Supporting the journey of a patient on constant care: A collaborative approach

Nursing Rounds, November 22, 2018
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Shirley Bell, Clinical Nurse Educator
Objectives

1. To review the background and objectives of the St. Michael’s Hospital Constant Care Program

2. To describe the journey of a patient on constant care

3. To demonstrate the application of the constant care guidelines, decision-making algorithm and documentation tools

4. To share clinician’s perspective toward providing person-centred care for patients with responsive behaviours on constant care
Hospitalization can be stressful for patients, resulting in responsive and other behaviours. 

Responsive behaviours - exhibited by people with altered cognitive state in response to internal or external factors (Allcroft & Loiselle, 2005)

Hospital staff may respond by assigning constant care.

Constant care - continuous observation to selected patients under the supervision of a registered nurse (Shever et al, 2011)
The Challenges with Constant Care

- Lack of constant care guidelines
- Inconsistent practice
- No decision-making criteria

Increased COST

St. Michael's
Inspired Care. Inspiring Science.
Finding a Common Ground

Toronto Academic Health Science Network

2012: SFH CoP
2014: MRB as focus
2015: 2 work streams: Constant Care + Language Taxonomy
2016: TAHSN CC guidelines
## Understanding the SMH Landscape

| **ProCon Study** | • “Preventing & managing behaviours is challenging because of lack of training”  
• “Decision-making is challenging due to absence of constant care guidelines and decision-making tools” |
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td><strong>iPMO Review</strong></td>
<td>• Ensure standard organizational approach to constant care informed by TAHSN guideline and leading practice.</td>
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</table>
| **Constant Care Working Group** | • Lack an organizational approach in initiating, continuing, weaning and discontinuing constant care  
• High constant care cost  
• Impact on patient flow and transition across the health care system |
## MRB and Constant Care Programs at SMH

<table>
<thead>
<tr>
<th>Implementation Time</th>
<th>Managing Responsive Behaviours</th>
<th>Constant Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Implementation Time</strong></td>
<td>2015 - 2016</td>
<td>2017-2018</td>
</tr>
<tr>
<td><strong>Scope of Implementation</strong></td>
<td>14CC, 9CC, 7CCN</td>
<td>All inpatient units</td>
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<tr>
<td><strong>Elements</strong></td>
<td><strong>Curriculum</strong></td>
<td>4-hour workshop</td>
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<tr>
<td><strong>Tools and Processes</strong></td>
<td>• MRB Care Plan</td>
<td>• Decision-Making algorithm</td>
</tr>
<tr>
<td></td>
<td>• Person-Centred Language</td>
<td>• Documentation tools</td>
</tr>
<tr>
<td></td>
<td>• My Story (personhood info)</td>
<td>• Person centred strategies</td>
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</table>
## Objectives

<table>
<thead>
<tr>
<th>Objective</th>
<th>Tool</th>
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<tbody>
<tr>
<td>Promote understanding of personhood</td>
<td><strong>My Story</strong></td>
</tr>
<tr>
<td>Identify patients at risk for RB</td>
<td><strong>Care Plan</strong></td>
</tr>
<tr>
<td>Describe behaviours using language taxonomy</td>
<td><strong>Care Plan</strong></td>
</tr>
<tr>
<td>Select management strategies</td>
<td><strong>Care Plan</strong>, <strong>My Story</strong></td>
</tr>
</tbody>
</table>
Purpose: quick reference for suggested sequence of actions on:

- Assessing patient risk for harm to self or others
- Constant care
  - initiation
  - continuation/weaning
  - discontinuation
RBCCR Form: Clinical Documentation

Purpose:

- Document patient assessment, behaviours and care provided for patients on constant care
- Track behaviours in support of clinical decision-making
- Document restraints
Purpose:
1. To find out patient’s patterns of behaviour and actions taken in preventing or managing behaviours.
2. To help us make decisions when to stop constant care.
Our journey at SMH

- MRB
- 7CCN
- 14CC
- 9CC
- All units
- Constant Care
- ED/CCD
Case Scenario

John was a 66 year old patient with history of ETOH use. Prior to hospitalization, he was living on his own. He was brought to SMH by a friend due to 4-6 week history of “bizarre behaviours” contributing to “difficulty coping at home”. John was admitted with a diagnosis of delirium and new onset of dementia to 14CC where he stayed for one year and six months (1 ½ year) until he was discharged to an out-of-province long-term care facility that is able to care for patients with responsive behaviours.

Behaviour: He was observed yelling, hitting patients/staff, resisting essential care, pacing, trying to leave the unit and not easily redirected when set to leave. He was assessed to be at risk to harm self and others. He had a bed in the locked unit. Constant care was initiated the day after his admission to 14CC. Code whites were called when his behaviours escalated.

Social history: John has a sister who resides in another province. Despite the distance, John’s sister was involved in his care. She visited on holidays and long weekends and stayed with patient for 10 hours during visits.
Initiation of Constant Care

Was John demonstrating an acute risk of harm to self or others?

What were the first steps that the team did to secure John’s safety, as well as the safety of staff and other patients?

What other St Michael’s policies and/or processes need to be considered within the context of what is happening with John?

What was the process that we took to initiate constant care?

