between the nursing assistant and the licensed nurse, making it clear when the interaction is happening and in what setting (e.g. on the phone as soon as possible, at change of shift etc.). Tell them their goals are to: 1. get all the information across; 2. communicate about the situation in a timely fashion; and 3. be able to push if the message does not seem to be getting across.

**Scenario 2.** Three roles: Pamela, Paulina, and Angela. Pamela, who has cared for Mrs. C for some time, does not recognize the names Mrs. C mentions when she is awakened. As Pamela passes Angela in the hall, Pamela asks what time Mrs. C got up over the weekend when Angela cared for her. Angela shares that Mrs. C. was not herself over the weekend either and that she told Paulina, the registered nurse, about it then. Together, they decide it's time to use the CUS method.

Tell the role players to simulate the interaction with the following goals: 1. how to decide if there was a change in Mrs. C's condition; 2. how to get Paulina's attention; and 3. have Pamela use CUS with Paulina.

**Discuss the role play:** Discuss the issues that came up in the role play. Everyone's input should be included. After each scenario is played out, ask the actors: What went well? What did not go well? What would they do differently next time? How did it feel to say \_\_\_\_? How did it feel to hear \_\_\_\_? Ask observers for their opinions about what the desired outcome was in each situation and how they might have handled the situation differently.

**Conclude the role play:** Encourage a round of applause as the participants return to "out of role." Summarize the major themes and issues. Consider with the group how to apply the role play to real life clinical situations. Emphasize what was learned during the role play.

### Debrief About the Teaching Method

- › Ask participants what methods they think you used. Get their thoughts on what worked and what could be done better.
- › Listen and thank them for their thoughts.

### Review Key Take-Home Points

- › Promote a safe environment based on teamwork and thinking about how the system of care works and how it can be improved, rather than thinking about blame.
- › Educate the entire staff about the importance of communicating about changes in a resident's condition.
- › Use appropriate reporting tools.

### Post-Test

Thank your participants for attending, and hand out the post-tests. Emphasize how important it is to complete the post-tests because they can get feedback on what they've learned (based on their answers to the pre- and post-tests). Tell participants that you will provide the correct answers and rationales for the tests after they are done.

Be sure to stress that the post-test is anonymous.

### Translating the Teaching into Practice

Often, it is difficult to ensure that what is taught in a classroom or in-service learning session is translated into action as part of resident care. Even if the

teaching has gone well and the learning was taken in and appreciated, it can be hard to put the new learning into practice. There are many possible barriers. For instance, the system of care may not accommodate the new practice, the culture of care may not accept the change, or the leadership may not be aware of the new learning and so may not make room for it.

Following up after a teaching session with a quality improvement project in which the new learning is put into practice by the whole team can help a lot. Quality improvement projects use a step-by-step approach to improving care by taking a long, hard look at what needs to be done. Participants will be starting out with a small change, watching it, adding to it, and continuing in this fashion until the job is done. It has a whole method to it, and the method is described in the “Quality Improvement” section.

Quality improvement methods often include a teaching step. This module can be the teaching material for that step. If the quality improvement project is to improve the way nursing assistants and licensed nurses detect and communicate changes in a resident’s condition, then this module is perfect for the teaching part of the project.

## Quality Improvement

Quality improvement (QI) is an approach that may be used by nursing staff and managers to improve quality and safety in patient care. QI’s three main components are to :

- › Gain knowledge and skills to understand systems of care and minimize adverse outcomes.
- › Apply methods to identify, measure, and analyze problems with care delivery.
- › Act on the results of data collection and analysis to improve both individual care delivery and systems of care delivery.

QI requires a team approach, involving everyone in thinking about innovation and recognizing that the key to improvement is the people who care for patients. It is not about individual rewards and punishments, but rather it relies on measurement to improve the center’s performance as a whole.

At the core of QI is the Plan-Do-Study-Act (PDSA) cycle, based on trial and error over time.

- › Plan: Identify a problem and design a change to address it.
- › Do: Implement a small change.

- › Study: Measure and analyze the effects of the change.
- › Act: Take action based on the results of analysis, such as trying another change, formally implementing a change, or extending implementation more broadly.

When you engage in a QI project you will be using information/data that you have on current practices at your site to develop goals based on both best practices and realistic expectations.

The five phases of the QI process are outlined here.<sup>3</sup>

## 1. Project Initiation Phase

### **Decide on the Area of Work that Needs Improvement**

In this example we focus on communication about changes in a resident's condition. Most likely, there already will have been a process at the center to get to this point. Still, it is helpful when starting the project to make sure everyone believes in its importance. Collect data to support your assumption that there is a problem and establish a baseline for measuring improvement.

### **Form Teams**

Leadership teams must include one or a few people with enough institutional authority to help get the resources that the project team needs.

For this project, the Director of Nursing, the Quality Improvement Officer, the center's overall Director, or the Chief Operating Officer would potentially be good choices.

Project teams must:

- › Have basic knowledge of the problem.
- › Represent all parts of the process and different levels of the organization.
- › Have at least one member trained in QI.
- › Recognize that good ideas can come from anyone.

The ideal team size is five to nine people. Additional temporary members with special areas of expertise can be invited to particular meetings as needed.

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<sup>3</sup> For more detailed information on QI and measurement tools, please see The Patient Safety Education Project (PSEP), Module 9: Methods for Improving Safety, which can be found at <http://patientsafetyeducationproject.org>.

For a communication of changes improvement project, the following project team members are one example of a good team.

- › Registered nurse.
- › Two nursing assistants.
- › Director of nursing.
- › Education director.
- › Geriatrician.

### **Write an Aim or Mission Statement that is “SMART”**

- › **S**pecific
- › **M**easurable
- › **A**ppropriate
- › **R**esult-oriented
- › **T**ime-scheduled

The aim should include a “stretch” goal that may be hard to reach but is achievable, for example: To decrease the rate of resident falls by 50 percent in 12 months.

### **Consider Appropriate Measures**

Examples of measurement (data) include a “process measure” like compliance rates for wearing ID badges with the SBAR or CUS acronym spelled out on the back, or documented nursing notes in the chart on reports of change; or an “outcome measure” like reported use rates for SBAR and for CUS.

To show improvement, you should be able to plot the variable being measured on a run chart (a graph that displays observed data in a time sequence).

## **2. Identifying the Problem**

### **Identify the Problem**

- › The problem and its extent—that is, what are the barriers to and how poor is communication of change now?
- › Changes that can be made that are expected to result in improvement—that is, what might improve communication by overcoming those barriers and how?

- › How the effects of the changes will be measured—that is, select the measures that you will use to assess change over time in communication about changes in a resident’s condition.

### **Plan for Data Collection and Analysis**

Tools include process flow charts, brainstorming, cause and effect diagrams, and consumer focus groups. These tools are readily accessible at: [www.health.nsw.gov.au/resources/quality/cpi\\_easyguide\\_pdf.asp](http://www.health.nsw.gov.au/resources/quality/cpi_easyguide_pdf.asp).<sup>4</sup>

## **3. Intervention Phase**

### **Get Consensus**

Get team consensus on priorities and changes most likely to result in improvement and then decide on an intervention.

