Observation Levels: Provision of Close or Constant Care (Acute Care)

Site Applicability

Richmond Hospital (Exception: 2 West In-patient Psychiatry, Psychiatric Emergency Unit [PEU])

Practice Level

Profession	Basic Skill
RN, RPN	• Most Responsible Nurse (MRN) for patient requiring close or constant care • Provision of Close or Constant Care
LPN	• Provision of Close or Constant Care in a team approach with MRN

Requirements

A Close or Constant Care Provider (CCCP) has direct patient care within their scope of practice and/or job description.

Close or Constant Care may be initiated with a provider's order, or by a nurse based upon evidence of an increased risk of harm to self or others. If initiated by an RN or RPN this needs to be communicated to the provider for further follow up.

The Staff Support Coordinator (SSC)/Patient Care Coordinator (PCC)/Charge Nurse (CN) works collaboratively with the Most Responsible Nurse (MRN) and other healthcare team members to determine the appropriate level of care and observation required to ensure the safety of all patients, staff and visitors.

Close or Constant Care may be discontinued by nursing once the presenting behaviours have resolved or have been successfully addressed through nursing, medical or other interventions. This will be completed in consultation with the most responsible provider (MRP).

This guideline does not apply to law enforcement custody or protection personnel (e.g. Police, corrections, Canadian Border Protection Agency). Close or constant care by a health care team member may still be required.

Need to Know

Determining Level of Observation

The level of observation for the patient is decided in collaboration with the PCC/CN, MRN, and provider, after considering the impact of presenting behaviours and/or contributing risk factors for unsafe/challenging behaviours that demonstrate evidence of increased risk of harm to self or others.

Close Care: Frequent Observation

Close Care is defined as ***observation of the patient at least every 15 minutes*** or more frequently as determined by the team's assessment of the patient's overall health status, general behaviour, and/or risk for intentional or unintentional harm to self or others.

- Close care may be required for behavioural or physical reasons.
- Close care may be required for multiple patients. Patients with challenging behaviours may be grouped in close proximity (cohorted) for frequent observation by one CCCP.

Constant Care: Continuous Observation

Constant Care is defined as care that is provided ***within safe proximity of the patient and the ability to fully visualize the patient at all times (e.g. make eye contact when patient awake).*** Patients who require constant care may be at extreme risk for intentionally or unintentionally harming themselves or others.

- Constant care may be required for behavioural or physical reasons
- One care provider is assigned to one patient
- Note: Mental Health Certification does not automatically require close or constant care

A patient requiring close or constant care should never be allowed to be behind a locked door (e.g. bathroom)

Determining Care Provider

In collaboration, the PCC/CN and the MRN will use clinical judgment and assessment of patient's immediate care needs to determine the required skill set and discipline of the CCCP to manage patient care safely.

Close or Constant Care Provider

Staff assigned to the role of CCCP should have the required skills necessary to provide observation to patients and have direct patient care within their scope of practice and/or job description.

Appropriate staff for the CCCP role may include, but not limited to: Patient Care Aide (PCA), Licensed Practical Nurse (LPN), Registered Nurse (RN) or Registered Psychiatric Nurse (RPN).

Guideline

- See Appendix A for Close or Constant Care Clinical Decision-Making Process diagram.
- See Appendix B for additional clinical considerations for Close or Constant Care.
- See Appendix C for additional considerations for appropriate use of a Security Sitter/Patient Watch Officer.
- See Appendix D for process of determining level of observation and assigning appropriate patient observation.

Assessment

Prior to deciding on a close or constant care, the following should be assessed and considered (See Appendix A):

1. Assess impact of presenting behaviours:

Threat to Self	Threat to Others
• Removal or manipulation of invasive devices that may interrupt medical therapy or result in physical harm (e.g. pulling out IVs, pulling on drains or chest tubes, etc.) • Repeatedly climbing out of bed when unsafe to do so • Wandering • Recurrent falls • Any intentional or unintentional behaviour that is likely to result in self-harm • Threats of suicide or recent suicide attempt	• Ongoing aggression and/or agitation (striking out, spitting, kicking etc.) • Inappropriate verbal or physical behaviour directed toward others.

Note: *Adapted with permission from Providence Health Care (PHC) Nursing Documentation*

2. Consider contributing risk factors for unsafe/challenging behaviours:

Threat to Self	Threat to Others	Medication
• Age 75 or more • Alcohol/drug withdrawal • Cognitive impairment • Functional Impairment • History of Depression • Relocation • Restraints • Sleep disturbance	• Advanced illness • Electrolyte imbalance • Fever • History of stroke • Hypotension • Hypoxia • Infection • Multiple co-morbidities • Surgery/anesthesia • Unrelieved pain • Need to void • Past episode of delirium • Vision/hearing loss	• Antipsychotics • Benzodiazepines • Cardiac Drugs • Narcotic Analgesics • Poly pharmacy (5 or more meds) • Use of over the counter drugs • Drugs or substance misuse

Note: *Adapted with permission from Providence Health Care (PHC) Nursing Documentation*

3. Consider risk factors for delirium, as per the Delirium: Screening, Assessment and Management DST.
4. Consider un-modifiable factors: e.g. age, permanent cognitive/functional impairment, medical history etc.
5. Consider impact of changing medical condition on behaviour: e.g. hypoxia, hypotension, infection, fever, pain, electrolyte imbalance, alcohol/drug withdrawal etc.
6. Consider influence of environment on behavior: e.g. over stimulated, isolated, increase risk of safety hazards, presence or absence of family/visitors
7. Seek input from patient/family as appropriate.