What documentation tools need to be started?
Behaviour Tracking Log

- Started and continued while patient has a constant care provider
- With the log, CAs and RNs documented and identified:
  - patterns of behaviour
  - triggers
  - helpful activities
- The tool guided our team in decision-making about continuing, weaning or discontinuing constant care
Both RNs and HD documented:
- Patient assessment
- Behaviours
- Care provided (including non-pharmacological interventions, physical restraints and constant care)

### Responsive Behaviours, Constant Care and Physical Restraints Form

<table>
<thead>
<tr>
<th>Risk of serious bodily harm to others?</th>
<th>Yes</th>
<th>Yes</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>High risk for falls?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Pulling IV lines &amp; tubes?</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Risk of leaving unit/hospital?</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>High risk for serious bodily harm to self or suicide?</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Behaviour Exhibited</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asleep</td>
<td>Patient is asleep</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physically Responsive</td>
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<td></td>
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<tr>
<td>Verbal Responsive</td>
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<tr>
<td>Emotionally/Cognitively Responsive</td>
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<tr>
<td>Risk to Self</td>
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<td></td>
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<tr>
<td>Other Behaviour:</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Triggers for Responsive Behaviours</td>
<td></td>
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<tr>
<td>Social/Emotional Triggers</td>
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<tr>
<td>Physical Triggers</td>
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<tr>
<td>Other Triggers:</td>
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<tr>
<td>II. Constant Care</td>
<td></td>
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<tr>
<td>Constant Care</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Constant Care Status:</td>
<td>Continue</td>
<td>Continue</td>
<td>Continue</td>
</tr>
</tbody>
</table>
Case Scenario

As the months progressed, attempts were made to taper off constant care with the goal of discontinuing it. A care plan was developed and revisited closely.

Interventions:

- Pharmacological:
  - Haldol 0.5-1mg q4h prn for agitation
  - Quetiapine ER 50mg PO qhs
  - Trazodone 25mg PO qhs
  - Melatonin 5mg PO qhs

- Non-pharmacological

Understanding Behaviours
### Understanding the patient’s behaviours

<table>
<thead>
<tr>
<th>What was the unique need?</th>
<th>What did we do?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Pain?</td>
<td>• Re-position, analgesia</td>
</tr>
<tr>
<td>• Needing to void?</td>
<td>• Assist to bathroom</td>
</tr>
<tr>
<td>• Loneliness?</td>
<td>• Move to chair by nursing station; visitors; My Story; etc.</td>
</tr>
</tbody>
</table>

#### Yelling

- Needing to void?
- Looking for family?
- Trying to find the source of the sounds in the hallways?

#### Trying to leave 14CC

- Assist with up to bathroom
- Call sister on phone; My Story
- Walk to hallway; explain sounds
Understanding the patient’s behaviours

What was the unique need?

- Pain?
- Needing to void?
- Loneliness?
- New room mate

- Hitting staff and other patients

What did we do?

- Assigned consistent staff
- Care plan – consistent routine

- Resists bathing & screams when RN enters room with meds

- Looking for family?
- New room mate

- Call sister on phone; My Story
- Walk to hallway; explain what we were going to do
Who needs to be involved in the discussion about whether to continue with constant care?

Where is assessment and care documented?

What have been John’s behaviours over the past 24 hours?

Are there specific times of the day that the behaviours tend to happen?

Are there any strategies that have successfully managed his behaviours?
Case Scenario

A year has passed and John remained on 14CC. Attempts to taper off constant care were unsuccessful. Medications were reviewed and adjusted.

MRB care plan communicated routine and strategies. The 14CC team noted that the sister chose to deviate from the care plan. The sister did not allow John to do own ADLs. The patient behaved differently with sister, thus the sister did not believe team’s description of behaviours. Whenever she leaves, John’s behaviours escalated. During outing with sister, John refused to come back to 14CC as he anticipated sister’s leaving.

Triggers:
- Sister – inconsistent approach
- New room mate – specially if another patient is ambulatory
- Unfamiliar staff

What worked:
- Sister recognized John’s behaviour and collaborated with team
- Adhering to the MRB care plan
- Assigning consistent consistent staff
Who needs to be involved in discussion about whether to continue with constant care?

What was John’s behaviours over the past 24 hours?

Is John now demonstrating an acute risk of harm to self or others?

Are there any strategies that have successfully managed his behaviours?

What other engagement strategies should the team continue with?
Case Scenario

With the team and patient’s sister consistently following the MRB care plan, John’s behaviour no longer posed risk to self and others. Constant care was discontinued.

The team facilitated the transfer of John out of province to be close to sister, and to a facility that was able to meet John’s needs. The team shared the MRB care plan to the admitting facility.
What’s new with the MRB / Constant Care Working Group?

- Practice based behaviour rounds
- Behaviour referral resources
- BPG champions working on spread of the constant care program
- Evaluation of constant care program
Acknowledgement: MRB Working Group

- Managing Responsive Behaviours Working Group:

- Pro-Con Study Team:

- Interprofessional Practice Based Research (IPBR) Group
  C. Santiago, L. Whelan, O. Smith, H. McDonald, L. Ringer, C. McNamee, S. Bell, L. Bolt, J. Egan, S. Choi, E. Fearon, M. Ellis
## Acknowledgement: Constant Care Working Group

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<td>Allison Rinne</td>
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Questions

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