

Constant Care Change in Practice Guidelines

Educational Resource Guide

Project 2.4 Constant Care
March 2004

Constant Care Education Resource Guide

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1. Introduction

1.1 Background/Statistics

1.1.1 What did the External Review identify¹?



- While there are guidelines for the use of constant care in many facilities, there is insufficient rigor in the process. Often constant care is requested before trying alternative interventions and it is not evaluated for timely discontinuation².
- At HSC (all programs), approximately 22 EFTs purchased in CC support in 2001/2002
- At SBGH (all programs), approximately 20 EFTs was used in CC in 2001/2002
- At several community sites, there was considerable use of constant care.
- The external Review report suggested:
“There should be a focused effort to reduce the use of constant care aides. This is a strategy that can be realized even in the ‘minimal restraint’ environment that has been adopted and will require:
 - Education of nursing and medical staff around alternative strategies for the management of difficult patients
 - Development of standard criteria care use and a standard process for accessing constant care resources when required.
 - Monitoring of utilization and follow up”.³

In summary, the External Review report recommended⁴:

- Development of regional criteria, guidelines, protocols
- Education of physician and staff

¹ <http://www.wrha.mb.ca/icare/abc/files/WRHAFinalReport.pdf> Report of the External Review of WRHA by Deloitte and Touche.

² <http://www.wrha.mb.ca/icare/abc/files/WRHAFinalReport.pdf> Report of the External Review of WRHA by Deloitte and Touche. P.73

³ <http://www.wrha.mb.ca/icare/abc/files/WRHAFinalReport.pdf> Report of the External Review of WRHA by Deloitte and Touche. P.75

⁴ <http://www.wrha.mb.ca/icare/abc/files/WRHAFinalReport.pdf> Report of the External Review of WRHA by Deloitte and Touche. p. 79.

1.1.2 What did the literature say?



Highlights:

- There is a lack of literature supporting improved patient care or prevention of injury with the use of constant care. “Research has not provided outcome data supporting the use of companions in relation to their benefit/expense ratio”.⁵
- The patient’s behaviour is challenging but the alternative interventions are numerous. Many authors are suggesting alternative interventions that look at early identification and treatment of root causes contributing to the patient’s behaviour/condition.^{6 7 8 9}
- Acute care facilities need a system in place to safeguard the consistency and validity of the decisions being made. Clear, comprehensive policies and procedures that utilize a collaborative approach are needed to support the decision-making process.¹⁰
- There is no article that shows effectiveness of a single intervention (beyond psych consultation).

Literature Review Summary¹¹

Policies:

(Note: **Bold face type has stronger evidence**, i.e. is a component of an effective program that decreased costs or stated by numerous articles. Others are suggestions, some supposedly effective but without clear documentation of such.)

1. Policies
 - Same policies and procedures in all sites to decrease confusion
2. Target population - define users of Constant Care (CC)
 - Reasons: at risk of serious harm to self or others (fallers, agitated or aggressive, suicidal, interfere with necessary treatment)
 - Prevent suicide in severe depression

⁵ Salamon, Lisa and Lennon, “Maureen Decreasing companion usage without negatively affecting patient outcomes: A performance improvement project.” *MEDSURG Nursing*, August 2003 12 (4) p. 231

⁶ Salamon, Lisa and Lennon, “Maureen Decreasing companion usage without negatively affecting patient outcomes: A performance improvement project.” *MEDSURG Nursing*, August 2003 12 (4).

⁷ Torkelson, D.J. and Dobal, M.T. “Constant observation in medical-surgical settings: a multihospital study.” *Nursing Economics*, 17(3), May-June 1999.

⁸ Worley, Kunkel, Gitlin, Menefee and Conway, “Constant observation practices in general hospital setting: a national survey.” *Psychosomatics*, 41(4), July-August 2000

⁹ Heyman, E.L. and Lombardo, B.A. “Managing costs: the confused, agitated, or suicidal patient.” *Nursing Economics*, 13(2), March-April, 1995.

¹⁰ Torkelson, D.J. and Dobal, M.T. “Constant observation in medical-surgical settings: a multihospital study.” *Nursing Economics*, 17(3), May-June 1999, p.153.

¹¹ See Reference List.

- No evidence for prevention of violence by CC presence? Found to be counterproductive with violent paranoid clients.
 - Fallers: one study suggested that it was ineffective
3. CC Attendant
- Contracted sitters better
 - Less costly staff suggested (hospital instead of agency). Hospital staff also promotes continuity of care.
 - Unpaid volunteer is an option
 - Family (mixed reports but more suggest this is good in particular situations)
 - CC attendants in suicidal cases need more qualifications, i.e. knowledge about suicidality. Typically a nurse of sorts.
4. CC Attendant Role
- Interact with client so that opportunity for rapport is not lost, less degrading (especially in psych uses)
 - Explore reasons for behaviour and feelings and needs of client, sitter presence may decrease regular staff knowledge of client (a hazard of CC)
 - Regular reports? (No specifics described)
5. Audits
- Consistent, ongoing monitoring
 - **Necessary to ensure policies and procedures are followed over time**
 - Patient (family) satisfaction, patient falls, restraint use, CC attendant use and costs
6. Education
- Mandatory 45 minute session for all staff
 - Train all new staff on orientation
 - Topics: suicide precautions and signs, alternatives to CC, delirium recognition
 - **Educating all RNs “Management of Patients at Risk”**
7. Costs
- **To unit so that they realize cost**
 - No cost to client or family, unless CC is at family request and does not fit criteria
8. Resources
- **Dedicated CNS, consult-liaison psych nurse or psychiatrist**
 - Equipment: **bed and chair alarms**, bed enclosure devices, safe rooms i.e. closer to nursing stations, **lower beds**, shatter-proof glass and non-opening windows
 - No video cameras, or dependence on family member
 - Others: recreational therapy, day program, regular exercise and toileting

Procedures:

(Note: **Bold face type has stronger evidence**, i.e. is a component of an effective program that decreased costs or stated by numerous articles. Others are suggestions, some supposedly effective but without clear documentation of such.)