Interventions

Prioritize assessment findings:

- Ensure the safety of patient/others
- Implement applicable patient safety procedures protocols
- Notify physician(s) for new onset behaviour(s) and/or escalating behaviour(s)

Implementation of Close or Constant Care

- Refer to RH SOP: Observation Levels: Close or Constant Care Provision (Acute)
- Develop a behavioural care plan to include the close or constant care.

Additional Considerations

- The MRN is responsible for the overall care of the patient. All relevant assessments and interventions to address increased care needs must continue to be performed and documented in the clinical health record.
- The Close or Constant Care Provider (CCCP) is responsible for documentation on the Close or Constant Care Observation Flow Record.
- The MRN/PCC will review the expectations of close or constant care with the assigned CCCP.
    - **At no time shall the assigned care provider leave the patient unattended or engage in activities that may distract them from observing the patient (e.g. read, use personal mobile devices.)**
- The MRN will provide a more detailed report to the CCCP outlining the plan of care with respect to managing the patient's behaviour and the need for a CCCP.
- The MRN and the CCCP will discuss the expectations for providing personal care to the patient and for reporting changes in the patient's behaviour/condition to the MRN or delegate.
- The MRN will also identify any dressings, tubes, IV's, drains or other equipment that may become dislodged or cause harm if disrupted by the patient's behaviour.
- The CCCP will document their initial assessment findings and any corresponding interventions on the Close or Constant Care Observation Flow Record and all other relevant patient care record forms at the beginning of each shift.
- The Close or Constant Care Observation Flow Record is used to document ongoing assessment findings and interventions.
- Restraints, seclusion room, vital signs, elimination, intake etc. will be documented on the appropriate patient care record.
- At change of shift/assignment, the CCCP will provide a verbal summary report to the next CCCP outlining the general behaviour, problems, and successful interventions for their patient(s).
- A Security Sitter, also known as a Patient Watch Officer (PWO), **cannot** provide any direct patient care. A Security Sitter/PWO should **only** be considered if additional contracted security resources are needed to support clinical staff in managing challenging patient behaviors posing extreme risk to the patient or others that cannot be effectively addressed by the nursing team or through the use of clinical patient observation (i.e. CCCP). This may include behaviours such as elopement, agitation, or aggression. See Appendix C for additional considerations.

Documentation

- Close or Constant Care Assessment Tool (VCH.RD.RH.0441)
- Close or Constant Care Observation Flow Record (VCH.RD.RH.0442)
- Close Observation Record: (Form 51786 RH ED only)

Related Documents

- Delirium: Screening, Assessment and Management DST
- Observation Levels for Patients in Acute Mental Health (Richmond – 2014)
- Elsevier/Clinical Skills:
  - Restraint-Free Environment
  - Restraint Application and Monitoring