### **Remember Culture and Teaching, as well as Protocols**

Many interventions focus on what is done; for instance, changing or adding a protocol. These are good, but they often don’t work as well as they could unless they are part of changing the culture to appreciate the importance of the new protocol. The best interventions tend to address culture with team meetings and other educational or inspirational materials at the same time that the new protocol is added. Usually, culture change includes implementing and disseminating some core teaching.

### **Conduct PDSA (Plan-Do-Study-Act) Cycles**

The cycle begins with a plan and ends with an action based on learning gained. It should specify who, what, when, and where. The end of each cycle leads directly to the start of the next one.

- › Try a change—for example, provide a new I.D. badge with SBAR and CUS on the back, as well as a 1-hour, online educational session for nurses on a specific ward.
- › Observe consequences by using the selected measures.

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<sup>4</sup> Easy Guide to Clinical Practice Improvement: A Guide for Healthcare Professionals. New South Wales, Australia: New South Wales Department of Health; 2002

- › Learn from consequences—for example, some used SBAR and CUS but others did not, and you discover that those who used the tools had taken the online learning and the others had not.
- › Try a change—for example, in-service time is given for all staff to complete the online education. Then run another PDSA cycle.

The way you document observations may be simple, such as counting and recording on a tally sheet, or it may be more complex, using sophisticated tools for data analysis.

If the data do not support the intervention, they may not be appropriate. Look at the data for clues about what to change, and run another PDSA cycle. When you have finally arrived at a sustained change of the kind you intended, that final version of the intervention may be implemented on a larger scale.

## 4. Implementation and Impact

### **Implement the Change**

When you implement the change it means making the change a permanent part of normal business throughout the unit or setting. It may mean applying the intervention throughout the nursing center, for instance. In this case, it would probably mean ensuring that all nurses and nursing assistants take the online teaching and receive badges with SBAR and CUS written on the back.

Relevant support processes have to be implemented at the same time. For instance, the rollout of education will need to be supported with suitable in-service learning time.

### **Measure the Impact of the Change**

To provide evidence that the intervention resulted in improvement in all places it was implemented, you will need to collect, analyze, and display the data. For example, you might create an annotated run chart showing changes in reported use rates for SBAR and CUS, unit by unit in the whole nursing center, after nursing assistants started using a new form to document changes in a resident's condition. You will be able to choose your measure from the experience you gained in the Intervention Phase (see item number 3, above).

## 5. Sustaining Improvement

The step in QI that fails most often is sustaining the improvement. When the project is done, even if it has been successful, if it is not monitored and no one is assigned to make sure the new standards are kept up, it will probably fade away.

Mechanisms for sustaining change include:

- › Standardization, ensuring that new methods are implemented consistently over time.
- › Documentation of the project from planning through testing, implementation, and followup.
- › Indefinite periodic measurement—for example, of reported SBAR and CUS use rates, and review to ensure that the change becomes routine practice. The measure chosen for this is called a quality indicator, and usually it is easy to establish (for instance, something that is part of the Minimum Data Set or some other set of data that are always collected) and part of what a senior person reviews regularly.
- › Staff training and education, geared to the type of change proposed, the people who will be asked to implement it, and the skill level and work experience of the target group.

## Applying QI to Improving Communication of Change in a Resident's Condition

### Starting the Improvement Effort

First you will generate and look at relevant data on communicating resident change in your area, probably with some of your lead team members. For instance, you might survey staff about how often they think a significant resident change that gets noticed also gets communicated in an optimal fashion. Then you will ask questions and discuss how this state of affairs stacks up against other institutional priorities. When you have decided that this is the area you want to work on, you will form your teams – you will have a leadership team of one or a few people and a project team of five to nine individuals. The project team will write a mission statement and select measures that the leadership team will review, adjust as needed, and approve.

Next, the project team will decide what problem to address in order to help communicate change. Whatever the intervention, it likely will be essential to enhance the culture of awareness and the importance placed on the topic. That is usually where the teaching module comes in. The project team will decide what area to work in first and what process to change; then the people in that unit will receive the training about the topic area.

## The Intervention

In the case of communicating change, the primary intervention may be teaching this module. But it is likely that there will be a counterpart change in standard operations. For instance, daily rounds may add a specific question for every resident: “Did you notice anything new about [resident name]?” Or it may add SBAR to the format used by nursing assistants in their change-of-shift verbal and written reports. Each QI effort may have its own intervention to enhance detection and communication of change.

## Including Teaching for Culture Change in the Effort

Finding the right person to teach the module is important. Someone that the participants will look up to and respect for their knowledge of the area is essential. A person who teaches well is also very important and not always easy to find. The person can be a lead nurse or other clinician, a QI officer, or a special guest teacher.

## Plan-Do-Study-Act (PDSA) Cycles

When the teaching is done and the new protocol is starting, the project team will have someone assigned to collect and review the data. That person will look at the data, decide what seems to be working and what seems to not be working, adjust the protocol, let the staff know, and try again. The cycle will continue until things seem to be where they should be for a sustained period of time.

## Implementation and Impact

Next, the protocol and education will be rolled out throughout the relevant area – say, the whole nursing center. A small number of key measures will be collected that the center can monitor to know how well the implementation worked.

## Concluding the Improvement Effort

Finally, a routine measure—such as the rates of documented nursing assistant reports of change, documented communications from nursing assistants to licensed nurses about change, or reported SBAR or CUS use rates—should be chosen as a quality indicator. The leadership team then needs to ensure that the quality indicator is routinely collected and reviewed by a responsible member of the center to ensure that the improvement is sustained over time and, if it falls off over time, that attention to the problem is renewed.

## Appendix 2-A. Suggested Slides for Module 2

Slide 1

### Knowledge Objectives

Participants will understand:

- › Why communicating changes in a resident's condition is an important safety issue.
- › Why communication lapses are a major risk factor for resident safety.
- › Key principles of effective communication.

Slide 2

### Knowledge Objectives (continued)

Participants will understand:

- › Typical obstacles to effective communication and how to overcome them.
- › What should be communicated about changes in a resident's condition.
- › How to communicate a resident's change in condition using the SBAR and CUS tools.

Slide 3

### Performance Objectives

Participants will be able to:

- › Demonstrate good communication techniques.
- › Practice good communication skills.
- › Effectively communicate a change in a resident's condition.
- › Use some simple tools to improve communication.

Slide 4

### Case Study: Mrs. C

- › What needs to be communicated?
- › By and to whom?
- › How?
- › When?
- › Where?
- › How do you know when the communication has worked?

Slide 5

### Reporting Changes in a Resident's Condition

- › Detecting and reporting changes: essential to patient care.
- › Reporting changes is necessary for quality resident care.
- › Reporting involves the following skills:
  - o Communicating what you have noticed to the care team.
  - o Working together to identify what the change might mean.
  - o Working with the team to take action to make sure the resident is safe.

Slide 6

### A Safe Environment

- › Reporting changes helps keep residents safe.
- › Learning and experience are what make safety possible.
- › Openly reporting anything that might affect a resident's well-being is essential for a safe environment.
- › Change in a resident's condition should be reported openly, whenever it happens.

