

**Originally Developed by B&F Consulting for Quality Partners of Rhode Island
Adapted to MDS 3.0 for the Pioneer Network National Learning Collaborative on
Using the MDS 3.0 as the Engine for Individualized High Quality Care**

Title: **Case Study: Mr. McNally**

Goal: This exercise has three instructional objectives:

1. To link an individual's customary routines with critical thinking and nurse assessment practices to prevent institution-centered care from inadvertently causing and accelerating an individual's clinical decline.
2. To illustrate how a unit/neighborhood/household problem-solving huddle in which every member of the care team participates can contribute to identifying and resolving risks and declines
3. To demonstrate link MDS 3.0 assessment and care planning processes in the MDS with quality improvement practices.

Description: Allow 10 - 15 minutes for this exercise, and 20 - 30 minutes for discussion afterwards.

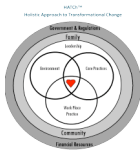
Divide into groups of 4 - 6 people. Give each group a set of cards. Have someone in each group deal out all the cards.

The cards contain fragments of information about Mr. McNally who came into the nursing home after a stroke, expecting short-term rehab and a return home. He rapidly declined. Each card has a clue about Mr. McNally's background, customary routines, or the events that occurred that caused his decline. Some of the information is clinical in nature, and some of it is personal. All the information is necessary to answer the two questions:

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

After all the clues are distributed, ask that in each group, all members of the group share the information they have with each other in order to answer the two questions. Encourage participants to put all the cards out on the table to work together to sort out what happened.

Discussion:



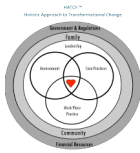
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1. **Huddle:** Point out that the process they have just gone through is similar to a neighborhood/household/unit huddle in which people have a quick 10 – 15 minute stand-up to review what they know about a resident they are concerned about, to determine 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.
2. **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. In Mr. McNally's case, 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.

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.

3. **Customary Routines:** The information about Mr. McNally's customary routines is 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, caused one problem after another. Ask the participants to piece this together with you.
 - 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 so 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



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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 was the root cause of his fall. 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.) 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.
- d. **Reviewing Incident/Accident 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



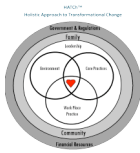
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sweet, independent, personable man. This triggers their intervention.

- e. **QI in Action.** They trace back the steps that led to his decline. They look at what other residents may have had similar declines. They focus first on restoring Mr. McNally's independence of bowel and bladder, and reducing suppository use. Within a few months, they are able to cut by 2/3 the number of suppositories used – by using basic nursing interventions – fluid, fiber, and exercise.

4. **Making MDS Customary Routines Information Available “just-in-time” for staff closest to a resident.** Ask the group what would have happened differently for Mr. McNally if the information on Section F of the MDS were available to his caregivers the first night he was there. The Quality of Life survey guidelines say that facilities must actively seek this information, assist residents in living by their customary routines, and make the information about their preferences and routines known to their caregivers. Ask who gets that information in their homes and how staff closest to the resident get the information in time for the first night and first morning of a new resident's stay.
5. **It takes a team.** Look at all the other sections of the MDS. If staff work on individual sections in “silos” they may not know the root cause of a problem and therefore the most effective intervention. A dietitian may see that Mr. McNally lost weight and recommend dietary supplements. However, the root cause of his weight loss is that his whole schedule has been thrown off and he is spiraling downward. Food supplements won't fix the root cause. The same is true for declines in mood, cognitive function, ADLs, skin, etc.
6. **Start by gathering information before or as soon as a new resident arrives.** Even though staff have several days to complete the first assessment and care plan, staff closest to the resident need the information about customary routines right away.



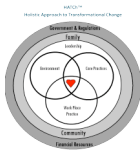
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7. **Share the information in shift and intershift huddles.** It is important to pass the information along to the next shift and to put a special focus on the social history, customary routines, mood, and ADL function of any new resident who is in the throes of making the major adjustment to the nursing home. Making this a part of each shift huddle conversation will allow staff to catch problems early, identify potential solutions, and intervene effectively.
8. **Unit-based QI.** Whether it's one person who's decline is a concern, or several residents who's conditions are a concern – such as people who frequently fall, who have pressure ulcers, or who are declining in their mood – the staff closest to the resident know the most about the person and are in the best position to look at the information, determine the root cause, and identify possible solutions.
9. **Fluid Care Planning.** When staff routinely huddle to look at residents' risks and opportunities, their discussions can lead to changes in the assessment, the care plan, and the instructions for daily care. Having “just-in-time” interventions whenever a situation changes makes care planning fluid, up-to-date, and meaningful.

OBRA '87 requires that nursing homes provide care and services to “attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The word “practicable” means what is innately possible based on the person's abilities and condition. A decline should only occur if it is a natural progression of a person's condition or illness. In Mr. McNally's case, he declined because of a series of responses by the nursing home rather than as a natural progression of his original condition.

The word “**iatrogenesis**” comes from the Greek, meaning, “we caused it.” The dictionary definition is “inadvertent and preventable induction of disease or complications by the medical treatment or procedures of a physician.” It's a clinical term used to describe a clinical problem caused by clinical treatment. In Mr. McNally's case, the staff inadvertently caused



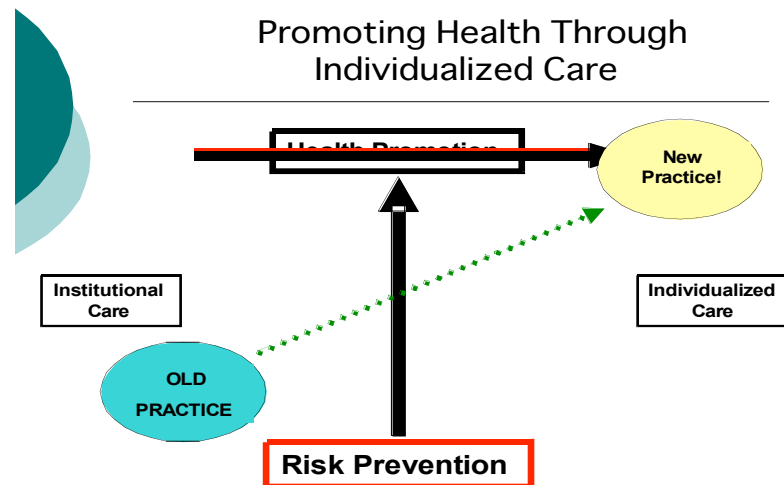
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his decline.

Just as we came to understand that while we used restraints for safety, they inadvertently caused harm, now we are seeing other ways that facility routines meant to provide care for residents inadvertently harm them. Centering care around an individual's routines, instead of the facility's routines, can reverse this harm and help individuals thrive.

Show this slide and ask the group to identify what happened to Mr. McNally that falls in to the lower left quadrant, being institutional practices that are generating by “risk prevention.”



- ∞ Institutional “risk prevention” practices include suppositories, alarms, incontinence products, and medications.

When the staff closest to the resident know the MDS information about the resident, and huddle for QI problem-solving, they can find individualized alternatives to each of these practices that promote the highest practicable physical, mental, and psychosocial well-being of each resident.