1. Pre CC Assessment

- CNS provide leadership, consultation, monitoring
- Decision tree by CNS and staff
- **Psych consult decreased cost of CC**, this was specifically to determine suicide risk. **Consultations to neurology and psychiatry must be timely.**
- Risk assessment, assess on admission for risk factors for falls or delirium
- Carefully evaluate elderly patients, early rapid detection and treatment of delirium is effective

2. Other Interventions

- **Delirium - Need medical intervention, recognize and treat**
- Behaviour
- Falls - **SAFE program** used in one facility (1-risk factors on admission, daily assessments and interventions)
- **Medical interference - reevaluate whether the therapy a risk in necessary, any alternatives?**
- OT, PT, good lighting, **regular toileting**, exercise program
- Four levels of observation (constant, frequent, less frequent, general) i.e. **documented 15-minute checks reduced CC**
- **Cluster fallers or delusional clients** (1:2 or 1:3 to decrease cost)
- Transfer to alternate unit

3. CC Process

- **Criteria for use of CC**, checklist, some variation of this is a listed component of an effective project to decrease CC use and costs
- Multidisciplinary decision suggested i.e. **discussion with the nurse manager (or acting after hours) mandatory before CC approved, to ensure that alternative approaches have been tried** (this has decreased use and costs)
- MD write order (most policies have this, whether necessary is unclear)
- Written orders to start and stop, specific stop policies i.e. auto stop after 24 hours if not reordered

4. Monitoring on CC

- **CNS involved** in some sites, very effective to ensure alternatives, education and monitoring
- Regular reports done, CC attendant notes?
- **Frequent reevaluation**, multiple times a day to change level
- **Daily rounds with nurse manager/CNS to reevaluate ongoing need, reevaluate medical therapy with physician**



1.2 ABC Constant Care Project Goals, Objectives and Expectations



Goals

- To reduce the use of constant care regionally by reviewing patient care staffing levels related to existing practices, exploring benchmarking sites with peer facilities across the country, and implementing leading practices.

Objective

- To reduce constant care hours regionally through the development and implementation of regional criteria, processes and alternative strategies to manage patients with difficult behaviours.

Expectations

Delivery of the objectives identified, will result in:

- Improved quality of care to patients utilizing an individualized approached assessment and treatment plan
- Redirection opportunities – savings equivalent to 55.5 EFT constant care aide staff = \$1.4 million
- Reduced constant care hours and cost per patient day
- Maintenance of safe patient care (liability, legal and ethical issues)
- Reduced number of patients requiring constant care
- No significant increase in negative occurrence reports (e.g. falls, complaints, line/tube removal, etc.)
- No significant increase in the use of chemical and physical restraints
- Increased adherence to established guidelines and processes
- It is recognized that some situations will still warrant the use of constant care

2. Review of the WRHA Constant Care Guidelines

2.1 Purpose of Constant Care Guidelines

(See WRHA Regional Constant Care Guidelines)

- To provide information that is based on best practice and/or clinical evidence to guide the use of constant care that is cost-effective and justifiable for patient care.
- To support appropriate use of constant care in acute care settings.
- 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.

Please Note: This guideline excludes personal care home (PCH) settings.

2.2 Definition of Constant Care



Constant Care

All patients receiving constant (continuous) care will have an increased level of observation and supervision by designated staff. This consists of one-to-one monitoring and use of alternate techniques to provide safety and to protect the well being of the individual and others in the patient care environment. To ensure safety, patients receiving constant care must have the appropriate personnel in attendance and providing care at all times.

Close observation i.e. being observed at 15-30 minute intervals is not considered constant care.

2.3 Criteria for use of Constant Care

- Patient exhibits behaviour that has potential of harm to self or others:
Examples:
 - ✓ Serious suicide or homicide attempt/risk
 - ✓ Certain situations under the Mental Health Act
 - ✓ At risk of sexual/physical assault
 - ✓ Elopement: Leaving the hospital and/or unit against medical advice, when cognitively impaired and a potential risk to self
 - ✓ Discontinuing or interfering with essential medical treatment as the result of temporary or permanent lack of judgment or insight
 - ✓ Uncontrolled aggressive behaviours such as combative, aggressive and/or poses potential harm to the safety of hospital staff, other patients or visitors
 - ✓ Interrupts essential medical therapy

2.4 Summary Highlights of the Constant Care Guidelines

Initiation of Constant Care:

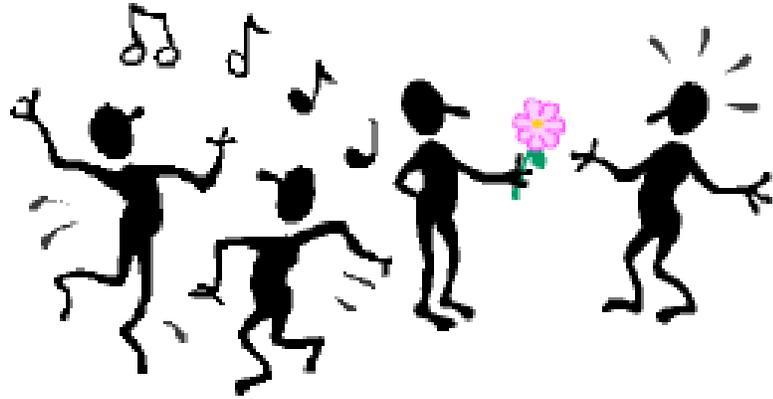
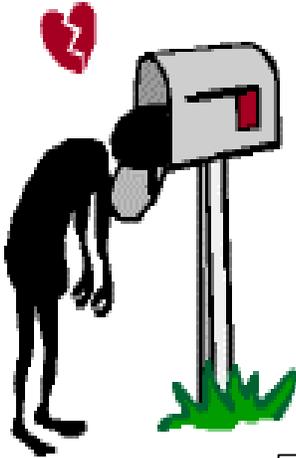
- Follow a constant care decision tree
- A physician's order may be required for:
 - Patients at risk of suicide.
 - Certain situations under the Mental Health Act.
- An assessment is completed and constant care approved by manager/director, supervisor/shift administrator for an 8-hour period with re-approval required every shift.
- Appropriate consultations are initiated.
- Adherence to site restraint policy is required.
- 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. Close observation of patient is maintained by staff 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.
- 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.
- Use of alternative interventions with documented outcomes of strategies tried e.g. close observation, family involvement.
- Staff assigned to a patient on constant care should have the required skills necessary to provide observation to patients:
 - Nurse assigned is responsible for overall patient care.
 - Health Care Aides assigned to constant care patients are responsible for completion of delegated tasks.
 - Security or other personnel may be used to provide constant observation only in accordance with facility policies and/or collective agreements.
 - The staff assignment record on each unit will indicate who is assigned to provide constant care.
 - Relief for staff assigned to constant care will be arranged by the nurse in charge.