Slide 7

## Communicating About Unwanted Events

- › Learn to communicate openly when something happens that might affect a resident's well-being.
- › Move beyond blaming anyone to being able to openly share experiences.
- › Show you care by speaking up.

Slide 8

## Communication

- › Express yourself in a way that you will be "heard."
- › "Hear" how other people answer you.
- › Two types of communication: verbal and non-verbal.

**We all are responsible for communicating about change in a resident's condition.**

Slide 9

## Stages of Communication

- › Get ready.
- › Give your information.
- › Check to see if it was received.

Slide 10

## Stages of Receiving Communication

- › Listening.
- › Responding.
- › Following up.

Slide 11

## Barriers to Communication

- › Differences in:
  - Gender.
  - Age/generation.
  - Language.
  - Culture.
  - Status.
- › Interpersonal issues.
- › Environmental or system barriers.
- › Workload issues.

**We may face several communication barriers at the same time.**

Slide 12

## Session 1 Summary

For good communication:

- › Have ideas about how to work around barriers.
- › Give clear messages.
- › Focus your attention by actively listening.
- › Be aware of nonverbal signals, both given and received.
- › Give and ask for feedback.

Slide 13

## SBAR

### **Situation:**

- › Identify yourself.
- › Identify the resident.
- › State the problem.
- › Give a physical assessment report.
- › Be brief and concise.

### **Background:**

- › Brief medical history.
- › Health care already provided.
- › Medications list.
- › Allergies.
- › Vital signs.
- › Lab results.
- › Advance directive or code status.

### **Assessment:**

- › Findings.
- › Severity.
- › Life-threatening?

### **Recommendation:**

- › What should happen next?
- › What do you need?
- › Timeframe?

Slide 14

## Benefits of SBAR

- › Teamwork.
- › Expectations.
- › Critical thinking skills.
- › Patient safety.

Slide 15

### Using the SBAR Tool

- › Speak clearly.
- › Review the chart.
- › Complete the SBAR.
- › Document the SBAR in progress notes.

Slide 16

### Example: Nursing Assistant to Nurse

Situation:

- › Ms C fell asleep in her clothes this evening and cursed at me.

Background:

- › She is the 85-year-old from room C6; she is usually pretty friendly and does her own ADLs.

Assessment:

- › She seems okay physically, but I am worried.

Recommendation:

- › I'd feel better if you would take a look at her and make an assessment.

Slide 17

### CUS

- › I am Concerned.
- › I am Uncomfortable.
- › The Safety of the resident is at risk.

Slide 18

### Information to Be Communicated

- › Top physical and non-physical changes to watch for in residents.
- › Nursing assistant communication tasks.
- › Licensed nurse communication tasks.

Slide 19

### Session 2 Summary

- › Noticing changes in a resident's condition is important, but it is not enough to ensure resident safety and well-being.
- › Changes must be detected early and communicated promptly.
- › A safe environment depends on good communication.
- › Everyone is responsible for speaking up.
- › Communication skills can be learned.
- › We all face barriers to communication.

Slide 20

### Pearls

- › Caring means communicating.
- › Communication happens in many directions, among many disciplines.
- › Communicating effectively = speaking up and listening for feedback.
- › Effective communication involves speaking and listening.
- › Often, there are barriers to communication, and frequently several barriers at the same time.
- › Communication tools like SBAR and CUS help us structure our communications.

Slide 21

### Pitfalls

- › Assuming that someone in a higher position knows what is happening is often incorrect.
- › Saying something does not mean you have been heard.
- › Assuming that someone from a different culture who speaks your language understands you is often incorrect.
- › Forgetting to listen can be as much of a problem as not speaking up.

## Appendix 2-B. Pre/Post-Test Questions and Answers for Module 2

### Pre/Post-Test Questions

1. The best way to communicate information about your resident to other members of the care team is:
  - a. Talking directly to the staff on the next shift.
  - b. Writing it on a loose piece of paper at the nurses' station.
  - c. Writing it next to the resident's name on a white board at the nurses station.
  - d. Telling the resident to tell the doctor.
  - e. All of the above.
2. Steps in good communication include:
  - a. Setting the stage, finding out what the coworker understands, giving the information, understanding the coworkers' perspective, and ending the communication with a plan for next steps.
  - b. Ensuring that the coworker receives the information in a phone message.
  - c. Making sure a supervisor communicates with the coworker.
  - d. Ensuring that the coworker knows it is his or her responsibility to understand relevant matters.
3. Which of the following should you communicate to the licensed nurse on duty in addition to the next shift nursing assistant?
  - a. Your resident drank only one glass of fluid all day today.
  - b. For the first time, your resident was not able to support her/his weight while transferring to a chair.
  - c. Your normally cooperative resident cursed at you this morning.
  - d. All of the above.

4. In giving information about a resident, it is often helpful to use the SBAR. In SBAR, there are four parts of the message you want to give; each one goes with one of the letters in SBAR. SBAR stands for:
- a. Situation, Background, Assessment, Recommendation
  - b. Sites and Sounds, Before the change, Ask me, Rate me.
  - c. Silent? Big? Aloud? Right?
  - d. See. Bring. Allow. Read
5. CUS is another communication tool. All of the following are correct except:
- a. CUS stands for I am Concerned, I am Uncomfortable, the Safety of the resident at risk.
  - b. CUS should be used in all situations.
  - c. CUS should be used if you need to get the attention of your supervisor fast or if the first try at communicating did not work.
  - d. CUS can be used by nursing assistants.

### Pre/Post-Test Questions with Answers

1. The best way to communicate information about your resident to other members of the care team is:
- a. Talking directly to the staff on the next shift.
  - b. Writing it on a loose piece of paper at the nurses station.
  - c. Writing it next to the resident's name on a white board at the nurses station.
  - d. Telling the resident to tell the doctor.
  - e. All of the above.

Answer: a

2. Steps in good communication include:
- a. Setting the stage, finding out what the coworker understands, giving the information, understanding the coworkers' perspective, and ending the communication with a plan for next steps.

- b. Ensuring that the coworker receives the information in a phone message.
- c. Making sure a supervisor communicates with the coworker.
- d. Ensuring that the coworker knows it is his or her responsibility to understand relevant matters.

Answer: a

3. Which of the following should you communicate to the licensed nurse on duty in addition to the next shift nursing assistant?
- a. Your resident drank only one glass of fluid all day today.
  - b. For the first time, your resident was not able to support her/his weight while transferring to a chair.
  - c. Your normally cooperative resident cursed at you this morning.
  - d. All of the above.

Answer: d

4. In giving information about a resident, it is often helpful to use the SBAR. In SBAR, there are four parts of the message you want to give; each one goes with one of the letters in SBAR. SBAR stands for:
- a. Situation, Background, Assessment, Recommendation.
  - b. Sites and Sounds, Before the change, Ask me, Rate me.
  - c. Silent? Big? Aloud? Right?
  - d. See. Bring. Allow. Read.

