Close or Constant Care: Providing

Site Applicability

PHC Acute Care Settings

Practice Level

Basic: PCA, LPN, RN/RPN **

**Although the Close or Constant Care Provider (CCCP) is not limited to the PCA, this protocol is written specifically to provide guidance to the PCA who is a CCCP. Any CCCP are expected to include these expectations in addition to practicing within their own scope of practice.

Need to Know

1. The level of close or constant care provider (CCCP) will be documented in Cerner in Orders section if ordered by provider. The Clinical Nurse Leader (CNL) or Charge Nurse (CN) in consultation with the Most Responsible Nurse (MRN) can determine the level of care based on the needs of the patient.
2. The CCCP reports to the CNL or CN to receive their assignment.
3. Report is received at the bedside from the CCCP going off shift.
4. CCCP must connect with MRN after they finished receiving their own report.
5. The CCCP break schedule is determined at shift start by the MRN and/or CNL.

CLOSE CARE: is defined as ***observation of the patient at least every 15 minutes*** and as determined by provider's order, 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.
- Patients with challenging behaviours may be grouped in close proximity for frequent observation by one CCCP.

CONSTANT CARE: is defined as care that is ***within arm's reach or safe proximity of the patient and having eye contact with the patient at all times***. Patients who require constant care may be at extreme risk for intentionally or unintentionally harming self and/or others. Patient conditions/behaviours that require constant care may include (but are not limited to) pulling out tubes, IV's, dressings, withdrawing from alcohol or substance intoxication, e.g. benzodiazepine withdrawal, delirium, multiple falls.

- Constant care may be required for behavioural or physical reasons.
- One care provider is assigned to one patient.
- However, there might be times when 2 constant care patients roomed together for short amount of time, so it will be 2:1 ratio until another constant care provider can be found.

Protocol

Assessment

CCCP Assessments:

1. The primary and secondary assessment occurs at the beginning of each shift and is the baseline for determining changes in the patient's condition for your shift.
2. The **primary assessment** is completed each time you resume care upon returning from your break. This ensures your accountability when care is transferred from one care provider to another.
3. In addition, you are expected to provide a continuous and ongoing assessment Q15mins documented in Behaviour Log, while you are assigned as a CCCP and should report any changes to the MRN as soon as possible or immediately if a change concerns you.

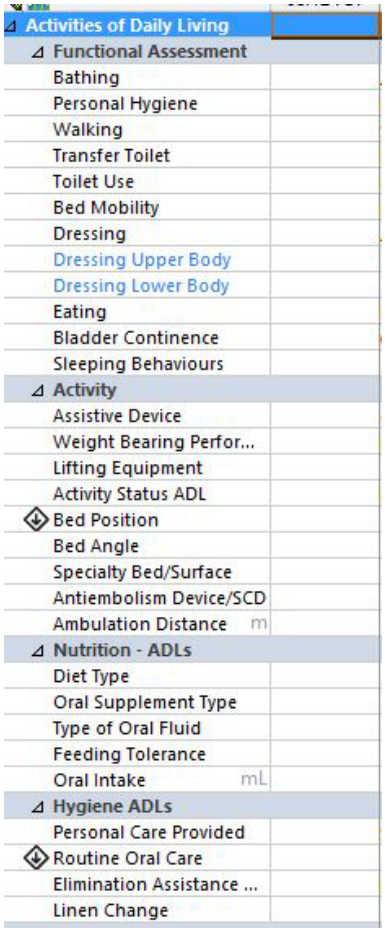
A. Primary Initial Assessment

Identify any life threatening problems. Call for immediate assistance if you find life-threatening problems or are unsure. **Your assessment should include**:

1. Quick visual assessment (airway, breathing, level of consciousness). Does the patient appear to be in distress (e.g. choking sounds, short of breath, pale in colour)?

2. Complete bedside safety check. Chart in Cerner in Interactive View and I&O -> Environmental Safety Management
    a. Bed in low position.
    b. Side rail as designated by least restraint protocol.
    c. Call bell in reach.
    d. Safety restraints/protective equipment applied as per hospital protocol.
    e. Falls precautions in place as per hospital protocol.

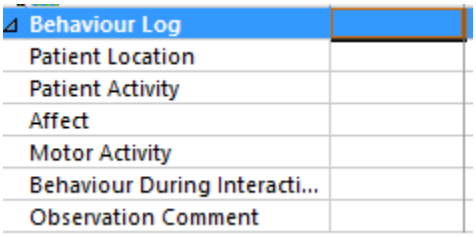
3. Is the patient safely positioned? Document your findings in Interactive View and I&O -> Activities of Daily Living



B. Secondary Assessment

Observe and describe patient responses/behaviour to your care, environment (e.g. response to light, noise, and movement) and others (e.g. visitors, volunteers) every 15 minutes.

1. When introducing yourself to the patient (and/or family), include your first name, designation, and role (why are you there?).
2. Note specific observations related to the patient's behaviour (verbal, physical, emotional) and document in Interactive View and I&O -> Behaviour log for all patients requiring close or constant care including Eating Disorder and Certified patients under the Mental Health Act.