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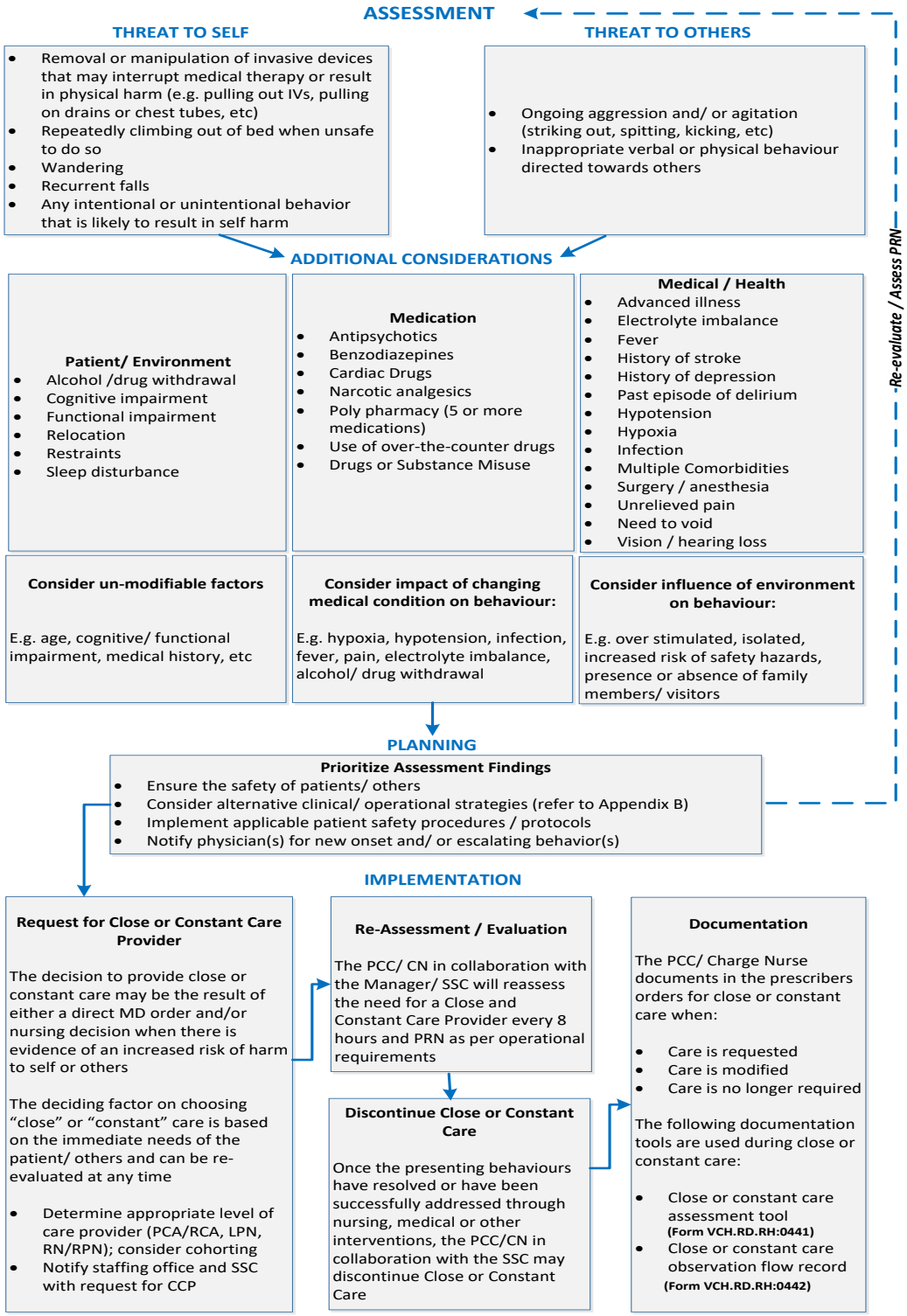
Appendix A: Close or Constant Care – Decision Making Process



Note: *Adapted with permission from Providence Health Care (PHC) Nursing Documentation*

Appendix B: Clinical/Operational Strategies to consider when determining the need for Close or Constant Care

1. Can other strategies to ensure patient and staff safety be implemented before using a CCCP?
    a. Provide comfort measures to the patient
    b. Increase frequency of rounding to address basic needs
        i. Toileting
        ii. Thirst/hunger
    c. Keep the patient busy or diversion techniques
    d. Implement fall prevention strategies such as moving mattress to the floor
    e. Use of bed or chair alarms
    f. Appropriate use of ordered PRN medications
    g. Encourage/facilitate family presence
    h. Use of a translator to facilitating communication/understanding of patient's needs
    i. Cohorting of patients
    j. Move the patient to a location on the unit where regular visualization can occur more easily
    k. Ensure attempts to meet baseline staffing have been fulfilled
    l. Adjust nursing assignments
    m. Moving patient to other unit with more nursing resources
    n. Move patients who are an elopement risk to a locked unit

2. Is patient acuity affecting workload on unit?
    a. Does this patient require a Nursing Assessment Response (NAR) call?
    b. Has the physician been contacted to review the patient's care?
    c. Should the patient be moved to a higher acuity unit?

Appendix C: Considerations for Appropriate use of a Security Sitter/Patient Watch Officer (PWO)

- The role of the Security Sitter/PWO is limited to supporting staff in managing behaviours that pose a risk to staff and patients. The Security Sitter defers to clinical staff in all matters relating to the care of the patient they are assigned.
    - **Security Sitters/PWOs DO NOT participate or provide any direct patient care.**

- Security Sitters may be employed where a patient has been determined to be high risk for elopement or extremely agitated and aggressive and cannot be managed through established clinical processes or existing site resources.

- Security Sitters are NOT used for patients where physical, environmental, or chemical restraint interventions are being implemented (e.g. four point restraints or seclusion) as these are clinical interventions and require clinical observation. Security resources should be utilized to ensure staff can conduct these clinical interventions safely.

- Security sitters are not to be used as replacements for PCAs, close or constant care provision or to supplement these functions.

- Security sitters cannot provide any clinical documentation such as Behaviour Pattern Records, Behaviour Identification tools, supply reports at the end of the shift or perform any duties that are clinical in nature.

- Approval for a security sitter / PWO must be obtained from the SSC / Manager / Administrator On-Call (AOC).

- PCC / CN is responsible for the coordination and discontinuation of sitter services with Paladin Security.

Contact number for Richmond Hospital Site

Paladin Security (non-urgent) to obtain Patient Watch Officer Services:

Local 4777

Appendix D: Determining Level of Observation & Appropriate Patient Observation