Answer: a

5. CUS is another communication tool. All of the following are correct except:
- a. CUS stands for I am Concerned, I am Uncomfortable, the Safety of the resident is at risk.
  - b. CUS should be used in all situations.
  - c. CUS should be used if you need to get the attention of your supervisor fast or if the first try at communicating did not work.
  - d. CUS can be used by nursing assistants.

Answer: b



# Module 3. Falls Prevention

## Instructor Guide

This Instructor's Guide describes how to use the materials in the companion Student Workbook as a teaching session and also how to apply a quality improvement project for the topic of falls prevention and management.

### Principal Message

The single most important message your audience should come away with is that they can help reduce the number of falls and fall-related injuries at their nursing center. Nursing staff should know the risk factors contributing to falls and ways to prevent them. In addition, they should be able to manage injuries that result from falls.

Staff should understand what it means to work in a safe environment, where nursing staff can work together as a team and share information openly. It also means they understand that keeping residents safe, and not worrying about who might be to blame when things go wrong, is the most important consideration. Participants should experience the setting of your teaching as an example of a safe environment, where information is freely shared and concerns are openly reported and supportively addressed.

### Principal Audiences

This training is geared towards licensed nurses (RNs/LPNs/LVNs) and nursing assistants. It is designed to be accessible and relevant to all these care providers, so you can teach your participants all together, mixing the professional roles.

Teaching the different professions together is important because it will, in and of itself, likely improve teamwork by allowing each profession to understand the other better. For instance, anecdotal research suggests that nursing assistants feel that licensed nurses rarely read their notes. Learning together presents an opportunity for nursing assistants to understand more about what licensed nurses need to see in a nursing assistant's note, and it allows licensed nurses to understand that it is important to read the notes and to let nursing assistants know that they do so.

If the learning culture of your audience suggests that staff from different professions cannot learn together, you can separate your participants into different sessions according to their professional roles.

## Workbook Content Overview

### Clinical Content

Falls are serious, unwanted events (negative effects on a resident's health) that happen in both hospitals and long-term nursing centers. They can lead to medical complications or even death.

This module reviews the problem of falls in nursing settings. Risk factors are identified, and ways to prevent injury are discussed.

### Content by Session

This module is designed for presentation in two sessions. The first session starts by describing what it takes to make a safe work environment in which sharing of events in a blame-free way allows supportive learning. It goes on to define and explain what a fall is, noting that falls should be distinguished from sudden medical events that can cause what looks like or also involves a fall, such as a stroke or seizure. It also describes risk factors for falls.

The second session describes how to do an assessment of fall risks for residents and how to respond to a fall or near fall.

Your teaching goals for both sessions of the module are to:

- › Ensure that participants understand how a safe environment means open reporting and supportive teamwork to minimize injurious falls.
- › Develop participants' knowledge and skills in preventing falls and fall-related injuries.

The module materials can be used flexibly to fit a range of session lengths. Selecting materials to suit a 30-minute single session, for instance, is quite possible. However, this module is designed to be a 2-hour session.

## Objectives of the Session

Objectives are separated into knowledge and corresponding performance objectives. Slides are provided (see Appendix 3-A), but they do not appear in the Student Workbook. You can provide these at the start of the session and even have them up on a flip chart or screen that stays on the side of the room during the session, or return to them at the end of the session to give participants a sense that they are following your road map. It is often best to select one, two, or three objectives and leave the others aside. In teaching things that you want participants to really take in and use in practice, often ‘less is more;’ people can take in and integrate the new material in a useable way. You can remove unwanted objectives on the slide or highlight the ones you will focus on.

### Knowledge Objectives for the Participants

For all:

- › Understand why falls are an important safety issue.
- › Understand the risk factors for falls.
- › Understand which residents are at high risk of falling.
- › Understand how falls can be prevented.
- › Understand how nursing assistants and licensed nurses can work together to prevent falls.

### Performance Objectives for the Participants

For all:

- › Describe nursing interventions to prevent falls, either:
  - Initiated by a nursing assistant.
  - Initiated by a licensed nurse.
- › Use particular interventions for particular risk factors.
- › Work as a member of a nursing team to:
  - Choose intervention(s) for a particular case.
  - Assess whether an intervention is effective.

## Preparing for a Session

### 1. Assess the Needs of Your Audience

These training materials are meant to be used as a complete package. However, you may tailor them to the needs of participants and current practice at their nursing center. To determine needs, you may use a survey or talk to individuals familiar with the nursing center. Whether you choose to use all or some of the material in the Student Workbook, decide on a focused goal for teaching. It is better for participants to learn and remember a few important pieces of new information than to feel overwhelmed by many new ideas.

Consider the language level that will best suit your audience. If you use technical medical terms, be sure to explain the meaning of the terms. If your audience uses English as a second language, speak clearly and not too quickly.

### 2. Consider Your Teaching Method(s)

Most instructors find that a combination of methods – lecture and interactive – works best. Consider using a selection of these teaching methods:

- › Lecture with slides.
- › Whole group discussion.
- › Break-out group discussion.
- › Case discussion.
- › Role play.

Suggestions for ways to use these methods can be found in the “Recommended Teaching Methods” section of this module.

### 3. Presentation Timing

The suggested timing for each part of this 2-hour module is:

Introduction of Instructor, Topic, and Objectives .....	5 minutes
Pre-test .....	5 minutes
Case Discussion .....	10 minutes
Presentation 1, Interactive Lecture .....	20 minutes
Case and “Critical Reflection” Discussion .....	15 minutes
Break .....	5 minutes
Presentation 2, Interactive Lecture.....	18 minutes
Case Discussion and Role Play (2 scenarios) .....	20 minutes
Debrief on Teaching Methods.....	5 minutes
Key Take-Home Points .....	5 minutes
Post-test.....	5 minutes
.....	Total: 115 minutes

Although this is a 2-hour module, you can teach it in two 1-hour blocks. You can also select material within the module to make a 30-minute or a 45-minute session, or two 30-minute sessions within a 1-hour slot. This flexibility is important, as some nursing centers might not have adequate nursing coverage for a 2-hour session.

### 4. Slides

The Student Workbook text is not meant to be used as a prepared speech. It assumes that you know the subject and offers material you may want to use. The suggested slides (Appendix 3-A) can be used to trigger your presentation. If you decide to do that, you will find it useful to practice speaking with them.

### 5. Overview of Effective Instruction for Adult Learners

Adult learning involves change – in knowledge, behavior, and skills.

This module aims to help participants know the risk factors contributing to falls, ways to prevent falls, and how to manage injuries that result from falls.

Adults are usually most motivated to learn when:

- › They see the subject as directly related to their own needs and goals.
- › They see ways for their learning to be applied to their own work settings.
- › They are responsible for their own learning.
- › Their knowledge and skills are appreciated.
- › “Mistakes” are seen as chances to learn.
- › Practical, hands-on experience is part of the instruction.

Adults take in new information more quickly and remember it better when it relates to their own experience. Structure your session to draw on what participants already know and what they want to learn. Make sure everyone feels that they have something to contribute.

Teaching methods such as interactive lecture, case discussion, and role play help lead adults to make changes in the workplace. A good way to get your group moving in this direction is by starting with a case for discussion. If the case reflects a situation that is familiar to participants, and includes a problem they want to solve, you will have a “teachable moment.”

