Winnipeg Regional Health Authority / Office regional de la sante de Winnipeg

# WRHA Constant Care Guidelines for Acute Care

## 1. PURPOSE

- To establish standardized guidelines and support appropriate use of constant care in acute care settings. Separate guidelines apply to residents in the LTC Program.
- To ensure that a decision making process is used which includes, ongoing assessment of patient need for constant care monitoring, use of alternative strategies, documentation, reassessment and monitoring of the process.
- To ensure the appropriate level of supervision is established for the protection and safety of the patient and/or hospital staff, other patients and visitors.

## 2. DEFINITIONS:

**Constant Care**: one-to-one monitoring of a patient and use of alternate techniques to provide safety and to protect the well-being of the individual and others in the patient care environment. May also include the cohorting of two or more patients who are continuously observed by a staff member. To ensure safety, patients receiving constant care must have the appropriate personnel in attendance and providing care at all times.

**Close Observation:** the patient is being observed at 15-30 minute intervals. This is not considered constant care.

## 3. GUIDELINES

WRHA sites shall implement and adhere to consistent regional constant care guidelines that include:

a) Following a decision making process and complete root cause analysis process

b) A physician's order may be required for:
   i. Patients at risk of suicide
   ii. Certain situations under the Mental Health Act.

c) Direction to initiate as required for patients exhibiting the following behaviour:
   i. A serious suicide attempt, self-harm, or at high risk of doing so based on behaviour and/or history.
   ii. Leaving the hospital and/or unit against medical advice, when cognitively impaired and a potential risk to self.
   iii. At risk to assault others either sexually &/or physically
   v. Discontinuing or interfering with essential medical treatment as the result of temporary or permanent lack of judgment or insight.
   vi. Combative, aggressive and/or poses potential harm to the safety of other patients, visitors, or staff.

d) An assessment is completed and constant care approved by manager/director, supervisor/shift administrator for 24-hour period

e) Appropriate consultations are initiated.

f) Adherence to WRHA restraint policy is required.

5. **ALTERNATIVE INTERVENTIONS**

The use of alternative interventions such as close observation and family involvement along with the documented outcomes is required.

6. **STAFFING**

Staff assigned to a patient on constant care should have the required skills necessary to provide observation to patients:

a) Nurse assigned is responsible for overall patient care.
b) Health Care Aide assigned to constant care patients is responsible for completion of delegated tasks.
c) The staff assignment record on each unit will indicate who is assigned to provide constant care.
d) Relief for staff assigned to constant care will be arranged by the nurse in charge.
e) Security or other personnel may be used to provide constant observation only in accordance with facility policies and/or collective agreements.

Family involvement

a) When the patient's status permits and the family confirms their understanding of the responsibilities of constant observation, a family member may be considered to take on this role. This discussion with the family must be documented on the Progress Notes. A staff member would maintain close observation of the patient to support the family member. A family member agreeing to provide constant care will be instructed to call a staff member should they need to leave the patient's room.
b) When constant care is not clinically indicated and the family requests constant care, it is the responsibility of the family to provide and pay for the service.

7. **DOCUMENTATION**

a) Initial patient assessment is recorded on the constant care intervention record.
b) Patient's condition, observations, interventions and/or response to treatment are to be documented at least every shift in the patient's health record.
c) Reassessment of the patient's status is completed at least every shift and documented on the health record.
d) Constant care personnel (RN, LPN or HCA) documents on the constant care 24 hour monitoring flow record (Part A & B).

8. **DISCONTINUATION**

a) Discontinue constant care with team/management or medical approval.
b) Constant care ordered by physician must be discontinued by physician (e.g. suicide risk).

9. **QUALITY MONITORING**

a) Evaluation to be completed by unit/ward.
b) Provide education to current and new staff on guidelines.
c) Documentation will be audited at least twice each time constant care is in place.

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**WRHA CONSTANT CARE PROCEDURES**

1. **Nurse reviews** WRHA Constant Care Guidelines

2. **Nurse follows** the Constant Care Decision Tree

3. Nurse assesses patient's need for constant care. Complete the **Assessment and Intervention Record Part A** which includes the following:
   a) Identified patient's safety risks
   b) Identified and implemented interventions/alternatives
   c) Evaluated effectiveness of interventions/alternatives

4. Nurse informs manager/director/supervisor on days/evenings/nights/weekends about patient's conditions and obtains approval for constant care.

