Close or Constant Care: Decision Making Process

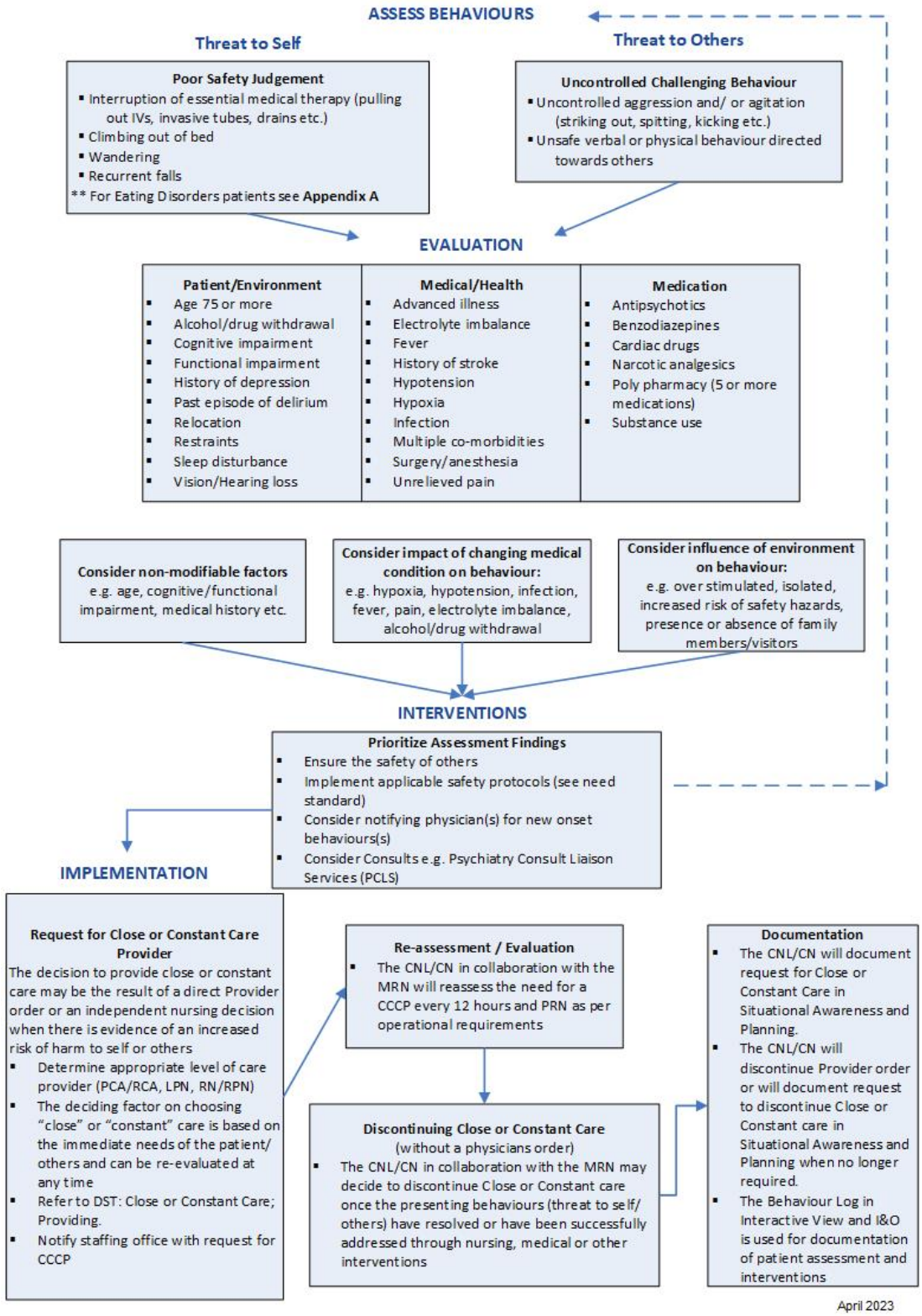
Site Applicability

PHC Acute Care

Practice Level

Basic: RN, RPN, LPN or PCA as per this Decision Support Tool

Algorithm (next page)



Need to Know:

The terms "Close Care" and "Constant Care" replace the term 1:1 Care.