### **Interactive Lecture**

With this method you present the material, using questions and answers, slides, and other visual aids.

### **Case Discussion**

The case tells a story. It involves situations like those participants face at work. You lead a discussion that brings in what they know and how they might handle the situation. You will want to be sure that different ideas are heard and see if anyone changes their mind. You will find a sample case in the “Giving Your Presentation” section, below.

### **Role Play**

“Learning through acting” gives participants a chance to use what they know and practice something new in a real-world setting. It can help them see a situation from different points of view. It also helps develop communication skills.

## **Writing It Down**

With all these techniques, it is useful to note participants' ideas and questions – a flip chart works well. This helps keep participants thinking and engaged. You can keep a “parking lot” list of thoughts that may not be on point at the moment, but should be kept in mind when you sum up the session.

More information on how to teach this material is below, in the “Giving Your Presentation” section.

## **6. Preparing a Handout for Participants**

These training materials are meant to be used as a complete package. However, you can choose to use only the parts you think are most relevant for your particular audience and their nursing center. The materials in the Student Workbook may be reproduced and provided to participants. The case is included in the Student Workbook.

## **7. Learning Settings that Work for this Module**

Think ahead about the kind of setting that will be available for this training and will best allow your targeted group to participate in the training. You also will want to consider work shifts and how your session can fit with in-service training requirements or other options. It helps if your session meets some of the nursing center's requirements for staff training. Provide refreshments if you can – that tends to increase attendance. Post announcements ahead of time so that people know when and where your session is going to happen. You might have a leader introduce the session to show that management believes the training is important.

## **8. Using Pre- and Post-Tests**

Pre- and post-tests (see Appendix 3-B) provide real-time feedback on how well the training session worked. The pre-test sets a baseline of what participants knew about the topic before the session; this information can be compared to the results of the post-test to answer the questions, “What changed from the beginning of the session to the end? Did participants learn what we wanted them to learn?”

## 9. Equipment

You will need equipment that allows you to display slides and also record discussion points and questions from participants. You may use:

- › PowerPoint slides.
- › Slide projector and screen.
- › Flip chart.
- › Overhead projector with transparencies.

## Giving Your Presentation

1. Introduce yourself and explain the purpose of the training.
2. Hand out the pre-tests. Explain that pre- and post-tests help participants evaluate themselves and help you evaluate the course. Have participants complete the pre-test.
3. Introduce the topic and review session objectives (using slides found in Appendix 3-A).
4. Present the material.

## Recommended Teaching Methods

For this module, a mix of teaching methods may be the best – some interactive lecture, some case discussion, and some role play.

### Interactive Lecture

The “stand-up” lecture works well when the topic is something participants care about and when the speaker is engaging. It is best used when a large amount of information needs to be delivered to a silent audience.

In an “interactive lecture” you still speak most of the time and control the subject being addressed, but the audience participates in different ways – asking or answering questions, giving examples from their experience, expressing opinions.

Like a story, any lecture – regardless of length – has a beginning (the introduction), a middle (the body), and an end (the summary). Each of these serves a different purpose.

**Introduction:** establishes the purpose of the lecture. The introduction states overall goals and specific objectives and should include an overview of the whole lecture. You are aiming to get participants interested and make them aware of expectations for the session.

**Body:** includes the material needed to meet the objectives stated in the introduction. Your session will be most effective if you:

- › Grab participants' attention in the first few minutes.
- › Involve them in fine-tuning the focus of learning.
- › Plan a change of pace every 8-10 minutes during a lecture.
- › Give participants a chance to reflect.
- › Use visual aids.
- › Give participants a chance to share experiences.

**Summary:** includes a recap of the material presented in the body of the lecture. It may also include an opportunity for participants' questions and feedback.

## Case Discussion

Most instructors prefer to use the case provided in this module. A clinically experienced instructor who is also a seasoned teacher may also invite participants to contribute relevant cases they have encountered. A new instructor, however, may prefer to keep the focus on a familiar case.

### Case Study

Mr. P is an 84-year-old man who has been a resident at the nursing center for the last 2 years. He has moderate dementia, and his blood pressure falls when he stands up too fast, making him dizzy. Until recently he shared a room at the nursing center with his wife, but she passed away earlier this year. Since that time, he has been more depressed and has had difficulty sleeping. On admission to the nursing center, he used a walker to get around, but now he mostly uses a wheelchair; he is less able to do his own toileting and grooming. His safety awareness is poor, and he has had many falls. Many of the falls have happened at night after his private duty caregiver has gone home.

**What are his risk factors for falling? How might you, as his nursing assistant, help protect him from having an injurious fall during the night?**

Once the case has been presented, pause and invite participants to comment.

Questions to get the discussion going and draw on prior knowledge might be of the “survey” type:

- › Have any of you seen a resident fall?
- › How often would you say this happens in your nursing center?
- › Does your nursing center have rules about what you are you supposed to do when a resident falls? If so, can you give an example of one of those rules?

Questions you could ask to reinforce the knowledge you are sharing might be:

- › Can you describe the physical conditions affecting Mr. P?
- › Can you describe the emotional conditions affecting Mr. P?
- › Mr. P seems to have several risk factors for falls. What do you think they are?

You can then encourage critical thinking and communication with questions such as:

- › How could Mr. P’s safety awareness be raised?
- › How could staffing be organized so that Mr. P’s needs at night are met?
- › What factors in the environment could be changed so that Mr. P is less likely to fall?
- › How do you think communication should work between private duty caregivers and nursing center staff?

You might ask participants to brainstorm safety ideas for residents with a history of falls.

Keep in mind that you are trying to get participants to think in terms of teamwork rather than blame.

Try to get them to talk with each other, not just to you. Have them discuss a topic in pairs or in groups of three. This method makes it easier for a shy person to be heard, as the less shy member of the pair or team can speak up for both or all of them.

If the number of participants is small, case discussion may be led with the whole group. Larger groups may be broken up into smaller ones, with each taking one or two questions and then reporting out to the whole group. You may also wish to divide participants into groups according to what they do (i.e., licensed nurses, nursing assistants, occupational and physical therapists, etc.).

## Role Play

This technique has participants take on roles in a clinical interaction. There is no written script, and the “actors” don’t have to memorize anything.

There are five parts to this technique.

**Set-up:** ask participants about their previous experiences with role play. Explain the goals of this exercise and relate them to the key learning objectives. Make sure everyone is familiar with the overview of the case. Only the “actors,” however, will know the details of their roles. It may be helpful to provide the description of the role play to those who are not participating as actors in the role play.

Then go over some guidelines:

- › Anything that comes up is confidential.
- › This is a safe place. Actors should not be afraid to take risks.
- › Feel free to be spontaneous.

**Assign the roles:** you may have actors play a role similar to the one they have in their real jobs; or you might encourage them to try out a new one. A licensed nurse, for example, could take the part of a resident, or a nursing assistant could act as a licensed nurse. Involve as many people as possible in the role play. Because role play requires participants to be somewhat emotionally open, they may feel anxious or resist being an actor. Your own positive attitude and a light touch will help. Any participants who are not assigned to a role should be asked to be observers.