5. Unit requests the appropriate constant care personnel and provides the required information following the site protocols for accessing staff resources. Complete Constant Care Tracking Form.

6. When constant care is approved for initiation, Nurse documents Constant Care Start Date on **Assessment and Intervention Record Part B**

7. Nurse informs all personnel of the patient's status.

8. Nurse explains the reason for constant care to patient/family or guardian as appropriate.

9. Nurse is responsible for developing an individualized patient care plan, documents the "Constant Care", supervises constant care personnel and continues with appropriate evaluation and treatment such as vital signs, medications and treatments.

10. Nurse informs and instructs constant care personnel about patient care plan.

11. Constant Care HCA implements patient care plan by providing activities of daily living as delegated and monitors/observes on a **CONSTANT** basis. This includes accompanying patient to the bathroom. When visitors are present, Nurse in charge decides if Constant Care personnel is required to stay with patient and visitors. If not, constant care personnel may be given other duties during this time.

12. Constant care personnel who are **not HCAs will not provide care.** They only monitor/observe patient on a **CONSTANT** basis.

13. Constant care personnel and Nurse document observations and care provided on the **Constant Care 24 Hour Monitoring Flow Record.**

14. Constant care personnel must inform Nurse of any change in patient's behaviour or health

status.

15. All personnel must consider a call light from this patient's room as urgent and must attend to it immediately.

16. Nurse must delegate a replacement to continue the required monitoring and supervision when constant care personnel cannot be present.

17. Constant Care personnel must give report to Nurse (verbal or written) before shift change.

18. At the change of shift, Constant Care personnel must remain with the patient until a replacement is physically present.

19. The nurse provides a report of patient's status/needs and orients the incoming constant care personnel to patient's care plan, and how to complete the Constant Care 24 hour Monitoring Flow Record.

20. Nurse reassesses patient every shift using information listed on Assessment and Intervention Record Part A for necessity of constant care.

21. Nurse charts every shift and summarizes patient's condition and responses to interventions and documents whether constant care is still indicated in the Assessment and Intervention Record Part B (Documentation is required either on Part B or patient's health record)

22. Patient status and constant care needs to be approved daily with manager/director/ supervisor and documented on Assessment and Intervention Record Part B.

23. When constant care is discontinued, Nurse documents Constant Care Stop Date on Assessment and Intervention Record Part B.

Special Case:

24. Patient who has exhausted all possible alternative interventions and treatments, and is determined by a multidisciplinary team and physician to have "long term" constant care, reassessment will be done weekly by Nurse and Manager to review the need to continue or discontinue Constant Care. Nurse documents patient's condition weekly in patient's health record instead of using the Assessment and Intervention Record. Constant Care 24 hour Monitoring Record should be completed by constant care personnel on a daily basis.

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# Constant Care Decision Tree

**Patient exhibits behaviour that has potential of harm to self or others:**

e. g. *Serious suicide or homicide attempt/risk*

- x At risk of sexual/physical assault
- x Elopement
- x Interrupts **essential** medical therapy
- x Uncontrolled aggressive behaviours

→ *Constant care until d/c by psychiatry*

Nurse to complete
Constant Care Assessment and Intervention Record
Part A

**Alternatives Effective?**

**YES** → Nursing staff continue alternatives and assess for potential injury to self or others

**NO**

**Constant Care needed**

RN contacts and reviews with Unit Manager, Director or Supervisor

**NO**

**Constant Care Approved?**

**NO** → Unit Manager or designate gives other alternatives to be tried before considering constant care use.

**Alternatives effective?**

**YES**

**YES**

**Reassessment** ; Need for Constant Care use is evaluated every shift by Nurse to continue or discontinue.

- Manager or designate will review with RN daily to reevaluate the need for Constant Care
- Consult Physician and interdisciplinary team as needed.