1. The decision to provide close or constant care may be the result of a direct Provider order or an independent nursing decision when there is evidence of an increased risk of harm to self or others.
2. The Clinical Nurse Leader (CNL)/Charge Nurse (CN) works collaboratively with the Most Responsible Nurse (MRN) and other healthcare team members to determine the appropriate level of care required to ensure the safety of all patients, staff, and visitors.
3. Follow the principles of culturally safe care and trauma-informed care.
4. Definitions:

   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 mental 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.

   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 or others. Patient conditions/behaviours that require constant care may include (but are not limited to) pulling out tubes, IV's, dressings, delirium caused by 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. 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

The patient may require immediate supervision until additional patient safety standards, guidelines/protocols have been implemented, after which the Close or Constant Care Provider (CCCP) may be discontinued should the condition/behaviour be resolved.

Ensure the safety of patient and others until the patient is appropriately supervised.

Assessment

1. **Assess impact of presenting behaviours**:

Threat to Self	Threat to Others
Poor safety judgment: • Interruption of essential medical therapy (pulling out IVs, invasive tubes and drains etc.) • Climbing out of bed • Wandering • Recurrent falls • Suicidal Ideation • Risk of self harm	*Uncontrolled Challenging behaviour*: • Uncontrolled aggression and/or agitation (striking out, spitting, kicking etc.) • Unsafe verbal or physical behaviour directed toward others

2. **Consider causes of unsafe/challenging behaviours**:

Patient/Environment	Medical/Health	Medication
▪ Age 75 or more ▪ Alcohol/drug withdrawal ▪ Cognitive impairment ▪ Functional Impairment ▪ History of Depression ▪ Past episode of delirium ▪ Relocation ▪ Restraints ▪ Sleep disturbance ▪ Vision/hearing loss	▪ Advanced illness ▪ Electrolyte imbalance ▪ Fever ▪ History of stroke ▪ Hypotension ▪ Hypoxia ▪ Infection ▪ Multiple co-morbidities ▪ Surgery/anesthesia ▪ Unrelieved pain	▪ Antipsychotics ▪ Benzodiazepines ▪ Cardiac Drugs ▪ Narcotic Analgesics ▪ Poly pharmacy (5 or more meds) ▪ Substance use

Adapted from B-00-13-10065 -Delirium Assessment and Care

3. Consider non-modifiable factors e.g. age, cognitive/functional impairment, medical history etc.
4. Consider impact of changing medical condition on behaviour e.g. hypoxia, hypotension, infection, fever, pain, electrolyte imbalance, alcohol/drug withdrawal etc.

5. Consider influence of environment on behaviour e.g. over stimulated, isolated, increase risk of safety hazards, presence or absence of family/visitors
6. Seek input from patient/family as appropriate.
7. Consider reaching out to Community Partners or Community Care Providers/Support Workers.

Interventions

Prioritize assessment findings:

- Ensure the safety of patient/others
- Implement applicable patient safety procedures protocols (see: Need to Know section)
- Consider notifying Provider(s) for new onset behaviour(s) or escalating behaviour(s)
- Consider consulting 'Nurse to Nurse' consultation teams (i.e. Palliative Care Outreach Consult Team, AMCT Liaison Team, Psychiatry Consult Liaison Service (PCLS), etc.)
- Notify family as appropriate

Implementation of Close or Constant Care

1. **Request Close or Constant Care Provider (CCCP)**:
    a. Determine appropriate level of care provider (PCA, LPN, RN/RPN).
    b. The deciding factor on choosing "close" or "constant" is based on the immediate needs of the patient/others and can be re-evaluated at any time.
    c. Refer to Appendix A: Constant Care of patients with Eating Disorders
    d. Refer to Close or Constant Care: Providing
    e. Notify staffing office with request for CCCP
    f. When care providers are not available and until a care provider is arranged a security guard may be requested.
    g. To request Additional Security Services, please see call non Urgent Security dispatch ext: 4777 and request extra security personnel on X unit for X amount of time. Security dispatch will contact their supervisor, who will contact the unit directly to get details to complete the requisition form for ordering extra guard.