Discontinuation of Constant Care:

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

Documentation:

- Initial patient assessment is recorded on the required forms per protocol.
- Patient's condition, observations, interventions and/or response to treatment is to be documented at least every shift in the patient's health record.
- Reassessment of the patient's status is completed at least every 8 hours and documented on the health record.
- Constant care personnel (RN, LPN or HCA) documents on appropriate forms.

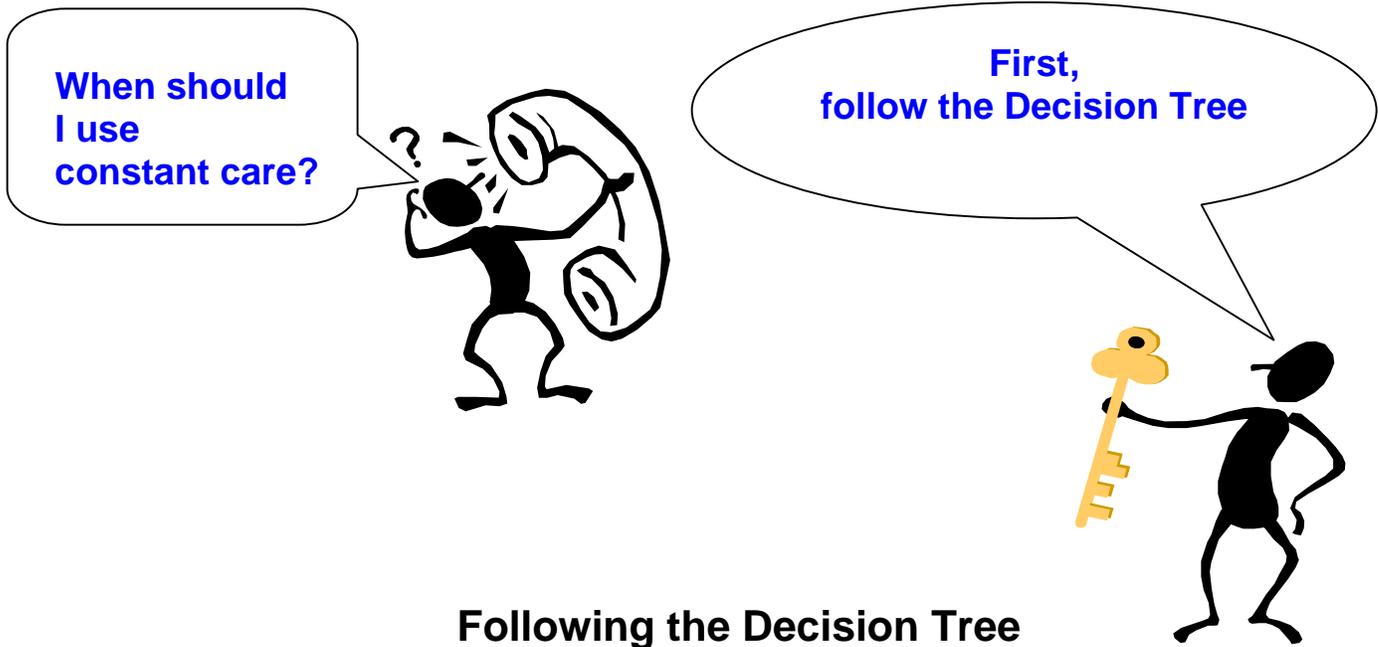


All human behaviours have meanings and there is a reason behind the action...

So... why is my patient acting this way?



3. Review of the WRHA Constant Care Procedures



3.1 Identify and Describe Patient's Behaviour (Be specific)

Does patient exhibit behaviours that meet the criteria for constant care?
i.e. Patient exhibits behaviour that has potential of harm to self or others:

Example:

- Serious suicide or homicide attempt/risk
- Certain situations under the Mental Health Act
- At risk of sexual/physical assault
- Elopement: Leaving the hospital and/or unit against medical advice, when cognitively impaired and a potential risk to self.
- Discontinuing or interfering with essential medical treatment as the result of temporary or permanent lack of judgment or insight
- Uncontrolled aggressive behaviours such as combative, aggressive and/or poses potential harm to the safety of hospital staff, other patients or visitors
- Interrupts essential medical therapy

3.2 Assessment and Alternative Interventions

Form: Constant Care Assessment/Intervention Record Part A and B

Before using constant care, the Nurse completes the Constant Care Assessment/Intervention Record to identify patient's risk factors and alternative interventions.



Q: What is your patient at risk of?

Part A: CONSTANT CARE ASSESSMENT/INTERVENTION RECORD

IDENTIFY RISK FACTORS: Please ✓ all that apply:

COGNITIVE

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: _____

My patient is confused and agitated. He keeps pulling on his I.V and Foley. He tries to climb out of bed. I tried using a physical restraint but it made his behaviour worse.

