# Toronto Academic Health Science Network

## Constant Care Guidelines

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Section 1 Background

Health organizations have introduced many strategies to prevent patient self-injury or harm to others, and reduce rates of falls and physical restraint use (Watson et al, 2009; Massachusetts Organization of Nurse Executives [MONE], 2009; Caplan & Harper, 2007; Tzeng et al, 2007; Giles et al, 2006; Donogue et al, 2005), in accordance with accreditation standards, legislation, and best practice guidelines. One strategy is the use of constant care providers (also referred to as sitters or constant observers) to provide continuous observation to selected patients under the supervision of a registered nurse (Shever et al, 2011). The role of constant care provider is to monitor the patient and provide licensed staff with an early warning of escalating behaviour or deteriorating status (Adams & Kaplow, 2013; Rochefort et al, 2011; Shever et al, 2011).

Constant care (CC) is commonly used in patients with signs of delirium, intoxication, violence, psychoses, or suicidality in both acute and long-term non-psychiatric and psychiatric settings (Harding, 2010; Mergui et al, 2008; Blumenfield, Milazzo, & Orlowski, 2000; Torkelson & Dobal, 1999; Moore et al, 1995), or in patients at risk for removal of lines, catheters, devices, or equipment (MONE, 2009).

Environmental stimulation may play an antecedent role in the behaviours that lead to a decision by the team to commence constant monitoring. Derived from work conducted with patients with dementia, the term responsive behaviours (RB) represents how actions, words and gestures are a response, often intentional, to something important to a person. Persons may use words, gestures, or actions to express something important about their physical body, personal, social, or physical environment (Murray Alzheimer Research and Education Program, ND).

Despite potential benefits of CC related to patient safety, there is little data to demonstrate that the use of CC actually prevents patient harm (Spiva et al, 2012; Flaherty & Little, 2011; Harding, 2010; Rausch & Bjorklund, 2010) and the evidence suggests that the practice can be costly and inefficient (Salomon & Lennon, 2003; Boswell et al, 2001). Locally, little is known about the experiences of nurses, health disciplines professionals and unregulated care providers (UCPs) associated with managing patients receiving constant monitoring. Smith and colleagues (2015) conducted a prospective, observational study of constant monitoring practices in a Toronto acute care setting. The study showed that clinicians find decision-making is challenging due to the absence of formal screening tools and guidelines, particularly regarding cessation of monitoring (Appendix A).

In 2011, the Toronto Academic Health Science Network (TAHSN) Senior Friendly Hospital Community of Practice (CoP) was formed to provide a platform for an interprofessional group of clinicians and clinical leadership to brainstorm and share ideas, experiences, and best practices to further enhance the provision of senior friendly care in TAHSN hospitals. The CoP specifically focused its efforts on interprofessional team building and addressing responsive behaviours in seniors. In 2014, the CC Working Group was formed and tasked to establish common guidelines related to CC and workplace safety in the management of responsive behaviours. The working group's environmental scan of CC guidelines among participating organizations showed variability in content and process (Appendix B).
Section 2 Purpose and Aims

The purpose of this guideline is to establish the principles and practice in the use of CC for the TAHSN health organizations.

The TAHSN Constant Care Guidelines aim to:

- Integrate evidence-based practice to inform the philosophy and practice of CC, and to provide clinical recommendations in promoting safety of both staff and patients.

- Provide a framework to guide decision making which includes, ongoing assessment of patient need for CC monitoring, use of alternative strategies, documentation, reassessment and monitoring of the process.

- Clarify the roles and responsibilities of different members of the healthcare team and families in relation to CC.

- Embed principles of engagement, patient-centred care and least-restrictive interventions into the practice of CC.

- Outline ongoing support for staff involved in the provision of CC.

- Facilitate the evaluation of the practice of CC by involving patients, family members/ SDM (if applicable), members of relevant committees, and point of care staff.

Section 3 Definition

Constant care is the assignment of an additional individual (outside of the primary care nurse) to provide constant or close observation of a patient for the purpose of providing a safer environment for the patient (Harding, 2010). Patients receiving CC have an increased level of observation and supervision by designated team members to provide safety and to protect the wellbeing of the individual and others in the patient care environment. The decision regarding the level of observation/ monitoring, e.g., one-to-one, is based on the complexity of patient care needs and environmental circumstances. To ensure safety, patients receiving CC must have the appropriate personnel, with required skills and training, in attendance and providing care at all times.