**Continue Constant Care with Team/Management/ Medical approval**

**OR**

**Discontinue Constant Care with Team/Management/ Medical approval**

# Hospital Logo CONSTANT CARE ASSESSMENT/ INTERVENTION RECORD

Addressograph

**Instructions for Nurse assigned to patient:**

1. Follow Constant Care (C.C.) Decision Tree.
2. Complete Constant Care Assessment and Intervention Record Part A.
3. Obtain approval from management for Constant Care.
4. Document name of management person who approves constant care, date and time of initiating Constant Care on Assessment and Intervention Record Part B (Left Upper Box).
5. Use Part A to reassess patient q. shift to identify changes and document the changes on Part B or in patient's health record.
6. Document date and time of discontinuation of Constant Care on Part B (Right Upper Box).
7. Instruct Constant Care personnel about required patient care and how to complete the 24 hour Constant Care Monitoring Flow Record (separate form).

**PART A:**

IDENTIFY RISK FACTORS: Please all that apply:

**COGNITITVE**

*☐ **Delirium** present if Confusion Assessment Method positive **(i.e. 1 and 2 plus 3 OR 4 of following)**:

1. ☐ **Acute mental status changes/fluctuating.**
   **and**
2. ☐ **Evidence of inattention (i.e. difficulty focusing, easily distracted, unable to follow topic).**
   **plus**
3. ☐ Evidence of disorganized thinking (i.e. rambling, irrelevant conversation).
   **or**
4. ☐ Altered LOC –Vigilant (Hyperalert)/ Lethargic/Drowsy/Stupor/Coma

☐ Known history of Dementia
☐ Problem with immediate recall
☐ Poor safety judgment
☐ Other: _____

**BEHAVIOURAL**

* ☐**Suicide Risk**
***ACTION: ☐ If present, consult psychiatry and initiate C.C. until D/C by psychiatry/physician**

☐ Disrupts essential medical therapy Specify_____
☐ Very Impulsive
☐ Disruptive or harmful to others
☐ Wandering with risk of elopement
☐ Other: _____

**MOTOR**

☐ Recurrent falls
☐ Orthostasis
☐ Unsteady gait
☐ Poor balance
☐ Urinary frequency or urgency
☐ Sensory impairment (sight, hearing, neuropathy)
☐ Medication related (e.g. polypharmacy, narcotics, sedative, neuroleptics)
☐ Other: _____

INTERVENTIONS/ALTERNATIVES: Please ✍ all that have been initiated or attempted prior to requesting C.C.
*If changes are made following reassessment, please initial and date them.

**Consultations**

☐ Geriatric Psychiatry ☐Geriatrics C☐NS P☐harmacist
☐ Recreational Therapist ☐OT P☐T
☐ Other (specify):_____

**Treatment Change**

☐ Review Medications
☐ Remove catheters, drains, tubes, as clinically indicated
☐ Camouflage tubes/lines - Cover dressing sites

**Wandering Behaviour Management**

☐ Take patient's picture as per facility's policy & notify Security
☐ Remove street clothes
☐ Apply Wanderguard/Locked Unit

**Psychosocial Interventions**

☐ Clock/calendar within view
☐ Frequent orientation/explanation. Do Not Argue with patient-use diversion (e.g. reminisce with patient, walk patient, offer ice-cream, snacks, and tea)

☐ **Involve Family:** (e.g. encourage family to sit with patient, bring familiar items such as pictures, favourite pillow/blanket/plush animal from home, obtain collateral information that has worked to calm patient)

**Falls Prevention interventions:** (Use own Fall Prevention Program, if none, use the following)

☐ **Ask the following 5 questions every time before leaving the patient alone in bed or in chair.**
   1. Do you need a drink of water?
   2. Do you need to go to BR/use a bed pan/urinal?
   3. Do you need something for pain?
   4. Do you have everything you need within reach?
   5. Show me how you can reach and use the call bell.
☐ Move person closer to the nursing desk if possible
☐ Bed in low position with brakes on or on blocks
☐ Obtain/use proper footwear (with non-skid sole)
☐ Walking aide within reach
☐ Urinal/commode at bedside
❑ Toileting routine Q1-2 hr.
☐ Continuous supervision while toileting
☐ Assist with exercise and mobility (e.g. walk 2-3x/day on unit)
☐ Bed Alarm ⓒ Chair Alarm
☐ Lying and Standing blood pressure x3 days

**Other:**

☐ Close observation Every 15-30 minutes without C.C.
☐ Cohort 2 or more patients for Close Observation with 1 C.C.
☐ Specify:

**Initial Assessment Date/Time** _____

**Nurse's Name (Print)** _____ **Initials:**_____

**CONSTANT CARE 24 HOUR**
**MONITORING FLOW RECORD**
**Part B**

**Constant Care Attendant Responsibilities:**

1. Obtain report from previous Constant Care Attendant and from Nurse. Ensure if entering room where "Care Plan Alert" is identified on door that care plan is reviewed prior to entering room.
2. Monitor, accompany and assist patient with all care activities on a constant 1:1 bases as directed by the Nurse.
3. Provide socialization to patient.
4. Complete documentation on reverse side of form.