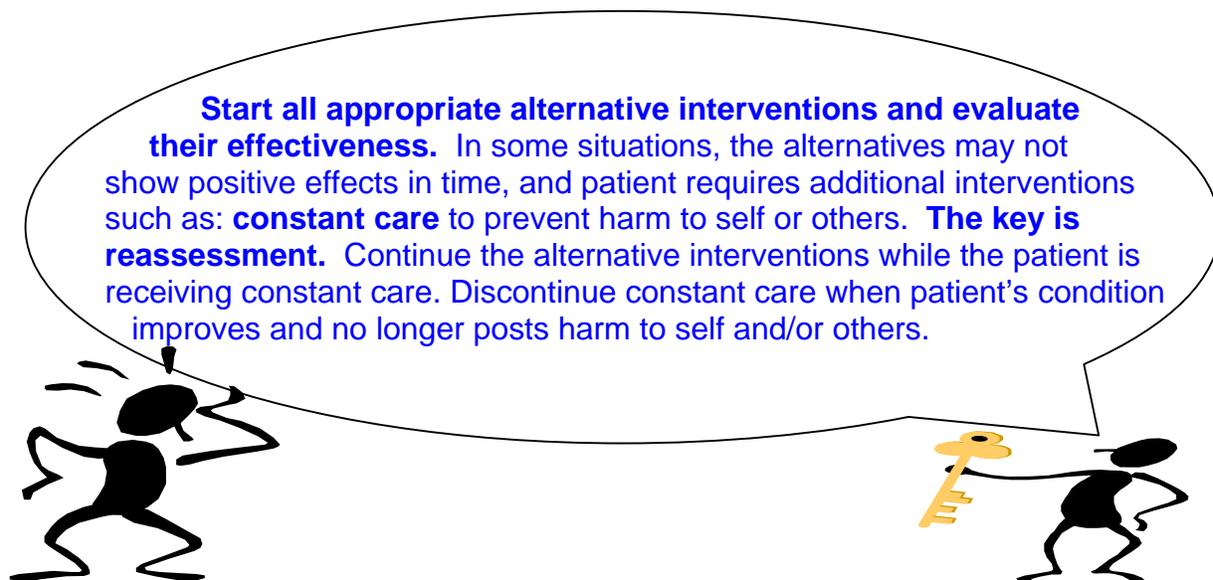


My patient keeps wandering into other patients' room and off the unit. He was brought back to us by the security officer. I tried putting him into a geri-chair with a laptray to stop him. But he kept sliding down and got his head caught between the laptray and the chair.

What are some of the possible root causes that contribute to the patient's behaviour?

What can you do to help reduce the possible effects of some of the possible contributing factors?





Part A: CONSTANT CARE ASSESSMENT/INTERVENTION RECORD (lower half section)

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.	
<p>Consultations</p> <input type="checkbox"/> Geriatric Psychiatry <input type="checkbox"/> Geriatrics <input type="checkbox"/> CNS <input type="checkbox"/> Pharmacist <input type="checkbox"/> Recreational Therapist <input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> Other (specify): _____	<p>Falls Prevention interventions: (Use own Fall Prevention Program, if none, use the following)</p> <p>■ Ask the following 5 questions every time before leaving the patient alone in bed or in chair.</p> <ol style="list-style-type: none"> 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 <u>and</u> use the call bell. <input type="checkbox"/> Move person closer to the nursing desk if possible <input type="checkbox"/> Bed in low position with brakes on or on blocks <input type="checkbox"/> Obtain/use proper footwear (with non-skid sole) <input type="checkbox"/> Walking aide within reach <input type="checkbox"/> Urinal/commode at bedside <input type="checkbox"/> Toileting routine Q1-2 hr. <input type="checkbox"/> Continuous supervision while toileting <input type="checkbox"/> Assist with exercise and mobility (e.g. walk 2-3x/day on unit) <input type="checkbox"/> Bed Alarm <input type="checkbox"/> Chair Alarm <input type="checkbox"/> Lying and Standing blood pressure x3 days
<p>Treatment Change</p> <input type="checkbox"/> Review Medications <input type="checkbox"/> Remove catheters, drains, tubes, as clinically indicated <input type="checkbox"/> Camouflage tubes/lines - Cover dressing sites	<p>Other:</p> <input type="checkbox"/> Close observation Every 15-30 minutes without C.C. <input type="checkbox"/> Cohort 2 or more patients for Close Observation with 1 C.C. <input type="checkbox"/> Specify: _____
<p>Wandering Behaviour Management</p> <input type="checkbox"/> Take patient's picture as per facility's policy & notify Security <input type="checkbox"/> Remove street clothes <input type="checkbox"/> Apply Wanderguard/Locked Unit	<p>Initial Assessment Date/Time _____</p>
<p>Psychosocial Interventions</p> <input type="checkbox"/> Clock/calendar within view <input type="checkbox"/> Frequent orientation/explanation. <u>Do Not Argue</u> with patient-use diversion (e.g. reminisce with patient, walk patient, offer ice-cream, snacks, and tea) <input type="checkbox"/> 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)	<p>Nurse's Name (Print) _____ Initials: _____</p>

Additional Resources Available

There are a variety of resources available, which can be accessed to customize the alternative strategies for different patient behaviours. The following are some examples.

Follow site policy and procedure (if available) on:

Falls Prevention, Wandering Behaviour Management, Delirium/Dementia Management, Medication Review, Consultation Process and Suicide Risk Protocol.

These procedures may be effective alternative interventions in managing patient's particular risk/behaviour.

Other available Resources: (This list is not exclusive)

***Please contact author for permission to use the materials.**

"Welcome to the Depression, Delirium, Dementia: Self-Study Package."

Contact: Lori Lamont at Deer Lodge Centre LLamont@deerlodge.mb.ca

"Falls Prevention Program Trial for acute care setting"

"Post – Op Delirium Watch Trial Protocol"

"Patients at Risk to Wander"

"Policy & Procedures on Physical Restraints"

"Guidelines on Confusion Assessment Method"

Contact Poh-Lin Lim at St. Boniface General Hospital plim@sbggh.mb.ca

"Falls Prevention Program" for long term care setting"

Contact: Carole Hamel at Riverview Health Centre chamel@rhc.mb.ca

"Managing Challenging Behaviours of the Alzheimer's Victim" Notes prepared by Tara Evans email: tevens@sogh.mb.ca

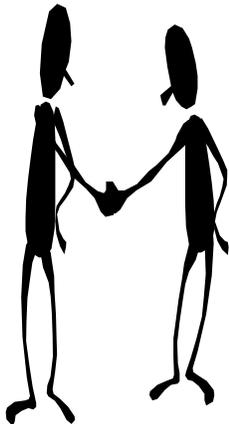
I have initiated the alternative interventions, but I am really worried about my patient's safety. My assessment indicates need for constant care. What should I do next?