2. **Re-assessment**:
    a. The CNL/CN in collaboration with the MRN will reassess the need for a CCCP every 12 hours and PRN as per operational requirements.

b. Refer to Appendix A: Constant Care of patients with Eating Disorders

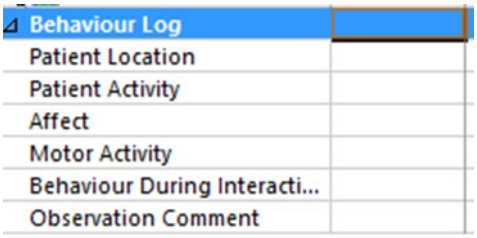
3. Discontinuing Close or Constant Care (without a provider order)

a. The CNL/CN in collaboration with the MRN may decide to discontinue close or constant care once the presenting behaviours (threat to self/threat to others) have resolved or have been successfully addressed through nursing, medical, or other interventions.

b. Refer to Appendix A: Constant Care of patients with Eating Disorders – the decision to discontinue Close or Constant Care is made in consultation with the consult liaison psychiatrist/EDP consult team.

Documentation:

1. The CNL/CN will document request for Close or Constant Care in Situational Awareness & Planning.
2. The CNL/CN will document request to discontinue Close or Constant Care in the Situational Awareness & Planning when the need for close and constant care is modified or no longer required.
3. 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.



4. Constant care staff must document patient status Q15 minutes in Behaviour Log. Narrative note to be used to document any significant changes (e.g.) harmful behaviour that led to code white being called.
5. For close care staff must document patient status Q15 minutes in Behaviour Log unless otherwise stated by provider orders i.e. Q30mins checks. Narrative note to be used to document any significant changes e.g. harmful behaviour that led to code white being called.
6. Behaviour Log is used in Eating Disorder Program to document assessment findings, interventions and outcomes for patients with an Eating Disorder.
7. Behaviour Log is also used in Mental Health and other areas for patients certified under the Mental Health Act to document observation at least every 15 minutes for patients requiring close/constant observation.

Related Documents

The decision to implement the Close or Constant Care Protocol is made with full consideration of other relevant patient safety resources guidelines and policies:

1. B-00-13-10013 - Alcohol Withdrawal: Screening and Management using the Clinical Institute Withdrawal Assessment for Alcohol, revised (CIWA-ar)
2. B-00-13-10059 – Least Restraint: Care of the Patient at Risk for or Requiring Restraint (Acute and Sub Acute Care)
3. B-00-13-10065 - Delirium Assessment and Care
4. B-00-10-10001 – Delirium Risk Care Plan – Acute & Sub-Acute Care
5. B-00-07-10011 - Falls Injury Prevention
6. B-00-11-10110 - Corporate Policy: Consent
7. Violence Prevention – PHC Occupational Health and Safety

Resources:

- Learning Hub Course 23901 "Introduction to Eating Disorders for Service Providers" https://learninghub.phsa.ca/Courses/23901/introduction-to-eating-disorders-for-service-providers
- This course on LearningHub is designed as an orientation to health care providers new to the field of eating disorders, including allied health and primary care providers.
- It aligns with the Clinical Practice Guidelines for the BC Eating Disorders Continuum of Services.