Section 4 Guiding Principles

- The practice guidelines on constant care are based on the principles of person centered care and professional regulatory standards on delegation, team collaboration and provision of therapeutic provides.

- The determination of how CC is achieved and the level of care required are based on the clinical rationale for CC, the overall patient care requirements and environmental circumstances. The patient’s acute care issues should be addressed first.
  - Criteria to be considered for overall patient care requirements include: the complexity of care needs, predictability of condition, cognitive requirements (e.g. secure units and wander guard use), medical treatment requirements and level and range of potential outcomes.
  - Criteria to be considered for environmental circumstances include: the level of patient autonomy required and availability of resources to consult/intervene.
CC involves ongoing engagement between members of healthcare team and patients/family members. To achieve this, the reasons for and the process involved in the initiation, continuation and cessation of CC should be openly discussed with all parties (patient, circle of care team, or family/SDM) in a timely manner.

Clear roles and responsibilities of each team member should be developed and shared among the healthcare team. Understanding of the roles and responsibilities enhances the team members' abilities to provide quality care to a patient requiring constant observation by incorporating practices that include collaboration, collegiality, use of clinical judgment, and accountability to monitor and support patients' care trajectory.

CC is a therapeutic intervention that promotes patient-centred care, safety of other patients and staff on the unit, and least-restrictive interventions. The observation of patients is a skilled activity involving ongoing assessments, as well as the development of therapeutic relationship with the patient being observed.

CC requires a comprehensive and collaborative team approach that involves family, community partners and supports. Information and assessments regarding baseline functioning, behaviors, potential triggers, monitoring parameters and effectiveness of interventions for managing, minimizing, eliminating behavior(s) needs to be shared and discussed regularly.

**Section 5 Recommended Procedures**

**Section 5.01 Initiation or Continuation of Constant Care**

1. Assess patient's triggers for behaviour, risk for self-injury, harming others or any other extenuating circumstances. Recognize the following warning signs that would lead to high risk behaviours and consider initiating CC to mitigate harm:
   a. A suicide attempt, self-harm, or at high risk of doing so based on behaviour and/or history.
   b. Leaving the hospital and/or unit against medical advice, when cognitively impaired and a potential risk to self and others.
   c. Discontinuing or interfering with essential medical treatment as the result of temporary or permanent lack of judgment or insight.
   d. Combative, aggressive and/or poses potential harm to the safety of hospital staff, other patients or visitors.

2. Assess the current level of risk and appropriate level of intervention or observation (for minimum of 24 hours). [Link to organization-based risk assessment/decision-making tool](#).

3. Adhere to organization-based least restraint policy.

4. Before initiating CC:
   a. Assess the following:
      i. Patient's clinical background: medical, physical, psychological
      ii. Patient's treatment plan
      iii. Positive factors (family support, specific motivations or goals, interests/hobbies, etc.)
   b. Determine if behaviours can be managed without the use of CC using strategies: using bed alarms, chair alarms, falls mat, low beds, posey strategies, wander guards
and shirts; cohorting patients; relocating patients close to the team station, reviewing medications, implementing delirium protocol, posting signage to enhance patient orientation, etc. The applicability of any of these strategies is determined by established organizational principles and practices.

c. Involve consulting services when applicable, e.g., geriatrics, psychiatry, advanced practice nurse (APN), nurse practitioner (NP), occupational therapist (OT), physiotherapist (PT), social worker (SW), patient advocate, spiritual care services etc.

5. Consider CC after alternative strategies were implemented. Once patient is deemed requiring CC, follow organizational policies/guidelines for approval of CC.

6. Adhere to organizational practices pertaining to CC for patients on Mental Health Act (e.g., on Form 1).

7. Develop strategies to communicate and document the use of CC with the healthcare team (including the CC provider) during transfer of accountability (handover, report) at various transition points using clear, concise, and structured format. Link to TAHSN Glossary.

8. Communicate the use of CC with the patient’s family or SDM (if appropriate) in a timely manner and document.

9. Develop care/service plan that is tailored to the need of the patient. The care/service plan should be easily accessible to all the healthcare team members.