Who should I ask for approval? Manager/ Director/Supervisor/ Doctor?



3.3 Obtain Approval for Constant Care

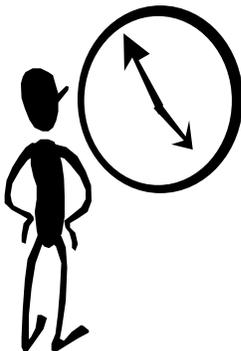
If constant care is deemed necessary based on the nurse's assessment, **approval must be obtained from management.**



In general, approval from physician is not needed. However, in some situations, physician's order may be needed e.g. in Mental Health Program. If a physician ordered constant care, then an order for discontinuation from the physician is required.

In cases such as suicide risk/attempt, or risk for sexual assault in mental health program, constant care is initiated and maintained until the patient is seen by psychiatry and an order of discontinuation is obtained.

3.4 Request for Constant Care (once approved by management)



- Call staffing office to request for constant care.
- Ask for one shift at a time as approved.
- Each shift request must be approved by the manager.
- Track the use of constant care as per facility's tracking process.



3.5 Nurse and Constant Care HCA/Personnel's Responsibilities

The Nurse's Responsibilities:

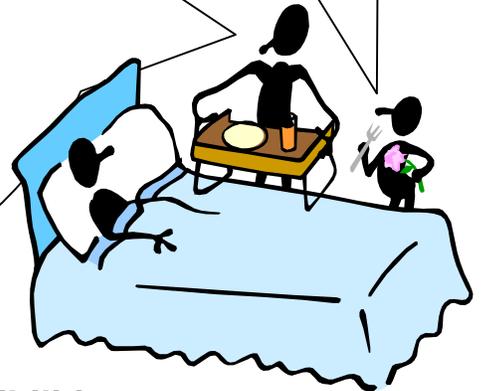
- The nurse is responsible for providing guidelines/instruction to Constant Care Personnel regarding care activities, what and when to alert nurse, and how to document in the 24-Hour Constant Care Monitoring Flow Record.
- An individualized care plan is essential to provide continuity of care and should be developed by the nurse.
- Ensure constant care personnel have the required knowledge and skills in working with the patient.
- Remember that only Nurses and Health Care Aides may provide care for the patient. Non-nursing personnel can only sit with patient and alert the nurse when patient requires help.
- Remind constant care personnel to monitor and accompany patient on a constant 1:1 basis at **all times** (including when toileting and when visitors are present unless otherwise directed by Nurse).
- Arrange break coverage at beginning of shift and inform constant care personnel and unit staff involved.
- Remove all potentially harmful objects from the patient's immediate environment (e.g. belt, razors, matches).
- Encourage family to be involved (e.g. to sit with patient, bring in familiar items from home).
- Ensure proper documentation is maintained.

Your responsibility depends on your training and the job description.

If you are a Nurse or a Health Care Aide, you provide all care required by the patient. You must always report any changes to the nurse, even when you are unsure.

If you are a security person or a porter who is not trained to provide care, then you are expected to provide 1:1 monitoring at all times and to alert the nursing staff for any care required by the patient. You too are required to always report any changes you noticed to the nurse, even when you are unsure.

I am the constant care personnel



The Constant Care Personnel's Responsibilities:

Patient Care

- Monitor and accompany patient on a constant 1:1 basis at all times (including when toileting and when visitors are present unless otherwise directed by Nurse)
- Constant Care Health Care Aide (HCA) to provide all needed care as instructed by Nurse
- Document in 24-hour Monitoring Flow Record
- Remove all potentially harmful objects from the patient's immediate environment (e.g. belt, razors, matches)

Change Of Shift

Remain with patient until the replacement personnel is physically present

Break Coverage

The Nurse will arrange at beginning of shift

Assisting On Unit

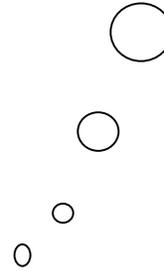
At the discretion of the Nurse, Constant Care HCA may be requested to assist with other HCA unit duties as required when no longer needed to provide constant care.

Report

- Obtain report and review Constant Care guidelines at beginning of shift from nurse.
- Report off and review care with Nurse at completion of shift.
- Anytime during the shift, report any changes in condition, if unsure, report to Nurse

Management's Responsibilities:
(e.g. Designated Manager/Supervisor/Director)

- Initial approval of Constant Care personnel
- Re-approval every shift as appropriate
- Perform audits to assess documentation and adherence to Constant Care use
- Accountable for ongoing tracking of constant care usage



4. Documentation

4.1 Guidelines for Using Documentation Records

Two documentation records have been developed for charting:

1. The Constant Care Assessment/Intervention Record Part A and B.
2. The Constant Care 24-Hour Monitoring Flow Record Part A and B.

1. The Constant Care Assessment/ Intervention Record, Part A and Part B.	2. The 24-Hour Monitoring Flow Record Part A and Part B
The nurse is responsible for completing the <u>Constant Care Assessment/Intervention Record, Part A and B.</u>	The nurse, the constant care personnel, and any nursing staff who provided care for the patient will document appropriate information/care provided in the <u>24-Hour Monitoring Flow Record</u>
This record will be kept on the clipboard in the patient's door slot. Until constant care is discontinued.	This record will be kept together with the <u>Constant Care Assessment/Intervention Record, Part A and B</u> on the clipboard in the patient's door slot. Old completed record will be filed in patient's health record binder following <u>the nurses' flow sheet</u> section.
The nurse must chart every shift on Part B of this record to indicate that an assessment is made and to provide reason for discontinuing or continuing constant care. *Detail events should be charted in patient's health record e.g. nurses/progress notes or flow sheet as per facility's policy. Indicate in the comment section to refer to Nurses/Progress notes or flow sheet. Brief comment may be written in the comment section.	<p>In <u>Part A</u> of the <u>24-Hour Monitoring Flow Record</u>:</p> <ul style="list-style-type: none"> • The nurse circles or writes required information for care, and informs/instructs Constant Care Personnel to initial when done. • The Constant Care HCA /Personnel ✓ the appropriate box to indicate patient's behaviour that he/she observed. Staff's Initial required. • The Constant Care HCA ✓ the appropriate box to indicate activities/care provided. Initial when done. <p>When patient exhibits verbal or physical aggression, a detail description of the event must be documented in <u>Part B</u> of the <u>24-Hour Monitoring Flow Record</u>. Detail information should include:</p> <ul style="list-style-type: none"> • Time/Place • What patient was doing before the behaviour started • Patient's specific behaviour • Staff's intervention • Outcome of the intervention <p>Documentation in Part B will be completed by the Nurse or the Constant Care HCA as per site policy. If Constant Care HCA is not expected to do detail charting, the Constant Care HCA must provide the details of the events for the Nurse to chart. Staff's initial is required.</p>
At the bottom of Part B of this record, enter information using appropriate key and initial	At the right upper corner of Part B of this record, enter information using appropriate key and initial
When constant care is discontinued, both records will be filed in patient's health record binder following <u>the nurses' flow sheet</u> section.	