References:

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Appendices

Appendix A: Constant Care for Patients with Eating Disorders

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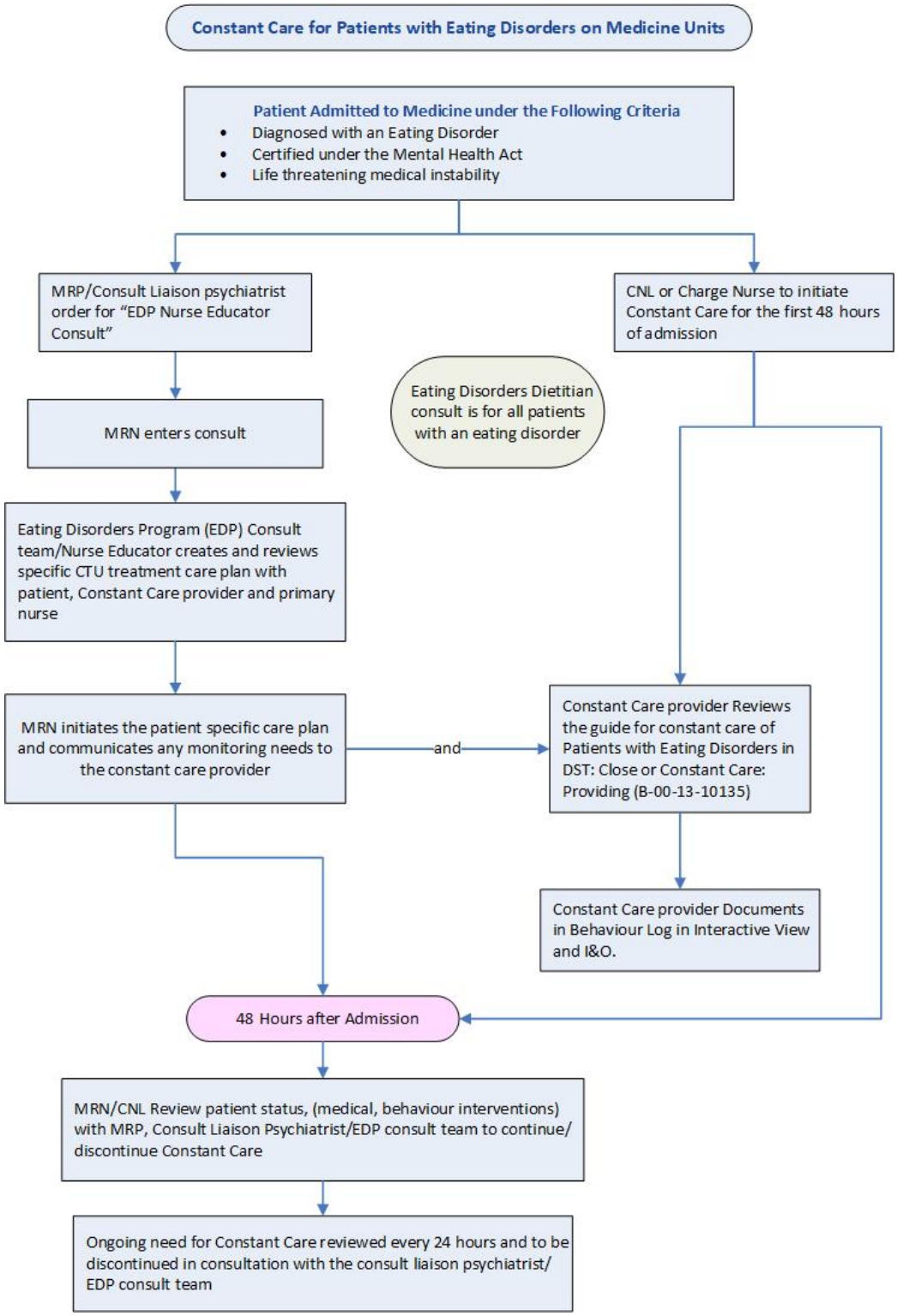

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