B&F CONSULTING

Quality Improvement Small Group Exercise:
Case Study on Engaging Staff in Individualizing Care

This exercise is a teaching tool for the following:

1. Providing an experience of a QI huddle with staff to understand why a resident has declined and identify what to do about it
2. Demonstrating how knowing a person's psychosocial history and customary routines contributes to better care outcomes
3. Displaying how important it is to determine the true cause of problems so that staff use cause specific interventions instead of automatic one-size-fits all interventions that mask the symptom without addressing the actual underlying issues.

Instructions

Have people sit in groups of 4 - 6 people.

Tell them that this is a case study about Mr. McNally. He came into the nursing home post-stroke for a short-term rehabilitation with the expectation of going home. He was in pretty good shape when he came in but he declined rapidly. None of his declines were medically related. They were "iatrogenic declines" – meaning they all had to do with decisions the nursing home made about how to respond to him.

Ask one person in each group to deal out the cards so everyone has cards, and then work as a team to piece together the sequence of events starting from the first night, that led to his decline. They are to answer two questions:

1. What was Mr. McNally like when he first came in to the nursing home?
2. What happened to him? What was the sequence of events, decisions, and interventions that contributed to his decline?

Explain to the group that all the information they need to answer these questions is on the cards. Encourage them to work together, to share their cards and discuss what they see. Guide them to start by laying out the cards related to what Mr. McNally was like when he first came in. Then have them piece together the chronology of what happened the first night, the next day, the day after, etc.

Remind them that none of his declines were caused by his stroke. All of his declines resulted from how the nursing home responded to him and the treatments they initiated. Tell each group to lay the cards out and organize them together so that people can sort through the information and figure out what happened.

Give people 10 - 15 minutes to work on this, checking in at each group to see how they are coming along.

Discussion:

When most of the groups have gotten pretty far along in figuring things out, bring everyone together for a group discussion.

1. **Huddle:** First, point out that what they just did was a quick 15 minute huddle that we call QI closest to the resident, bringing the staff who work with a resident together for a quick stand-up to sort out what's going on. Point out that the information never would have been fully available to the team in the conference room as it was by gathering the care team together.

2. **Baseline:** Then ask why we start with what Mr. McNally was like when he first came in? After hearing and responding to their answers, highlight that it gives us a baseline, a start to understanding that he has declined and what we want to bring him back to. While he came to you post stroke so this is not his true baseline of what he was at home, it lets us know that he has declined since he has been here. Also, when a resident is verbally and physically aggressive, it's important to help staff step back and see that some of his behavior is a reaction to our treatment. It gives the staff clues for what might work.

3. **What was he like?** Now, have the group reconstruct what Mr. McNally was like when he first came in. You will hear that he was sweet, independent, interested in others, a night owl. Ask then if he's still that way? Ask why it's important to know these things, especially that he's a night owl. Staff didn't know his routine and tried to have him fit into the facility's routine instead of his own.

4. **Reconstruct the cascading decline:** Then ask what happened to Mr. McNally. Let people piece it together with your facilitation. Start by asking what happened the first night. It was the first night sleeping pill – not knowing his routines and not knowing he was in pain, that got everything off to a bad start. As people offer their ideas about the chronology of events, point out that when the nursing home tried to make him fit into the institutional routine instead of supporting his own individualized customary routines, this led to one problem after another -- sleeping pills the first night made him unbalanced and groggy. Ask why the nurse gave him a PRN sleeping pill? Because she didn't know his routine and saw he was awake. Why did he take it? Because everyone else was asleep and he didn't see any option for staying up and knew the only way he'd sleep is if he had the pill. What was keeping him up – his routines, and pain. But the nurse didn't ask about or learn about it. Do your evening nurses have this information?

5. **Interventions aren't based on the cause of the issue:** After discussing the sleeping pill, ask what happened next. Next he fell. So ask, why did he fall? It's the sleeping pill that led to his falling the next night on his way to the bathroom. That and an unfamiliar environment – with a bed at the wrong height, and the bedside table on wheels that he grabbed as he fell and went right out under him.

However, the fall intervention was not related to why he fell. Ask what the nursing home did after he fell. The answer – they put an alarm on him. Nursing interventions are supposed to be cause-specific. What were the causes of his fall? Sleeping pill and unfamiliar environment. How did the alarm address either of these? We get rote about automatic interventions. Good nursing practice requires an individualized assessment of the root cause of the fall and a cause specific intervention – like making a safe passage to the bathroom, adjusting the bed height for easy ambulation, and stopping the sleeping pills. This is what requirements for participation mean about being person-centered and preventing adverse events.

In this case, they had a standard protocol to put on the alarm and as a result he couldn't sleep. Ask how he responded to the alarm. He hated the alarms (he was a fireman and it made his jump). He was agitated by the alarms so he was given another medication. This made him more sluggish. Keep having the group piece together what happened next, and connect the dots between lack of true cause-specific interventions and his cascading decline. He skipped therapy, stopped eating breakfast, and got more ornery. He stopped drinking to prevent the need for a bathroom trip in the middle of the night. This gave gave him a UTI. The meds, lack of activity, and lack of appetite made his bowels sluggish. He couldn't get up to go to the bathroom on his own anymore and he hated the briefs. The suppository in the morning led him to take a swing at a staff person.

Point out that each earnest effort to care for him made him worse because the caring was all done according to the nursing home's automatic policies and not based on the true cause-specific interventions, or on his individualized needs and own natural rhythms. He came in short-term and ended up with conditions that could have led to a hospital readmission. If it did, would this hospitalization have been avoidable?

Action

1. **Systems:** Ask people, if they could turn back the clock and start over, what would they do differently so that this wouldn't happen to Mr. McNally? Encourage people to look at systems and processes. What gets in the way of being able to individualize, and what is pushing the schedule now -- like meals, meds. Brainstorm ways to individualize these systems.

2. **Getting customary routines to staff closest to the residents:** Discuss how staff caring for residents find out about the residents' customary routines and social history in time for their first care encounters? Map your current process. Who gathers the information and how is it shared? Does it ever get to the staff? What information would you want to know? Who should ask it? How will you make sure the CNAs and nurses know about it? Is this information taken by activities and put in the computer days later?

How can it get to the staff who care for the resident in time for care? Should it be part of the initial assessment? Can the CNA ask about routines and pass it along?

3. **First 24 hours:** In Mr. McNally's case he was already set back by the first night gone awry. As we have shorter stays we have to get it right, right from the start. Look at the first 24 hours in the nursing home – what can be done to get to know people better, adapt to their routines, and help them settle in.

4. **True assessment and individualized care planning:** Make sure that when an intervention is put in place, the team looks at the real causes and uses interventions specific to those causes. Challenge yourselves not to go to an automatic protocol. Follow up on interventions. Individualize to each person's routines.