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:

COGNITIVE	BEHAVIOURAL	MOTOR
<p>*<input type="checkbox"/> Delirium present if Confusion Assessment Method positive (i.e. 1 and 2 plus 3 OR 4 of following):</p> <ol style="list-style-type: none"> 1. <input type="checkbox"/> Acute mental status changes/fluctuating. <li style="text-align: center;">and 2. <input type="checkbox"/> Evidence of inattention (i.e. difficulty focusing, easily distracted, unable to follow topic). <li style="text-align: center;">plus 3. <input type="checkbox"/> Evidence of disorganized thinking (i.e. rambling, irrelevant conversation). <li style="text-align: center;">or 4. <input type="checkbox"/> Altered LOC –Vigilant (Hyperalert)/Lethargic/Drowsy/Stupor/Coma <hr/> <input type="checkbox"/> Known history of Dementia <input type="checkbox"/> Problem with immediate recall <input type="checkbox"/> Poor safety judgment <input type="checkbox"/> Other: _____	<p>*<input type="checkbox"/> Suicide Risk</p> <p>*ACTION: <input type="checkbox"/> If present, consult psychiatry and initiate C.C. until D/C by psychiatry/physician</p> <input type="checkbox"/> Disrupts essential medical therapy Specify _____	<input type="checkbox"/> Recurrent falls <input type="checkbox"/> Orthostasis <input type="checkbox"/> Unsteady gait <input type="checkbox"/> Poor balance <input type="checkbox"/> Urinary frequency or urgency <input type="checkbox"/> Sensory impairment (sight, hearing, neuropathy) <input type="checkbox"/> Medication related (e.g. polypharmacy, narcotics, sedative, neuroleptics) <input type="checkbox"/> Other: _____
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Very Impulsive <input type="checkbox"/> Disruptive or harmful to others <input type="checkbox"/> Wandering with risk of elopement <input type="checkbox"/> Other: _____	<input type="checkbox"/> 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.

<p style="text-align: center;">Consultations</p> <input type="checkbox"/> Geriatric Psychiatry <input type="checkbox"/> Geriatrics <input type="checkbox"/> CNS <input type="checkbox"/> Pharmacist <input type="checkbox"/> Recreational Therapist <input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> Other (specify): _____	<p>Falls Prevention interventions: (Use own Fall Prevention Program, if none, use the following)</p> <p>■ Ask the following 5 questions every time before leaving the patient alone in bed or in chair.</p> <ol style="list-style-type: none"> 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 <u>and</u> use the call bell. <input type="checkbox"/> Move person closer to the nursing desk if possible <input type="checkbox"/> Bed in low position with brakes on or on blocks <input type="checkbox"/> Obtain/use proper footwear (with non-skid sole) <input type="checkbox"/> Walking aide within reach <input type="checkbox"/> Urinal/commode at bedside <input type="checkbox"/> Toileting routine Q1-2 hr. <input type="checkbox"/> Continuous supervision while toileting <input type="checkbox"/> Assist with exercise and mobility (e.g. walk 2-3x/day on unit) <input type="checkbox"/> Bed Alarm <input type="checkbox"/> Chair Alarm <input type="checkbox"/> Lying and Standing blood pressure x3 days
<p>Treatment Change</p> <input type="checkbox"/> Review Medications <input type="checkbox"/> Remove catheters, drains, tubes, as clinically indicated <input type="checkbox"/> Camouflage tubes/lines - Cover dressing sites	<p>Other:</p> <input type="checkbox"/> Close observation Every 15-30 minutes without C.C. <input type="checkbox"/> Cohort 2 or more patients for Close Observation with 1 C.C. <input type="checkbox"/> Specify: _____
<p>Wandering Behaviour Management</p> <input type="checkbox"/> Take patient's picture as per facility's policy & notify Security <input type="checkbox"/> Remove street clothes <input type="checkbox"/> Apply Wanderguard/Locked Unit	
<p>Psychosocial Interventions</p> <input type="checkbox"/> Clock/calendar within view <input type="checkbox"/> Frequent orientation/explanation. Do Not Argue with patient-use diversion (e.g. reminisce with patient, walk patient, offer ice-cream, snacks, and tea)	
<input type="checkbox"/> 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)	

Initial Assessment Date/Time _____ Nurse's Name (Print) _____ Initials: _____

Evaluation



How are we doing with reducing constant care?



5.1 Quality Monitoring

- Education of staff to guidelines, procedures and forms will be provided.
- New staff will be educated during orientation.
- Audits to be completed by unit/ward.

5.2 Performance Indicators

- Constant care hours are reduced by n %
- Constant care guidelines are adhered to by staff at n %
- Constant care documentation is evident at n% from chart audits
- n % of cases where constant care is used after alternatives have been initiated or attempted
- # of falls/1000 patient days are not increased
- # of physical/chemical restraints are not increased
- # of serious injuries are not increased
- # of patient complaints are not increased

6. Forms

- WRHA Constant Care Guidelines
- WRHA Constant Care Procedures
- Constant Care Decision Tree
- Constant Care Assessment/Intervention Record
- Constant Care 24 Hour Monitoring Flow Record
- Constant Care Audit



WRHA CONSTANT CARE GUIDELINES

1. BACKGROUND

Over the past decade, constant care (also referred to as constant observation, one-to-one and sitters) has been used as a method for monitoring patients at risk for self-harm, falls and disruption of clinical treatment. Currently, there is a lack of literature supporting that constant care improves patient care or prevents injury. The focus of this document is to establish standardized guidelines for the use of constant care in acute care settings.