3. Report assessment findings to MRN at the first available opportunity or immediately if you have any concerns.

4. Guide for Constant Care for Patients with Eating Disorders can be found in Appendix A.

Patient Safety:

- Unless you are concerned with your own immediate safety, **the assigned CCCP will at no time leave the patient(s) unattended.**
- For immediate (urgent) assistance use the "Nurse Call" button where available.

  If the 'nurse call' system is not available:
  - Use the patient call bell - Step into the hallway - Call for Help - Return to the patient immediately.
  - For non-urgent assistance or if relief is required, use the patients call bell to summon assistance.
- If **Personal Protection Alarm** is available on the unit, then the CCCP is required to wear it at all times; unit staff will instruct you on its use. Use the personal protection alarm in the event you need the immediate assistance of staff.

Ongoing Care and Management

Report:

- The CCCP should provide a verbal summary report to the next CCCP outlining the general behaviour, problems, and successful interventions for their patient(s).
- 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.
- Ask MRN about 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 actively seek the above information from the MRN/CNL if it is not provided in a timely manner.

Interventions

- Organize, provide, and evaluate care for patients receiving Close or Constant Care as detailed per your role and responsibilities.
- Identify priorities for care as outlined on the patient care plan (or in discussion with the MRN).
- Base choices and actions on a clear understanding of the patient's condition and factors contributing to the challenging behaviours: (e.g. mental health challenges, addiction, withdrawal, dementia, pain).
- Orientate the patient to person, place and time
- Consider, and modify where possible, environmental factors that affect behaviour (lighting, noise level, use of clocks and calendars, disruptive patients etc.)

- Provide diversionary activities (music, reading, conversation, TV, writing, ambulating as tolerated, consult with family when possible).

Communication

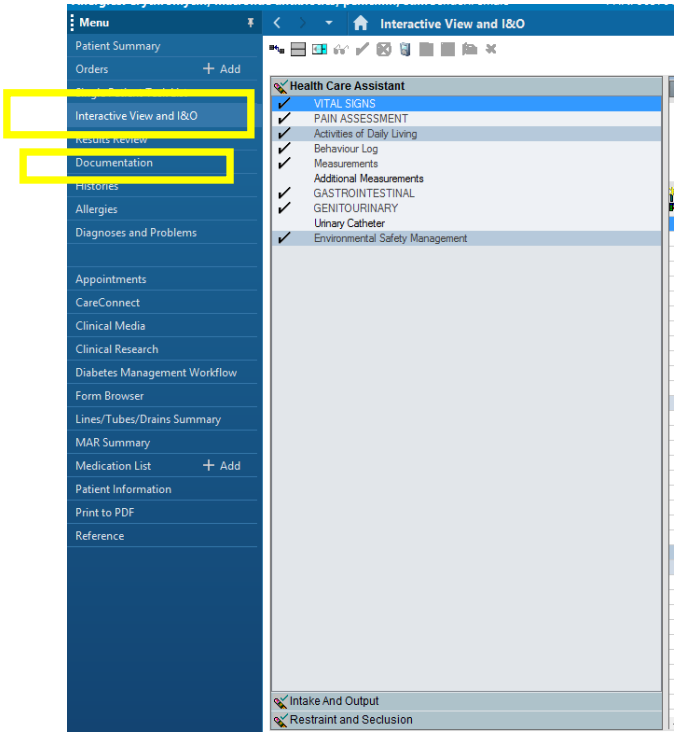
- Use language and a communication style that is appropriate to the patient/family.
- Recognize non-verbal communication.
- Use respectful communication with all members of the healthcare team.
- Communicate changes in the patient's condition to the appropriate healthcare team member.
- Base interactions on a clear understanding of the various roles and responsibilities of the healthcare team.

Professionalism

- Maintain appropriate interpersonal and professional boundaries.
- Interact in a manner that respects the rights, needs, interests and preferences of others.
- Observe common courtesies such as addressing the patient/family by name of choice.
- Use appropriate self-disclosure.
- Use humor appropriately.
- Recognize abusive communication and report to the MRN, CNL or your Manager.

Documentation

- The CCCP will document their initial assessment findings and any corresponding interventions at the beginning of each shift in Documentation section and appropriate section in Interactive View and I&O.
- Constant care staff must document patient status Q15 minutes in Behaviour Log. Use a Narrative note to document any significant changes, e.g. harmful behaviour that led to code white being called.



- The CCCP will document ongoing assessment findings, interventions, and outcome of interventions Q15mins and PRN unless instructed otherwise by MRN or CNL.
- The Behaviour Log is used in acute care to document q15mins assessment findings, interventions and outcomes for patients requiring CCCP which includes patients with Eating Disorders, Mental Health patients and patients certified under the Mental Health Act. Guide for Constant Care for Patients with Eating Disorders can be found in Appendix A.
- Documentation of restraints, vital signs, elimination, intake etc. to be entered on the appropriate section of Interactive View and I&O.
- Use clear, factual, non-judgmental language when documenting or reporting information.