Section 5.02 Tapering off (Weaning) Constant Care

Tapering off (weaning) is the process of reducing the period a patient is assigned a CC, ultimately resulting in its discontinuation. The process may not be applicable for patients who only require CC at certain times, e.g., nights only. In some cases, the process can be achieved rapidly when the original cause for need of CC has resolved. In other cases, a more gradual method of withdrawing CC is needed. To enable tapering off (weaning) CC, the following process is recommended:

- Examine constant care documentation form for the following: patterns of behaviour; identification of high risk behaviours, sleeping patterns, possible triggers precipitating significant events; review of management strategies, and outcome of strategies implemented. The documentation form and timeframe for reviewing documentation (24-hour vs. 12-hour documentation) are determined by each organization.

- Consider tapering off (weaning) CC once team has established that patient’s pattern of responsive behaviours no longer pose risk of harm to patient and staff for a consistent period of time. Strategies may include the following:
  - Positioning CC provider away from the patient but within view of the patient at all times, e.g., moving CC from the bedside to doorway or hall.
  - Cohorting two non-ambulatory patients requiring CC into the same room and assigning one observer to both patients.

- Engage the family/SDM to facilitate the process.

- Document the process in the patient’s care plan.

- Reevaluate the need for CC.
Section 5.03 Discontinuation of Constant Care

1. Discontinuation of CC may be achieved rapidly when patient’s behaviours have resolved and at other times it may occur with a weaning process.

2. Similar to the initiation or continuation of CC, its discontinuation is based on the clinician’s and/or team’s assessment of risk. To help guide healthcare team members with this decision, the following items should be considered:
   a. Review clinical documentation regarding patient’s response to weaning (with particular attention to behaviours or reasons why patient was initially put on CC).
   b. Review identified risk factors and warning signs.
   c. Review factors associated with prevention, e.g., family support, patient-specific routines, interests, hobbies, etc.
   d. Review issues in regards to the physical environment, e.g. crowded hallway.
   e. Assess staff and patient safety, practicality, and effects of prolonged use of CC, e.g., weeks to months.
   f. Assess the current level of risk and appropriate level of intervention or observation (Q1 hour, Q15 minutes, or specific CC time frame).
   g. Assess and document patient’s response and/or readiness to discontinuing CC.

3. Discontinue CC with team, authorizing personnel or medical approval. Constant care ordered by physician must be discontinued by physician, e.g., suicide risk.

Section 6 Engagement Activities

To ensure that a therapeutic relationship is maintained, as well as preserving the patient’s dignity while on CC, meaningful interactions or engagement with patient, patient’s family / SDM and community resources (CAMH). Based on the assessment of the healthcare team and family, and the current clinical needs of the patient on CC, specific activities should be considered if these can be facilitated safely.

- Assess / Reassess patient’s understanding of why he/she is receiving CC. Assist the patient in building insight and self-awareness regarding the specific behaviours and safety concerns that are warranting constant care.
- Educate the patient and family that the identification and self-management of these specific behaviours would facilitate the discontinuation of CC and enhance safety and independence.
- Provide opportunities for the patient to voice/identify their basic needs, in order to enable independence in directing their own care and by recognizing the situations where they require assistance. This involves call bell training (cueing, visual reminders, repetition) and modeling positive behaviours (call bell use) to develop appropriate safety judgment.
- Assist the patient in developing or recognizing their goals, personal strengths, creativity, and resilience. Document these in the patient’s record and/or care/service plan.
- Engage patient/family in gathering personhood information, e.g., sleeping routine, habits, etc.
- Ask the patient to tell you a story or goal that he/she is comfortable sharing with you. Ask the patient about the meaning of this story or goal. Develop a genuine curiosity or interest in the patient’s unique experience. During these activities, CC provider integrates assessment or observation of the patient’s health status, risks to self and/or others, and other needs (e.g., medical, social, and leisure).
Utilize unit resources throughout the day (e.g., use of activity room, quiet room/comfort room).

Schedule programming time and/or consultation with SW, OT, RT, PT, or other healthcare providers during periods of CC (if the patient is willing to participate and is not showing overt signs of harming self and others).