2. PURPOSE

- To support appropriate use of constant care in acute care settings.
- 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.

Please Note: This guideline excludes personal care home (PCH) settings.

3. DEFINITIONS

Constant Care

All patients receiving constant (continuous) care will have an increased level of observation and supervision by designated staff. This consists of one-to-one monitoring and use of alternate techniques to provide safety and to protect the well being of the individual and others in the patient care environment. To ensure safety, patients receiving constant care must have the appropriate personnel in attendance and providing care at all times.

Close observation i.e. being observed at 15-30 minute intervals is not considered constant care.

4. GUIDELINES

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

- a) Follow a decision making 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 for sexual assault in mental health settings.

- iv. At risk for sexual/physical assault in other settings.
 - 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 hospital staff, other patients or visitors.
- d) An assessment is completed and constant care approved by manager/director, supervisor/shift administrator for an 8-hour period with re-approval required every shift.
 - e) Appropriate consultations are initiated.
 - f) Adherence to WRHA restraint policy is required.

5. **ALTERNATIVE INTERVENTIONS**

Before initiating constant care:

- a) Use of alternative interventions with documented outcomes of strategies tried e.g. close observation, family involvement.

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) Security or other personnel may be used to provide constant observation only in accordance with facility policies and/or collective agreements.
- d) The staff assignment record on each unit will indicate who is assigned to provide constant care.
- e) Relief for staff assigned to constant care will be arranged by the nurse in charge.

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. Close observation of patient is maintained by staff 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 required forms per protocol.
- 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 8 hours and documented on the health record.
- d) Constant care personnel (RN, LPN or HCA) documents on appropriate forms.

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) Quarterly audits to be completed by unit/ward.
- b) Provide education to current staff on guidelines and procedures.
- c) New staff will be educated to guidelines and procedures during orientation.



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 Interventions Record Part A** which includes the following:
 - a) Identify patient's safety risks
 - b) Identify and implement interventions/alternatives
 - c) Evaluate effectiveness of interventions/alternatives and chart outcomes.
4. Nurse informs manager/director/supervisor on days/evenings/nights/weekends about patient's conditions and obtains approval.
5. Unit calls staffing office to request the appropriate constant care personnel and provides the staffing office with required information. Complete Constant Care Tracking Form as directed.
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 on Kardex: "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 monitor/observes on a **CONSTANT one-to-one** 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 one-to-one** basis.
13. Constant care personnel and Nurse document observations and care provided on the **Constant Care 24 Hour Monitoring Flow Record**.

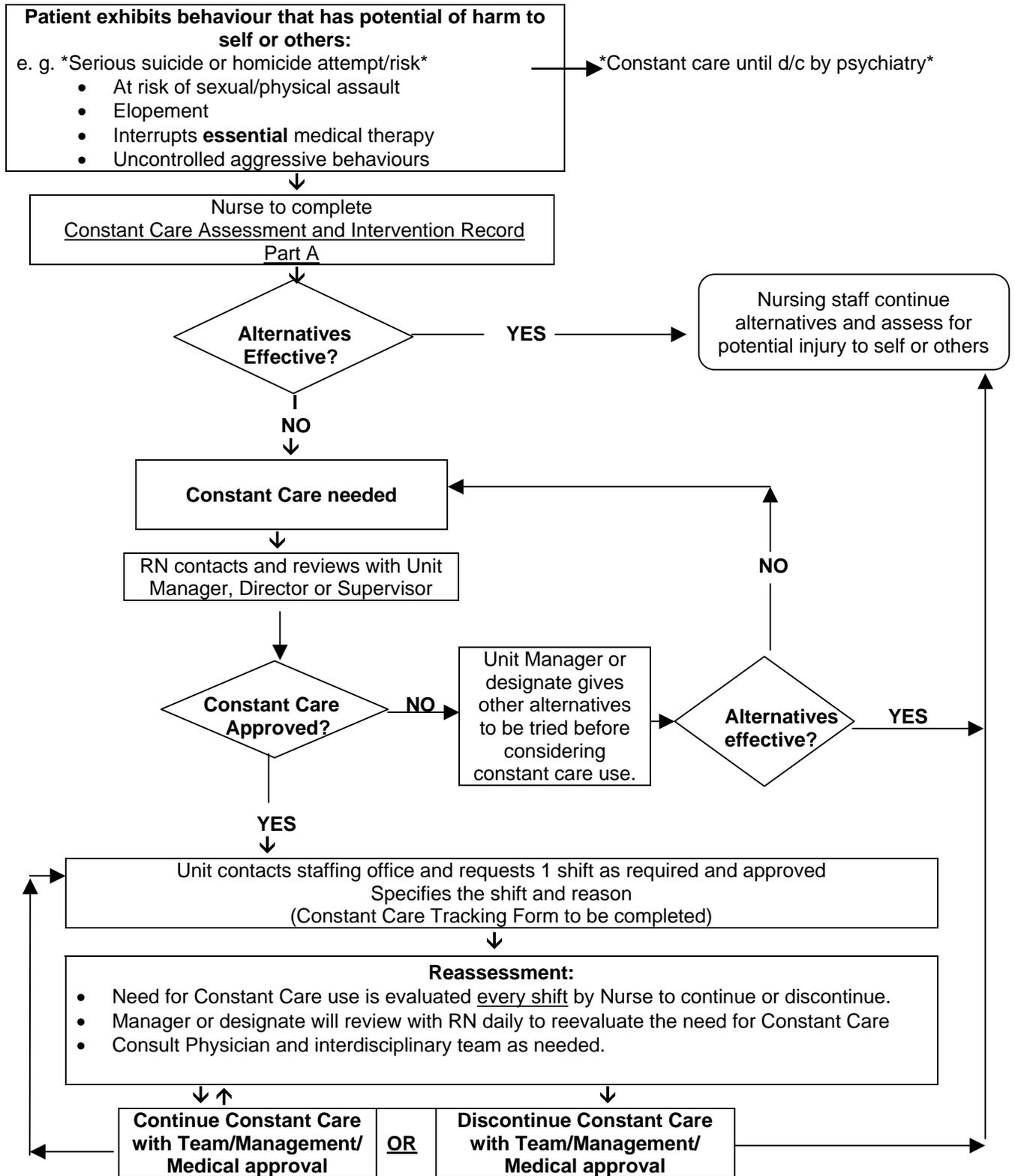
14. Constant care personnel must inform Nurse of any change in patient's behaviour or health status.
15. **All personnel must consider a call light from this patient's room as urgent and must attend to it immediately.**
16. Nurse must delegate a replacement to continue the required monitoring and supervision 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.



