Facilitator Instructions

How to Use this Guide:
This guide offers learning material that can be used in part or whole, depending on the needs of the group. Each section after the Introduction can stand alone.

Teaching Method:
The guide includes opportunity to stop the webinar for a small group discussion and learning experience for participants to apply what presenters have said to the their own experience. Adults learn best through applied learning so the guide's learning experiences support reflection and time for participants to think about how to use what they have learned.

Background:
This webinar series supports nursing homes to engage staff closest to the residents in problem solving for better outcomes. It applies a core principle of quality improvement – results depend on systems, and systems depend on the relationships among those involved in the systems. This is called *relational coordination.* To be most effective, assessment, care planning, and quality improvement systems need the information and ideas from the staff closest to the residents to guide and document delivery of care.

The webinar series was part of a core curriculum used by forty-nine nursing homes who participated in the Pioneer Network's National Learning Collaborative on *Using MDS 3.0 as the Engine for High Quality Individualized Care.* Using B&F Consulting's method for activating high performance, the homes incubated four systems to strengthen their working relationships - consistent assignment, huddles, involving CNAs in care planning, and QI closest to the resident – and, as a result, reduced falls, alarms, pressure ulcers, hospitalizations, and antipsychotic medications The webinar series guides homes through B&F Consulting's 3 step method: (1) strengthen relational coordination systems, (2) apply systems to priority clinical areas, and (3) use staff's knowledge of residents to individualize care to improve outcomes. The webinars feature nursing home teams sharing how they use relational coordination to improve outcomes.

For the collaborative's free Starter Toolkit on *Engaging Staff in Individualizing Care* go to www.PioneerNetwork.Net

A word about language:
You'll notice that as the staff tell their stories, their language is sometimes less person-directed than their actions. Explain this to participants and use any examples from their language that provide learning opportunities.

Facilitator's Guide

Opening Process and Explanation:

Process

Mix the group so that people sit with people other than their co-workers. While people might have some initial discomfort, they will benefit from talking with people they don't usually work with and will learn new ideas they can bring back to co-workers.

If people don't know each other, to get more comfortable sharing, ask participants to spend the first few minutes in a go-around sharing who they are, where they work, what their position is, and how long they have worked there.

Introduction: Integrating MDS into Daily Practice: Quality Improvement

Time 1 minute

Content Explain to the group:

This webinar provides several examples of Quality Improvement (QI) closest to the resident, a major principle under Quality Assurance & Performance Improvement. Nursing home staff share their experiences and how-to tips. Their ability to problem solve is strengthened by having consistent assignment and engaging in huddles in place. Their QI activities use the customary routines information from Section F of the MDS, and tie back in to the care planning process when changes are needed.

The beginning of the webinar contains information participants don't need.
Start the webinar at 2:13 and play until 13:55. Then pause for exercise # 1.

Learning Experience # 1 – A Case Study

Time 20 - 30 minutes

Materials
McNally Cards (enough sets for each group of 4-6 people)

Process
Explain that the speakers talked about the importance of having quality improvement problem solving happen among the staff closest to the person and right in the area where the concern occurred. QI closest to the resident can be used for an individual situation or for an area of improvement. In either case, the CNAs, nurses, and others who care directly for each resident know that person's normal self, notice small changes and red flags, are familiar with the person's routines, and know ways to intervene successfully to prevent declines. Sometimes, in a QI huddle, staff can piece together factors contributing to a decline and turn them around.

In this learning experience, you'll have the opportunity to experience a QI huddle for an individual using a case study based on a real person's experience in a nursing home. The person was supposed to be there for a short-term post-acute stay, but instead, declined rather quickly. Staff noticed changes, huddled to problem solve and determined that his decline was actually a result of their approach with him rather than his medical condition. They adjusted their approach and reversed the decline.

His case study is captured in the deck of cards at each table. Deal out the entire deck of cards to all the people at the table.

As a QI huddle team your job is to answer two questions:

1. What was Mr. McNally like when he first came in?
2. What is the sequence of events that caused his decline?

All the information needed to answer these questions is in the cards. Some of it is clinical and some of it is personal. Work together to answer the two questions by sharing the information in the cards.

Encourage groups to clear off space on their table to be able to lay their cards out, and to move around so that everyone can see the cards.