**Nurse Responsibilities:**

1. Provide report to Constant Care Attendant; review care plan with Constant Care Attendant if required. Complete/assist with documentation about report and priorities for shift.
2. Review flow record with Constant Care Attendant and expectations for shift.
3. Initial on flow record every hour ensuring Constant Care Attendant is completing tasks as required.
4. Provide guidelines to Constant Care Attendant regarding coverage required if family present.
5. Arrange for break coverage for Constant Care Attendant.
6. If constant care is no longer required then provide direction to Constant Care Attendant to assist on unit.
7. Document in IPN notes every shift regarding effectiveness of constant care.

| REPORT | PRIORITIES FOR SHIFT (determined by nurse) |
|---|---|
| NIGHTS | |
| DAYS | |
| EVENINGS | |

| PART C | Patient name: | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| DATE: dd/mmm/yyyy | TIME IN HOURS | | | | | | | | | | | | | | | | | | | | | | | |
| | 00 | 01 | 02 | 03 | 04 | 05 | 06 | 07 | 08 | 09 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| Behaviour: Behavior Care Plan in place □ Yes □ No Reviewed with Constant Care Attendant □ Yes □ No | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient Sleeping | | | | | | | | | | | | | | | | | | | | | | | | |
| Awake and calm | | | | | | | | | | | | | | | | | | | | | | | | |
| Mild to mod behaviour | | | | | | | | | | | | | | | | | | | | | | | | |
| Extreme behaviour | | | | | | | | | | | | | | | | | | | | | | | | |
| Restraints used | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient drowsy | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | |
| Hygiene/Elimination: | | | | | | | | | | | | | | | | | | | | | | | | |
| Bath: wipes shower | | | | | | | | | | | | | | | | | | | | | | | | |
| Hair wash/ shower cap | | | | | | | | | | | | | | | | | | | | | | | | |
| Bed Changed | | | | | | | | | | | | | | | | | | | | | | | | |
| Oral Care: q _____hr | | | | | | | | | | | | | | | | | | | | | | | | |
| Eye Care: q _____hr | | | | | | | | | | | | | | | | | | | | | | | | |
| PeriCare | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient voided | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient had BM | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | |
| Nutrition: Diet: _____ Intake and output required □ Weight today □ _____kg | | | | | | | | | | | | | | | | | | | | | | | | |
| % of meal eaten | | | | | | | | | | | | | | | | | | | | | | | | |
| Food offered | | | | | | | | | | | | | | | | | | | | | | | | |
| Fluids offered | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | |
| Mobility: Lift and Transfer Status_____ Bed Mobility _____ Fall Risk □ Yes □ No | | | | | | | | | | | | | | | | | | | | | | | | |
| Ambulate x _____/shift | | | | | | | | | | | | | | | | | | | | | | | | |
| Up in chair x ____hrs | | | | | | | | | | | | | | | | | | | | | | | | |
| Turned q _____hours | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | |
| Safety: | | | | | | | | | | | | | | | | | | | | | | | | |
| Call bell in reach | | | | | | | | | | | | | | | | | | | | | | | | |
| Side Rails x _____ | | | | | | | | | | | | | | | | | | | | | | | | |
| Bed Check in place | | | | | | | | | | | | | | | | | | | | | | | | |
| Chair Check in place | | | | | | | | | | | | | | | | | | | | | | | | |
| Fall Mat | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | |
| Socialization/Diversion Activities: | | | | | | | | | | | | | | | | | | | | | | | | |
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| Constant Care Initials | | | | | | | | | | | | | | | | | | | | | | | | |
| Nurse Initials | | | | | | | | | | | | | | | | | | | | | | | | |

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