**Conduct the role play:** participants act out their roles in the “scenarios” you provide (examples below), based on the case. Try not to interrupt the role play while it is running; just let the interactions flow naturally.

Before each scenario, explain how much time it will take, and that it will be followed by discussion. It should take only 2-3 minutes, followed by perhaps 5 minutes of discussion.

Don’t let the role play go on for too long – most of the learning happens in the first few minutes. If actors seem too carried away by their roles, remind them to keep it simple.

**Scenario 1.** Two roles: A licensed nurse and a nursing assistant. It is the nursing assistant’s first time on this floor. When she stops by Mr. P’s room for a routine check after dinner, she finds him at the bathroom door, trying to get out of his wheelchair. He seems irritable and does not want the nursing assistant to help him.

Tell the role players to simulate the interaction between the nursing assistant and the licensed nurse, making it clear when the interaction is happening and in what setting (e.g., on the phone as soon as possible, at change of shift, etc.). Tell them their goals are to: (1) get all the information across, (2) communicate about the situation in a timely fashion, and (3) be able to push if the message does not seem to be getting across.

**Scenario 2.** Three roles: Mr. P's son Paul, a licensed nurse, and a nursing assistant. Paul comes to visit his father after work; he is aware that his father fell yesterday, without injury. When the nursing assistant comes by to take Mr. P's temperature, Paul asks about his father's condition and the fall. Paul asks that his father be put into restraints so that he does not get hurt again.

Tell the role players to simulate the interaction with the goals of: (1) helping Paul to understand that the fall was without injury because of precautions taken, and that his father would be unhappy in restraints and less safe; and (2) explaining to Paul what is being done to limit injury from falls.

**Discuss the role play:** discuss the issues that came up in the role play. Everyone's input should be included. After each scenario is played out, ask the actors: What went well? What did not go well? What would they do differently next time? How did it feel to say\_\_\_\_? How did it feel to hear\_\_\_\_? Ask observers for their opinions about what the desired outcome was in each situation and how they might have handled the situation differently.

**Conclude the role play:** encourage a round of applause as the participants return to "out of role." Summarize the major themes and issues. Consider with the group how to apply the role play to real life clinical situations. Emphasize what was learned during the role play.

### Debrief About the Teaching Method

- › Ask participants what methods they think you used. Get their thoughts on what worked and what could be done better.
- › Listen and thank them for their thoughts.

### Review Key Take-Home Points

- › Promote a safe environment based on teamwork and thinking about how the system of care works and how it can be improved and not about blame.

- › Educate the entire staff about the importance of falls, risk factors for residents, and methods of prevention.
- › Use appropriate risk-assessment and reporting tools.

## Post-Test

Thank your participants for attending. Let them know that you enjoyed being with them. Hand out the post-tests. Emphasize how important it is to complete the post-tests because they can get feedback on what they have learned (based on their answers to the pre- and post-test questions). Tell participants that you will provide the correct answers and rationale for the tests after they are done. Be sure to stress that the post-test is anonymous.

## Translating the Teaching into Practice

It is often hard to get what is taught in a classroom or in-service learning session translated into action as part of resident care. Even if the teaching has gone well and the learning was taken in and appreciated, it can be hard to put the new learning into practice. There are many possible barriers. For instance, the system of care may not accommodate the new practice, or the culture of care may not accept the change, or the leadership may not be aware of the new learning and so may not make room for it.

Following up after a teaching session with a quality improvement project in which the new learning is put into practice by the whole team can help a lot. Quality improvement projects use a step-by-step approach to improving care by taking a long, hard look at what needs to be done; and by starting out with a small change, watching it, adding to it, and continuing on in this fashion until the job is done. It has a whole method to it, and the method is described in the “Quality Improvement” section.

Quality improvement methods often include a teaching step. This module can be the teaching material for that step. If the quality improvement project is to improve nursing assistants’ and licensed nurses’ understanding of ways to prevent and manage falls, then this module is perfect for the teaching part of the project.

## Quality Improvement

“Quality Improvement” (QI) is an approach that may be used by nursing staff and managers to improve quality and safety in patient care. It has three main objectives, which are to:

- › Gain knowledge and skills to understand systems of care and minimize adverse outcomes.
- › Apply methods to identify, measure, and analyze problems with care delivery.
- › Act on the results of data collection and analysis to improve both individual care delivery and systems of care delivery.

QI is a team approach, involving everyone in thinking about innovation and recognizing that the key to improvement is the people who care for patients. It is not about individual rewards and punishments, but rather it relies on measurement to improve the center’s performance as a whole.

At the core of QI is the “Plan-Do-Study-Act (PDSA) Cycle,” based on trial and error over time.

- › Plan: Identify a problem and design a change to address it.
- › Do: Implement a small change.
- › Study: Measure and analyze the effects of the change.
- › Act: Take action based on the results of analysis, such as trying another change, formally implementing a change, or extending an implementation more broadly.

When you engage in a QI project, you will be using information/data that you have on current practices at your site to develop goals based on both best practices and realistic expectations.

The five phases of the QI process are outlined here.<sup>5</sup>

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<sup>5</sup>For more detailed information on QI and measurement tools, please see The Patient Safety Education Project (PSEP), Module 9: Methods for Improving Safety, which can be found at <http://patientsafetyeducationproject.org>. Accessed January 23, 2012.

## 1. Project Initiation Phase

### **Decide on the Area of Work that Needs Improvement**

In this example, we focus on risk factors for falls. Most likely, there is already a process at the center to get to this point. Still, it is helpful when starting the project to make sure everyone believes in its importance. Collect data to support your assumption that there is a problem and establish a baseline for measuring improvement.

### **Form Teams**

Leadership teams must include one or a few people with enough institutional authority to help get the resources that the project team needs.

For this project, the Director of Nursing, the Quality Improvement Officer, the center's overall Director, and/or the Chief Operating Officer would be potentially good choices.

- › Project teams must:
- › Have basic knowledge of the problem.
- › Represent all parts of the process and different levels of the organization.
- › Have at least one member trained in QI.
- › Recognize that good ideas can come from anyone.

The ideal team size is five to nine people. Additional temporary members with special areas of expertise can be invited to particular meetings as needed.

For an improvement project focused on communication of changes, the following project team members are one example of a good team:

- › Registered nurse.
- › Two nursing assistants.
- › Director of nursing.
- › Education director.
- › Geriatrician.

### **Write an Aim or Mission Statement that Is “SMART”**

- › Specific.
- › Measurable.
- › Appropriate.
- › Result-oriented.
- › Time-scheduled.

The aim should include a “stretch” goal that may be hard to reach but is achievable—for example: To decrease the rate of resident falls by 50 percent in 12 months.

### **Consider Appropriate Measures**

Examples of measurement (data) include a “process” measure like compliance rates for wearing ID badges with the SBAR or CUS<sup>6</sup> acronym spelled out on the back, documented nursing notes in the chart on reports of change, in a resident’s condition or an “outcome measure” like reported use rates for SBAR and for CUS.

To show improvement, you should be able to plot the variable being measured on a run chart (a graph that displays observed data in a time sequence).