Section 7 Roles and Responsibilities

Section 7.01 Physician (MD) / Nurse Practitioner (NP)

1. Conduct a comprehensive assessment for the possible etiology of the high risk responsive behaviours, e.g., delirium.

2. Seek additional consultation for managing behaviours, e.g., psychiatry and/or geriatrics, OT, PT, etc., as per organizational practice.

3. Collaborate with the health care team and family in the development and implementation of individualized, patient-centered and coordinated care plans/service plans.

4. Reevaluate patient’s need for constant care.

Section 7.02 Registered Nurses (RN) / Registered Practical Nurse (RPN)

1. Assign CC task to unregulated care providers (UCP): personal support worker, health care aide, clinical assistant, or security personnel (College of Nurses of Ontario Practice Guideline: Working with Unregulated Care Providers).

2. Provide the overall care and management of the patient including ongoing assessment of risk factors and unmet needs contributing to responsive behaviours.

3. Collaborate with healthcare team and family in the development and implementation of individualized, patient-centred and coordinated care plan/service plans.

4. At the beginning of the shift:
   a. Provide CC the following information: patient’s condition; individual care requirements, routines, and practices; reason for CC, and when and how to call for help.
   b. Review the expectations and responsibilities of the CC provider (including documentation).

5. During the shift:
   a. Provide guidance and follow up with the CC to note any change in patient status.
   b. Arrange for the relief of the CC and provide direct report to the relieving CC provider about the patient’s condition, individual care requirements and reason for CC.

6. At the end of shift:
   a. Conduct transfer of accountability with the outgoing CC provider
   b. Debrief with the constant care provider

7. In consideration of the safety needs of the patient and the CC, arrange to provide assistance as necessary with care, and deploy team members as necessary for emergency responses.
8. Document in the nursing progress notes the rationale for initiating or discontinuing CC and the level of health care provider selected.

Section 7.03 Constant Care Provider
Unregulated care providers or security personnel, who provide CC in accordance with facility policies and/or collective agreements, are responsible for completion of assigned tasks as follow:

1. Receive report from the RN/RPN about the patient’s behaviour, condition, reason for CC and specific duties before approaching the patient.

2. Give report to the RN/RPN when relieved for breaks and at the end of the shift.

3. Collaborate with healthcare team and family in the development and implementation of individualized, patient-centred and coordinated care plan/service plans.

4. Immediately report to the RN/RPN any changes in patient’s observed behaviour or condition as it relates to the individual patient situation.

5. Ensure that environment modifications outlined by the RN/RPN are maintained, e.g., ensure plastic cutlery is on the food tray at each meal.

6. Ensure that the patient is always within a safe distance, as defined by the RN/RPN, for quick response, e.g., washroom, corridor or another department.

7. Engage patient in activities (refer to section on Engagement Activities).

8. Document as per organizational requirements/practices.

9. Provide report to incoming CC provider.

Section 7.04 Health Disciplines / Allied Health

1. Assess patient's risk factors and unmet needs contributing to responsive behaviours.

2. Collaborate with healthcare team and family in the development and implementation of individualized, patient-centred and coordinated care plan/service plans.


4. Reassess patient’s need for constant care provider.

Section 7.05 Family

1. The family is encouraged to collaborate with the healthcare team in the development of individualized, patient-centred and coordinated care plan/service plan for the patient.

2. When CC is not clinically indicated and the family requests CC, it is the responsibility of the family to provide and pay for the service. Follow organizational policies regarding the use of external constant care providers.
Section 7.06 Management Personnel (e.g. manager, director, supervisor, shift administrator)

1. Ongoing tracking of constant care usage
2. Perform audits to assess documentation and adherence to Constant Care use

### Section 8 Documentation

1. Initial patient assessment is recorded on the required forms per organizational protocol.
2. Use TAHSN person-centred language in describing behaviours. [Link to TAHSN Person Centred Language Guidelines](#)
3. Patient’s condition, observations, interventions and/or response to treatment are to be documented at least every shift in the patient’s health record.
4. Reassessment of the patient’s status is completed at least once a shift and documented on the health record.
5. CC personnel (RN, RPN, PSW, security) documents on appropriate forms.

### Section 9 Quality Monitoring

1. Audits to be completed by healthcare setting. [Adapt/Develop audit tools](#)
2. Provide education to current staff on guidelines and procedures.
3. New staff will be educated to guidelines and procedures during orientation.
References


Centre for Addiction and Mental Health. *Continuous Observation Guideline*.