Allow 10 - 15 minutes for the groups to figure out what happened. Circulate among the tables to help any group that needs assistance.

Bring the table work to an end so that all the participants can piece together what happened as a group.

The Debrief will take about 15 minutes.

Start the room wide discussion by making two points:

Huddle: Point out that the process they have just gone through is similar to a **QI huddle** in a neighborhood/household/unit, in which people have a quick 10 – 15 minute stand-up to review what they know about a resident they are concerned about, to determine the root cause of problems and possible solutions. Just as occurs in the exercise, many people on the care team have valuable information, including CNAs and nurses, housekeeping and maintenance staff, activities and social services, and others.

Baseline: It's important in such a discussion to start with a review of what a resident was like when he first came in. Sometimes when a resident has started to have incidents and declines, staff forget the person's baseline.

Ask the group to share what Mr. McNally was like when he first came in. In addition to his personality and interests, the group will note aspects of his customary routines.

The group will share information about Mr. McNally. When they have pieced together what he was like when he first came in, recap by noting that he was sweet in his temperament, independent in his life, engaged in many activities, and used to helping others. He was also independent of bowel and bladder, had lived on his own for many years and had developed his own ways. Hold off on any discussion of his medical decline – keep the focus at first on Mr. McNally as a person.

Customary Routines: The information about Mr. McNally's customary routines are **key** to understanding why he declined and what can be done to resolve the concerns and restore his well-being. He was a night owl. Expecting him to follow the nursing home's routines instead of his own was the cause of his decline. Trying to fit him into their routines instead of supporting him in his has caused one problem after another.

Ask the participants to piece this together with you. What caused his decline, what started it? Help them piece it together using the following information and sequencing of the discussion with asking them questions and filling in from their answers and this back story:

a. **Night owl.** It started with a sleeping pill the first night, which he accepted because he saw that others were going to bed and then felt the need to go along. The sleeping pill made him groggy in the middle of the night when he got up to go to the bathroom. He was in an unfamiliar environment where the bed width and height were different than what he was used to. When he started to fall he grabbed for the first piece of furniture nearby to steady himself – the bedside table, with wheels. At this point he fell.

b. **Critical thinking and root cause analysis.** Ask the group what was the staff's response to the fall. Staff put on a bed alarm. Ask what the root cause of his fall was. It was the sleeping pills and an unfamiliar environment. Ask if the alarm addresses either root cause. Clearly it doesn't. What would be better interventions? Answer – not giving him the sleeping pill, and helping prepare him and his environment so he can navigate safely when he needs to go to the bathroom at night.

c. **One thing leads to the next.** Once Mr. McNally has the bed alarm, he starts to decline further. The alarm bothers him and bothers his roommate. He can't sleep and is upset when the alarm goes off. (And, he's a fireman, so it makes him feel like he needs to get up when he hears it go off.) He is given medication because he is upset. So that he will not set off the alarm at night, he decides to curb his need to go to the bathroom at night. He stops drinking. This leads to a UTI. He is given medication for his behavior that contributes, with not drinking, to sluggish bowels and eventually constipation. He also misses therapy appointments and is behind in rehabilitation for return home. As he declines, he develops the beginnings of a pressure ulcer, affected by his lack of movement and his poor nutrition.

d. **Reviewing Incident/Accident (I&A) Reports.** When the nurse wakes him early in the morning to give him a suppository for his constipation, he slugs her. His situation finally comes to the attention of the Administrator and Director of Nursing. They are starting to look for ways to make their care more person-centered and are using the I&A reports as "red flags" to identify areas that may need to be looked at. They conclude that if they had been Mr. McNally, awakened early in the morning to receive a suppository, they might also have had a negative reaction. They are surprised that Mr. McNally needed a suppository because his records indicate that he was independent of bowel and bladder when he first came in. They are also surprised to see how his mood has changed, because they knew he was a very sweet, independent, personable man. This triggers their intervention.

Closing

In a huddle among staff closest to the resident, each person can contribute their knowledge so the group has a more complete picture of the situation and develop a game plan. When everyone is in on the discussion, people understand better how they can contribute to the situation.