## **2. Identifying the Problem**

### **Identify the Problem**

- › The problem and its extent (i.e., what are the existing barriers to recognizing risk factors for falls?).
- › Changes that can be made that are expected to result in improvement (i.e., what might reduce the barriers to recognizing risk factors for falls and how?).
- › How the effects of the changes will be measured (i.e., select the measures that you will use to assess change over time in nursing assistants’ abilities to recognize risk factors for falls).

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<sup>6</sup>SBAR = Situation, Background, Assessment, Recommendation; CUS = Concerned, Uncomfortable, Safety.

### **Plan for Data Collection and Analysis**

Tools that can help in data collection and analysis include process flow charts, brainstorming, cause and effect diagrams, and consumer focus groups.<sup>7</sup>

## **3. Intervention Phase**

### **Get Consensus**

Get team consensus on priorities and changes most likely to result in improvement and then decide on an intervention.

### **Remember Culture and Teaching, as well as Protocols**

Many interventions focus on what is done; for instance, changing or adding a protocol. These are good, but they often don't work as well as they could unless they go hand-in-hand with changes in culture to appreciate the importance of the new protocol. The best interventions tend to address culture with team meetings and other educational or inspirational materials at the same time that the new protocol is added. Usually, culture change includes implementing and disseminating some core teaching.

### **Conduct PDSA (Plan, Do, Study, Act) Cycles**

The cycle begins with a plan and ends with an action based on learning gained. It should specify who, what, when, and where. The end of each cycle leads directly to the start of the next one.

- › Try a change, e.g., provide a new I.D. badge with SBAR and CUS on the back, as well as a 1-hour, online educational session to nurses on a specific ward.
- › Observe consequences by using the selected measures.
- › Learn from consequences, e.g., some used SBAR and CUS, but others did not. You discover that those who used the tools had taken the online learning, and the others had not.
- › Try a change, e.g., in-service time is given for all staff to complete the online education, then run another PDSA cycle.

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<sup>7</sup>Such tools are readily accessible at: [www.health.nsw.gov.au/resources/quality/cpi\\_easyguide\\_pdf.asp](http://www.health.nsw.gov.au/resources/quality/cpi_easyguide_pdf.asp) (Easy Guide to Clinical Practice Improvement: A Guide for Healthcare Professionals. New South Wales, Australia: New South Wales Department of Health; 2002).

The way you document observations may be simple, such as counting and recording on a tally sheet; or it may be more complex, such as using sophisticated tools for data analysis.

If the data do not support the intervention, they may not be appropriate. Look at the data for clues about what to change and run another PDSA cycle. When you have finally arrived at a sustained change of the kind you intended, that final version of the intervention can be implemented on a larger scale.

## 4. Implementation and Impact

### **Implement the Change**

This means making it a permanent part of normal business throughout the unit or setting where you work. It may mean applying the intervention throughout the nursing center, for instance. In this case, it would probably mean ensuring that all nurses and nursing assistants take the online training and receive badges with SBAR and CUS written on the back.

Relevant support processes have to be implemented at the same time. For instance, the rollout of education will need to be supported with suitable in-service learning time.

### **Measure the Impact of the Change**

To provide evidence that the intervention resulted in improvement in all places it was implemented, you will need to collect, analyze, and display the data. For example, you might create a chart showing changes in the number of times nursing assistants recognize that a resident is doing something that puts him or her at risk of falling, unit by unit, in the whole nursing center. You will be able to choose your measure from the experience you gained in the Intervention Phase (see item 3, above).

## 5. Sustaining Improvement

The step in QI that fails most often is sustaining the improvement. When the project is done, even if it has been successful, if it is not monitored and no one is assigned to make sure the new standards are kept up, it will probably fade away.

Mechanisms for sustaining change include:

- › Standardization, ensuring that new methods are implemented consistently over time.

- › Documentation of the project from planning through testing, implementation, and followup.
- › Indefinite periodic measurement, e.g. of reported SBAR and CUS use rates, and review to ensure that the change becomes routine practice. The measure chosen for this is called a quality indicator, and it usually is easy to establish (for instance, something that is part of the Minimum Data Set or some other set of data that is always collected) and part of what a senior person reviews regularly.
- › Staff training and education, geared to the type of change proposed, the people who will be asked to implement it, and the skill level and work experience of the target group.

## Applying QI to Improving Falls Prevention and Management

### Starting the Improvement Effort

First you will generate and look at relevant data on falls prevention and management in your area, probably with some of your lead team members. For instance, you might look at relevant Minimum Data Set<sup>8</sup> (MDS) numbers from your center and nationally. Then you will ask questions and discuss how this state of affairs stacks up against other institutional priorities. When you have decided that this is the area you want to work on, you will form your teams – you will have a leadership team of one or a few people and a project team of five to nine. The project team will write a mission statement and select measures that the leadership team will review, adjust as needed, and approve.

Then the project team will decide which problem to address in order to help prevent falls. Whatever the intervention, it will likely be essential to enhance the culture of awareness and the importance placed on the topic. That is usually where the teaching module comes in. The project team will decide what area to work in first and will identify which process or processes to change. Next, the people in that unit will be trained about the topic area.

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<sup>8</sup> See the MDS Basic Assessment Tracking Form, available at <https://www.cms.gov/NursingHomeQualityInits/downloads/MDS20MDSAllForms.pdf>. Accessed January 23, 2012.

## The Intervention

In the case of falls prevention and management, the primary intervention may be teaching this module, but it is likely that there will be a counterpart change in standard operations. For instance, daily rounds may add a specific question for every resident: What is [resident name] falls risk and management plan? Or the change may involve adding this question to the format used by nursing assistants in their written reports. Each QI effort may have its own intervention to enhance falls prevention and management.

### Including Teaching for Culture Change in the Effort

Finding the right person to teach the module is important. Someone that the participants will look up to and respect for their knowledge of the area is essential. Finding a person who teaches well is also very important and not always easy to identify. The person can be a lead nurse or other clinician, a QI officer, or a special guest teacher.

### Plan-Do-Study-Act (PDSA) Cycles

When the teaching is done and the new protocol is starting, someone on the project team will be assigned to collect and review the data. They will look at the data, decide what seems to be working and what seems to not be working, adjust the protocol, let the staff know, and try again. They will continue in this manner until things seem to be where they should be for a sustained period of time.

## Implementation and Impact

Next, the protocol and education will be rolled out throughout the relevant area – say, the whole nursing center. A small number of key measures will be collected that the center can monitor to know how well the implementation worked. For falls prevention and management, MDS data may be sufficient or perhaps another measure will be added, such as the rate of performing documented falls risk assessments and formulation of management plans for residents.

## Concluding the Improvement Effort

Finally, a routine measure - such as the rate of documented nursing assistant reports of falls risk assessments and management plans - should be chosen as a quality indicator. The leadership team then needs to ensure that the quality indicator is routinely collected and reviewed by a responsible member of the center to ensure that the improvement is sustained over time and, if it tapers off over time, that attention to the problem is renewed.