Patient and Family Education

- Collaborate with the MRN for assistance when informing family regarding the need for close or constant care.
- Reinforce the need to prevent harm to the patient.
- Ensure the use of simple, clear language when providing explanations to patient/family.
- Avoid use of terms that may be misinterpreted (e.g. non-compliant, violent, crazy, wild)

Related Documents

B-00-13-10081 - Close or Constant Care: Decision Making Process

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Appendices

Appendix A - Guide for Constant Care for Patients with Eating Disorders

Appendix A: Guide for Constant Care for Patients with Eating Disorders

REASONS FOR CONSTANT OBSERVATION OF A PATIENT WITH AN EATING DISORDER		
• To ensure patient's Treatment Plan is being followed. • To monitor and record all eating disordered behaviours in Behaviour Log in Cerner. • To monitor the patient's lever of anxiety and report changes in status to the nurse/medical team. • To help keep the patient sage while they are in the hospital.		
GUIDE FOR CONSTANT CARE STAFF WHEN MONITORING PATIENTS WITH EATING DISORDERS		
1.	**Remain at arm's reach of the patient AT ALL TIMES** to ensure the patient's safety. Refrain from assisting other patients.	
2.	**Monitor tube feed**. Patient's head and hands should be visible, never covered under blankets etc. Monitor and discourage patient from disconnecting the tube feed. Ensure patient does not try to dilute the tube feed with water. Check that pump is running at the correct rate.	
3.	**Monitor meals** - OBSERVE AND RECORD how much the patient is eating and drinking. What percentage of the tray was completed? What items were eaten or avoided	*RATIONALE: to provide essential nutritional data to the dietitian/medical team.* ***Watch patient carefully while eating.***
4.	The patient should use a COMMODE AT THE BEDSIDE unless otherwise ordered by the physician.	
5.	If the patient is allowed to use the bathroom, keep the bathroom DOOR OPEN so that the patient, NG tube, and feeding pump are visible.	*RATIONALE: the patient may try to vomit, pour out solution or dilute it with water.*
6.	Redirect the patient from using the bathroom for one-hour after meals.	*RATIONALE: the risk of purging and other eating disorder behaviors is highest immediately after eating a meal*
7.	Help limit the patient's activity (if on bedrest, patient should NOT be getting up or moving around too much.). Legs must be on the bed rather than dangling	
8.	Do not weigh patient or allow patient to weigh self. This is only be done by the dietician/medical team.	
9.	Monitor patient's reading choices (magazines, books, electronic media etc.) to ensure it does not feature fashion, food, dieting, exercise or body shape ideas because these might make the patient's unhealthy thoughts worse.	
10.	If the patient is given an off-ward pass, or has to leave the room for a test etc., they must go IN A WHEELCHAIR and the Constant Care staff must go with them.	

11.	**Visitors should not bring the patient any outside items such as:** food, drinks, medicines, herbal remedies, gum, ice chips, coffee, etc. Random room checks will be done if needed.	*RATIONALE: outside foods will interfere with re-feeding. Medicines and herbal remedies may contain substances which conflict with treatment (e.g. metabolism boosters, laxatives*)
12.	Constant Care staff must remain with patient when visitors are present. It is staff's responsibility to keep the patient safe. Not the visitors'.	

DOs and DON'Ts	When to alert RN
• **Do** redirect questions about the care plan to the RN • **Do** encourage leisure activities at the bedside such as board games, reading, coloring, watching TV (provided it does not interfere with bed rest) • **Do** provide bedside care, in consultation with RN • **Don't** get into any discussions about food or body weight and shape. • **Don't** read fashion, food or health magazines in front of the patient • **Don't** eat or drink in front of the patient	• When the patient is becoming restless or anxious • When the patient is purging and you can't stop it • When patient is trying to remove or disconnect the feeding tube or IV and you can't stop them • When the patient is exercising or not staying in bed and does not respond to your direction. • When there are signs that the feeding solution is being watered down or it is almost empty • If the patient has chest pain, is short of breath or faints / falls

When to alert the NURSE
• When the patient is becoming restless or anxious. • When the patient is purging (vomiting) despite redirection. • When patient is trying to remove or disconnect the feeding tube or IV despite redirection. • When the patient is exercising or not staying in bed despite redirection. • When there are signs that the feeding solution is being watered down or it is almost empty. • If the patient has chest pain is short of breath or faints/falls. • When patient requesting outside items to be brought in. • When you require relief.

Persons/Groups Consulted:
Mental Health
Addictions Medicine Consult Team

Developed By:
Practice Consultant, PHC
Clinical Nurse Specialist, Medicine
Clinical Nurse Specialist, Elder Care, SPH

Revised By:
Patient Care Manager, Mental Health Program, SPH
Clinical Nurse Specialist, Medicine
Nurse Educator, Access Services, SPH/MSJ

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