Now we will look at QI closest to the resident for performance improvement in an area of concern. Now we'll hear two stories of quality improvement with staff closest to the residents. Listen for good ideas and practices. What makes these homes successful? What ideas does this give you?

Restart the webinar at 13:55 and play until 35:05. Then pause for exercise # 2.

Learning Experience # 2 QI Closest to the Resident: Changing Workflow not Changing Forms

Time 15 minutes

Process

Explain that at the beginning of the webinar, Dr. Gifford said most quality improvement solutions involve changing the way work flows rather than changing the form. He said that when staff closest to the situation are involved in addressing concerns or problems, they share first hand information and identify individualized meaningful and lasting solutions.

Having regular meetings of the staff most closely involved provides a forum for problem solving. This kind of problem solving takes a systematic approach and good analytical skills. You've now heard two examples of QI closest to the resident. In the first case study, the home solved the problem of cold eggs through regular "focus group" discussions among CNAs, unit managers, and administration. Through small pilot tests, they realized how they needed to change the way they served breakfast. In the second case study, the team working closest with the residents figured out the problems and solutions together as they reduced noise, agitation, and alarms, and in the process improved outcomes.

Staff in both homes used several good QI steps to get there. They collected data, determined root causes of the current problem, identified possible solutions and pilot tested them.

Have participants, in small groups, identify how involving staff closest to the residents got them to their solutions. Ask them to discuss how staff in the case examples were involved in gathering information and identifying solutions, and what participants liked about what they heard and what ideas it gives them for QI closest to the resident.

Invite room-wide sharing of what was discussed in small groups.

Summarize key points you note from the discussion.

Closing

Staff closest to the resident and the area of concern have a first hand knowledge that is crucial to effective quality improvement. They are in the best position to pilot test solutions and evaluate whether they are working. When staff know residents well through consistent assignment, and huddle regularly to discuss their residents, they can take on performance improvement projects and proactively improve outcomes.

Now we'll hear two management QI approaches.

Return to Webinar at 35:05 and play through to 44:30.
Then pause for learning experience # 3.

Learning Experience # 3 The How-to of QI Huddles

Time 15 minutes

Process

Tell participants that we just heard the speaker describe ways to make the QI huddle work. Ask participants, in small groups, to discuss what they heard in the webinar or know from experience about how to have success QI huddles.

Invite room-wide sharing of what was discussed in small groups.

Summarize key points you note from the discussion.

Closing

Having a good QI huddle requires skills and good facilitation to keep on track and move toward solutions. Doing the QI with the staff closest to the situation gives you essential information to solve problems. The staff in turn really appreciate knowing the big picture from the data, and seeing how their efforts contribute to good results.

Now we'll hear from a QA nurse and an administrator about QI practices that prevent declines through rounding and regular close communication. The second story is from the administrator at the home where the Mr. McNally case came from.

Return to Webinar at 44:30 and play through to 1:10:05.
The closing minutes have information participants don't need.

Learning Experience # 4 Preventing Decline through Rounding and Huddling

Time 15 minutes

Process

QI closest to the resident helps staff prevent resident declines. One presenter shared about daily clinical rounding to check in with staff about residents at risk, and used those daily rounds for just in time learning and problem-solving. The second presenter shared what they now have in place, after what they learned from Mr. McNally, which is to make special efforts to really know new residents right away and communicate well as a team to prevent avoidable declines.

Have participants, in small groups, identify what they liked about what they heard and what ideas it gives them for sharing information with their own co-workers.

Invite room-wide sharing of what was discussed in small groups.

Summarize key points you note from the discussion.

Closing

When staff have regular ways to talk through what their residents need, they can prevent declines and promote the best outcomes.

Learning Experience # 5 Reflections and Take Homes

Time 10 minutes

Process

Either in their small groups, or in the whole group, in a go-round, ask each person to share reflections on ideas they got and how they can put them to use.

Closing

When systems support staff to share information and problem solve, they can work together to take the best care of their residents.

Additional Resources: A free Starter Kit on *Engaging Staff in Individualizing Care* has tip sheets for QI closest to the resident, as well as on consistent assignment, huddles, and involving CNAs in care planning. It is available at www.Pioneernetwork.net under "provider resources." Consider handing out copies of the tip sheet, and/or showing participants how to access them.