Constant Care Decision Tree



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:

COGNITIVE	BEHAVIOURAL	MOTOR
<p>*<input type="checkbox"/> Delirium present if Confusion Assessment Method positive (i.e. 1 and 2 plus 3 OR 4 of following):</p> <p>1. <input type="checkbox"/> Acute mental status changes/fluctuating. <u>and</u></p> <p>2. <input type="checkbox"/> Evidence of inattention (i.e. difficulty focusing, easily distracted, unable to follow topic). <u>plus</u></p> <p>3. <input type="checkbox"/> Evidence of disorganized thinking (i.e. rambling, irrelevant conversation). <u>or</u></p> <p>4. <input type="checkbox"/> Altered LOC –Vigilant (Hyperalert)/Lethargic/Drowsy/Stupor/Coma</p> <hr/> <p><input type="checkbox"/> Known history of Dementia <input type="checkbox"/> Problem with immediate recall <input type="checkbox"/> Poor safety judgment <input type="checkbox"/> Other: _____</p>	<p>*<input type="checkbox"/> Suicide Risk *ACTION: <input type="checkbox"/> If present, consult psychiatry and initiate C.C. until D/C by psychiatry/physician</p> <p><input type="checkbox"/> Disrupts essential medical therapy Specify _____</p> <p><input type="checkbox"/> Very Impulsive</p> <p><input type="checkbox"/> Disruptive or harmful to others</p> <p><input type="checkbox"/> Wandering with risk of elopement</p> <p><input type="checkbox"/> Other: _____</p>	<p><input type="checkbox"/> Recurrent falls <input type="checkbox"/> Orthostasis <input type="checkbox"/> Unsteady gait <input type="checkbox"/> Poor balance <input type="checkbox"/> Urinary frequency or urgency <input type="checkbox"/> Sensory impairment (sight, hearing, neuropathy) <input type="checkbox"/> Medication related (e.g. polypharmacy, narcotics, sedative, neuroleptics)</p> <p><input type="checkbox"/> Other: _____</p>

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.

<p style="text-align: center;">Consultations</p> <p><input type="checkbox"/> Geriatric Psychiatry <input type="checkbox"/> Geriatrics <input type="checkbox"/> CNS <input type="checkbox"/> Pharmacist <input type="checkbox"/> Recreational Therapist <input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> Other (specify): _____</p> <p>Treatment Change</p> <p><input type="checkbox"/> Review Medications <input type="checkbox"/> Remove catheters, drains, tubes, as clinically indicated <input type="checkbox"/> Camouflage tubes/lines - Cover dressing sites</p> <p>Wandering Behaviour Management</p> <p><input type="checkbox"/> Take patient's picture as per facility's policy & notify Security <input type="checkbox"/> Remove street clothes <input type="checkbox"/> Apply Wanderguard/Locked Unit</p> <p>Psychosocial Interventions</p> <p><input type="checkbox"/> Clock/calendar within view <input type="checkbox"/> Frequent orientation/explanation. Do Not Argue with patient-use diversion (e.g. reminisce with patient, walk patient, offer ice-cream, snacks, and tea)</p> <p><input type="checkbox"/> 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)</p>	<p>Falls Prevention interventions: (Use own Fall Prevention Program, if none, use the following)</p> <p>■ Ask the following 5 questions every time before leaving the patient alone in bed or in chair.</p> <ol style="list-style-type: none"> 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 <u>and</u> use the call bell. <p><input type="checkbox"/> Move person closer to the nursing desk if possible <input type="checkbox"/> Bed in low position with brakes on or on blocks <input type="checkbox"/> Obtain/use proper footwear (with non-skid sole) <input type="checkbox"/> Walking aide within reach <input type="checkbox"/> Urinal/commode at bedside <input type="checkbox"/> Toileting routine Q1-2 hr. <input type="checkbox"/> Continuous supervision while toileting <input type="checkbox"/> Assist with exercise and mobility (e.g. walk 2-3x/day on unit) <input type="checkbox"/> Bed Alarm <input type="checkbox"/> Chair Alarm <input type="checkbox"/> Lying and Standing blood pressure x3 days</p> <p>Other:</p> <p><input type="checkbox"/> Close observation Every 15-30 minutes without C.C. <input type="checkbox"/> Cohort 2 or more patients for Close Observation with 1 C.C. <input type="checkbox"/> Specify: _____</p>
---	---

Initial Assessment Date/Time _____ **Nurse's Name (Print)** _____ **Initials:** _____

CONSTANT CARE AUDIT

Name of Auditor (Please print): _____

Date _____

Unit: _____

Patient Initials and Health Record Number		Date constant care started and stopped		Initial assessment completed		Alternative strategies attempted		Constant Care requested		Constant Care approved by Manager/ Designate		Patient Status reviewed q shift by Manager/ Designate		Comments
										Yes	No	Yes	No	
Patient Initials	Health Record Number	Start	Stop	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	

7. References

CONSTANT CARE REFERENCE LIST

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**Achieving Benchmarks through Collaboration
Care Delivery & Staffing Initiative
2.4 Constant Care Project Team
2003-2004
Team Members**



Back L-R: Betty Steeves, Tara Evans, Wendy McDiarmid, Sue-Ann Hobbs, Rose Dziadekwich, Theresa Fox, Sandy Rossnagel
Front: L-R: Dr. Suzanne Thille, Laurie Walus, Poh Lin Lim (Missing: Barb Petrowski)

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