Flaherty, J.H. & Little, M.O. (2011). Matching the environment to patients with delirium: Lessons learned from the delirium room, a restraint-free environment for older hospitalized adults with delirium. *Journal of America Geriatric Society, S295-300*


Ontario Association of Non-Profit Homes and Services for Seniors (ND). Retrieved from http://www.oanhss.org/AM/template.cfm?Section=Home&Template=/CM/ContentDisplay.cfm&ContentID=8070


Watson et al, 2009


Toronto Academic Health Sciences Network  
Senior Friendly Community of Practice  

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Reference: Santiago, C. & Davidson, S. et al. (2016). Toronto Academic Health Sciences Network, Senior Friendly Community of Practice: Constant Care Guidelines
Appendix A: Prospective, observational study of constant monitoring practices in an acute care setting

Prospective, observational study of constant monitoring practices in an acute care setting: The Pro-Con Study

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**BACKGROUND**
- The Managing Responsive Behaviours (MRB) Working Group at St. Michael’s was tasked with the responsibility of improving the capacity of the inter-professional team to manage patient responsive behaviours.
- Little was known about responsive behaviours in our patients or about existing individual and team capacity to identify and manage these behaviours.
- To generate the data necessary to achieve our mandate, we designed a mixed methods study to investigate responsive behaviours in a selected cohort of four patients receiving constant monitoring in addition to standard nursing care.

**RESPONSIVE BEHAVIOURS:** Behaviours exhibited by patients who are “challenging” for health providers to manage, including, but not limited to, physical and verbal acting out, problems with thinking, or risk to self that emerge in response to something negative, frustrating, or confusing in the patient’s environment

**CONSTANT MONITORING:** “The assignment of an additional individual (outside of the primary care nurse) to provide constant or close observation of a patient.”

**OBJECTIVES**
1. To describe characteristics of patients receiving constant monitoring
2. To quantify the extent to which patients receiving constant monitoring exhibit responsive behaviours
3. To explore the experiences of nurses, health disciplines professionals and clinical assistants associated with managing patients receiving constant monitoring

**METHODS**
- Mixed methods study inclusive of a longitudinal cohort (patients) and focus groups (staff)
- Patient inclusion: Incident case of constant care during study period on index unit
- Patient exclusion: Hospitalized under a Form 1, or in police custody
- Staff inclusion: Employed as a clinical care provider (regulated or non-regulated) on an index unit, provision of informed consent
- Patient-level data was obtained from bedside staff, the medical chart, and the Scareian database and entered into a standardized case report form
- Focus groups were audiotaped and transcribed verbatim; content analysis was used to identify themes

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**RESULTS**

**Quantitative**
- Between May 2 – June 11, 2014, 80 patients were assigned a constant observer and were entered into the study cohort:
  - General internal medicine (n=27; 34%)
  - Cardiovascular surgery (n=23; 29%)
  - Trauma/surgical (n=30; 37%)

Table 1. Patient Demographics

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>N (%) or Mean (SD) and Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, years</td>
<td>67 (15), Range 24 – 97</td>
</tr>
<tr>
<td>Age group</td>
<td></td>
</tr>
<tr>
<td>Less than 40</td>
<td>8 (8)</td>
</tr>
<tr>
<td>41-55 years</td>
<td>22 (27)</td>
</tr>
<tr>
<td>56-75 years</td>
<td>37 (46)</td>
</tr>
<tr>
<td>76 years or older</td>
<td>18 (23)</td>
</tr>
<tr>
<td>Sex (male)</td>
<td>54 (68)</td>
</tr>
<tr>
<td>Duration of hospital stay, days</td>
<td>17 (15), Range 1 – 76</td>
</tr>
<tr>
<td>Duration of constant observation, days</td>
<td>9 (3), Range &lt; 1, 30</td>
</tr>
<tr>
<td>Re-institution of constant observation</td>
<td>3 (4%)</td>
</tr>
</tbody>
</table>

**Mental status**
- Common: behaviour change
- Single: maintenance
- Unknown: unknown

**Reason for hospitalization**
- Surgical: 45 (51)
- Medical: 53 (66)
- Trauma: 11 (13)

**Location prior to presentation**
- Hospital: 61 (76)
- Acute, rehab, or complex care LTCH or treatment facility: 23 (29)
- Home: 39 (50)
- Community dwelling: 11 (13)
- Other: 1 (1)