## Appendix 3-A: Suggested Slides for Module 3

Slide 1

### Knowledge Objectives

Participants will understand:

- › Why falls are an important safety issue.
- › The risk factors for falls.
- › Which residents are at high risk of falling.
- › How falls can be prevented.
- › How nursing assistants and licensed nurses can work together to prevent falls.

Slide 2

### Performance Objectives

Participants will be able to:

- › Describe nursing interventions to prevent falls, including:
  - Interventions that may be initiated by nursing assistants.
  - Interventions that may be initiated by licensed nurses.
- › Use particular interventions for particular risk factors.
- › Work as members of a nursing team to:
  - Choose one or more interventions for a particular case.
  - Assess whether an intervention is effective.

Slide 3

### Case Study: Mr. P

- › What are his risk factors for falling?
- › How might you, as his nursing assistant, help protect him from having an injurious fall during the night?

Slide 4

### Facts About Falls

- › One of the biggest safety challenges is preventing falls.
- › Three of every four nursing center residents fall each year.
- › Most nursing centers have more than 100 falls per year.
- › There are many interventions that providers can use to reduce the number of falls.
- › Nursing staff must have the knowledge and skills to prevent injury from falls.

Slide 5

### A Safe and Enjoyable Environment Requires:

- › Awareness.
- › Responsiveness.
- › Sharing and teamwork.
- › Reporting and supporting by:
  - Learning through talking with team members.
  - Avoiding blame.
  - Fixing “accidents waiting to happen.”
  - Expecting teamwork.

Slide 6

### Is it a fall?

A fall is an unintentional change in position, coming to rest on the ground or the next lower surface that does not result from:

- › Being pushed down.
- › Collapsing from a sudden medical condition.

Slide 7

### Resident Risk Factors for Falls

- › Previous falls.
- › Diminished strength.
- › Gait and balance impairments.
- › Medications.
- › Alzheimer's disease or dementia.
- › Vision impairment

Slide 8

### Environmental Risk Factors for Falls

- › Design problems.
- › Lack of Space.
- › Obstacles.
- › Equipment misuse or malfunction.
- › Staffing and organization of care

Slide 9

### HEAR ME Tips to Help Prevent Falls

Hazards—Notice and eliminate hazards in the environment.

Educate—Educate residents about safety.

Anticipate—Anticipate the needs of residents.

Round—Round frequently to learn residents' needs.

Materials—Ensure materials and equipment are in working order

Exercises—Assist residents with exercise and ambulation.

Slide 10

### Responding to a Fall or Near Fall

- › Observe and evaluate.
- › Investigate and document.
- › Implement an individualized care plan.
- › Develop a falls management program.

Slide 11

## Examples of Fall Prevention Interventions

To prevent falls, you should address:

- › Things about the environment (e.g., rearrange the resident's furniture).
- › Things about the resident (e.g., review medications).
- › Things about the equipment or care plan (e.g., monitor blood pressure frequently).
- › Things about the nursing center (e.g., provide education on falls prevention).

Slide 12

## Things to Remember

- › Not every fall is just a fall.
- › There are many risk factors for falls.
- › Using the HEAR ME tips can help reduce falls.
- › Appropriate interventions can minimize future falls.

Slide 13

## Pearls

- › Awareness is a watchword in falls prevention.
- › Teamwork is necessary to prevent falls.
- › Fall prevention requires active engagement.
- › You must go beyond an incident report to develop a revised care plan.

Slide 14

## Pitfalls

- › Forgetting to do a falls assessment for a resident.
- › Failing to make a new falls assessment and care plan for a resident who has fallen.

## Appendix 3-B. Pre/Post-Test Questions and Answers for Module 3

### Pre/Post-Test Questions

1. All of the following are examples of good teamwork to prevent falls except:
  - a. Every team member feels equal responsibility for improvement.
  - b. A nurse coordinator, a back-up coordinator, and a falls team meet each week.
  - c. The team members have the authority to complete appointed tasks.
  - d. When you help your team member with a resident who is not assigned to you, leave your resident in a restraint until you get back.
2. All of the following are common results of falls except:
  - a. The resident is limited in his/her activities after a fall because of fear of another fall.
  - b. Increased levels of care are required for fallers.
  - c. The resident can't do as much after the fall.
  - d. Cancellation of the nursing center's insurance policy.
3. Risk assessments of residents for falls include all of the following except:
  - a. Strength.
  - b. Balance.
  - c. Hearing.
  - d. Medications.
4. Which of the following is the best reason to have an individualized care plan?
  - a. The team has to watch out for any environmental risks.
  - b. Everything has to be documented.
  - c. An individual's condition and treatment can directly impact his/her fall risk.
  - d. The more the team thinks about care plans, the better they get at responding to falls.

5. Environmental risk factors for falls include all of the following except:
- a. Having a resident's eyeglasses out of reach from the bed.
  - b. Sharing wheelchairs among residents.
  - c. Raised door thresholds.
  - d. All of the above.
6. How does falls management and response lower the likelihood of future falls?
- a. It requires assessment of new developments in a resident's condition.
  - b. An assessment of the environment is done after each fall.
  - c. The staff is educated on how to prevent falls.
  - d. All of the above.
7. Which of the following should be reported as a fall or near-fall?
- a. Finding a resident lying on the ground.
  - b. A resident rolls off a mattress and the ground is 2 feet down.
  - c. A resident stumbles and is caught by a nearby licensed nurse.
  - d. All of the above.

### Pre/Post-Test Questions with Answers

1. All of the following are examples of good teamwork to prevent falls except:
- a. Every team member feels equal responsibility for improvement.
  - b. A nurse coordinator, a back-up coordinator, and a falls team meet each week.
  - c. The team members have the authority to complete appointed tasks.
  - d. When you help your team member with resident who is not assigned to you, leave your resident in a restraint until you get back.

Answer: d

2. All of the following are common results of falls except:

- a. The resident is limited in his/her activities after a fall because of fear of another fall.
- b. Increased levels of care are required for fallers.
- c. The resident can't do as much after the fall.
- d. Cancellation of the nursing center's insurance policy.

Answer: d

3. Risk assessments of residents for falls include all of the following except:

- a. Strength.
- b. Balance.
- c. Hearing.
- d. Medications.

Answer: c

4. Which of the following is the best reason to have an individualized care plan?

- a. The team has to watch out for any environmental risks.
- b. Everything has to be documented.
- c. An individual's condition and treatment can directly impact his/her fall risk.
- d. The more the team thinks about care plans, the better they get at responding to falls.

Answer: c

5. Environmental risk factors for falls include all of the following except:

- a. Having a resident's eyeglasses out of reach from the bed.
- b. Sharing wheelchairs among residents.
- c. Raised door thresholds.
- d. All of the above.

Answer: d

6. How does falls management and response lower the likelihood of future falls?

- a. It requires assessment of new developments in a resident's condition.
- b. An assessment of the environment is done after each fall.
- c. The staff is educated on how to prevent falls.
- d. All of the above.

Answer: d

7. Which of the following should be reported as a fall or near-fall?

- a. Finding a resident lying on the ground.
- b. A resident rolls off a mattress and the ground is 2 feet down.
- c. A resident stumbles and is caught by a nearby licensed nurse.
- d. All of the above.

Answer: d



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