**Discharge disposition**
- Acute, rehab, or complex care LTCH or treatment facility: 20 (25)
- Home: 39 (49)
- Community dwelling: 2 (2)
- Other: 1 (1)

**Pre-existing conditions**
- Substance use: 21 (26)
- Neurologic injury: 19 (24)
- Physical injury: 16 (20)
- Documented mental illness: 15 (19)
- Communication barrier: 16 (20)
- History of dementia: 19 (24)
- History of violence: 19 (24)
- Other: 24 (31)

**MD/NP orders to commence and discontinue constant monitoring**
- Written for 13 (16%) and 2 (3%) patients respectively
- Decisions to start most often made by bedside nurses in consultation with charge nurses (n=40; 61%)
  - In 15 patients (19%), there is no record of discussion
  - Decisions to discontinue most often made by bedside nurses in consultation with charge nurses (n=21; 26%)
  - In 38 patients (48%), there is no record of decision to stop
  - 3 (4%) patients re-started constant monitoring during hospital stay
  - Geriatrics consulted for 5 elderly patients (10%) prior to constant monitoring and for 7 (13%) between Days 1 – 12
  - Psychiatry consulted for 2 patients (3%) prior to constant monitoring and for 8 (7.5%) between Days 1 – 3

**Theme 1: Decision-Making is Challenging**
- “Decision-making regarding constant monitoring is driven by nurses yet is collaborative with health disciplines influenced by individual patient factors, and often represents a dissonance between the MD/NP’s decision to initiate constant monitoring and the bedside nurse’s judgment, at times with a disconnect that tells us when a patient needs a constant because right now it’s all over the place. It depends on my decision ... Everybody has different judgment. It makes us nervous.”

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**PRELIMINARY RESULTS**

**Quantitative**
- Between May 2 – June 11, 2014, 80 patients were assigned a constant observer and were entered into the study cohort:
  - General internal medicine (n=27; 34%)
  - Cardiovascular surgery (n=23; 29%)
  - Trauma/surgical (n=30; 37%)

Table 2. Patient Characteristics 24 Hours Prior to Constant Observation

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsive Behaviour Documented yes</td>
<td>71 (88)</td>
</tr>
</tbody>
</table>

**Theme 2: Managing Behaviours is Challenging**
- Nurses, clinical assistants, and health disciplines work together to provide the best care possible to patients under observation; managing behaviours is seen as a team responsibility
  - “Definitely you have to work together and listen to each other or consider what someone else has learned about the patient. It’s always more helpful with another pair of eyes and ears.”
  - Staff lack knowledge related to triggers and intervention strategies
  - Patient management tends to be reactive as opposed to proactive
  - Formal care plans are beneficial but infrequently available
  - Assessment, recommendations, and support from specialists are beneficial for patients and staff but availability is inconsistent
  - Physicians and security services are engaged to help manage escalating situations; security services are viewed as a last resort

**Theme 3: Communication and Documentation is Challenging**
- Most harm communication about behaviours is verbal
  - Paper-based unit specific logs exist with variable awareness, utilization, and utility
  - “Documentation is very good with a lot of nurses also misusing with a lot of secure... There’s a lot of ones that there’s no comment at all and nobody writes why they need a constant.”
  - Inconsistencies and lack of specificity in language compound communication
  - Lamented the necessity in securing care plans is problematic

**Theme 4: Training is Necessary**
- Staff report a lack of confidence in knowledge and skills to manage responsive behaviours
  - Staff are interested in receiving training in responsive behaviours
  - Staff would not receive training in responsive behaviours
  - “If it would make sense if all of us who are dealing with these patients have training because we are here everyday. It doesn’t make sense to only train certain people; what if they are not here when a crisis happens?”
  - Concern about adequate education on de-escalation and tools is helpful in recognizing and mitigating risk associated with responsive behaviours

**NEXT STEPS**
- Complete data analysis for initial data set
- Finalize identification and management algorithm using study findings
- Pilot MRB education program on one unit and evaluate process and outcomes
- Pilot algorithm and evaluate processes and outcomes on one unit