A Review of Constant Care

A Client Centred Approach
Melvin Layden B.N., M.N., R.N.
What is Constant Care?

- According to Eastern Health, a patient getting **constant care has one-on-one supervision; there is a care provider with them at all times.** This type of care has to be medically warranted, and approval is required prior to someone receiving constant care (Understanding Constant Care and Hours of Care, 2012, P.1).
Our Success – Constant Care Hours

- 2009/10
  - Neurosurgery – 6,565 hours
  - Urology – 4,806 hours
- 2012/13
  - Neurosurgery – 3,237 hours
  - Urology – 4,888 hours
- 2013/14
  - Neurosurgery – 1,457 hours
  - Urology – 817 hours
- 2014/15
  - Neurosurgery – 293 hours
  - Urology – 138 hours
- 2015/16
  - Neurosurgery – 160 hours
  - Urology – 34 hours

(Payroll Data)
Unit Variance - Urology
Unit Variance - Neurosurgery
Learning Leaders Project April – June 2015

- Included 4 Surgery Units at the HSC
  - 4NB General Surgery
  - 5NA Orthopedics
  - 5SB Urology
  - 5SB Neurosurgery

- **Data:**
  - All graphs are in hours.
  - Data from payroll (payroll months not 1st-30th)
  - No constant care offservice patients were sent back to their home units during this quarter while on Constant Care.
Quarter 1
Common Reasons Identified for Constant Care

- Delirium
- Dementia
- Physician Ordered
- Wandering/Elopement Risk
- Admission from LTC
- Falls Risk
- Family Pressure
- Another program/area has put the client on constant
- Preservation of Medical Equipment (IV lines, etc)
- Psychiatry Recommended
- Attempted Suicide
- Fear that something will happen and we will be blamed
  (Neurosurgery & Urology)
Consequences of Constant Care

- Increased LOS
- Doesn’t address the issue
- Often puts the patient on an alternative discharge path

Constant Care is needed at times and its purpose is to keep the patient safe.
We race to discover what is happening with a patient when they have a change in vital signs, etc. Do we do the same when they have a change in behaviour?
What is Causing the Behaviour?

There is a reason for the behaviour!
Delirium

- What has caused the delirium?
  - Blood work – Metabolic issues, dehydration, low blood sugar, infection, etc.
  - Urine sample to rule out infection.
  - Oxygen saturation when he/she is confused.
  - Has the pt spent time in the ICU?
  - Has the pt slept through the night?
  - Is the pt in a ward or private?
  - How many times have we moved the pt since admission?
  - Did the pt have delirium on a prior admission – what caused it?
Delirium

- What medications have we given the pt? (Antihistimines, Pain Meds, Asthma Meds, etc)
- Are there medications that the pt takes regularly that were not administered?
- Is there medication toxicity?
- Is the pt experiencing alcohol or drug withdrawal?
- Has the pt taken any street drugs?
- Has this happened to the pt before?
- Does the pt have a diagnosed psych illness? Is there an undiagnosed psych illness?
- Has the pt been checked for diseases that cause delirium (Heart Failure, Kidney Failure, Liver Failure, Thyroid Disorders)?
- Has the patient had any recent losses in his/her life?
Managing Delirium

- Interventions are based on elimination of causative factors:
  - BW
  - Chest X-ray
  - Urine sample
  - Drug review
  - Medications as needed
  - Behaviour modification
  - Environment modification
  - Disease treatment

- Learn to identify the signs delirium before it is an issue.
Dementia

- Has the pt been diagnosed with dementia?
- Delirium vs. Dementia
- Have we ruled out the earlier questions surrounding delirium? Theses things make dementia behaviour worse.
Dealing with the Behaviour

While we are looking for the cause we can control the behaviour by:

- Decreasing Sensory Stimulation
  - Avoid noisy wards
  - Minimize moving pts
  - Create an environment that promotes sleep at night
  - Provide cues to distinguish day from night
  - Turn lights off at night
  - Put a sign on the bathroom door
  - Put a stop sign on the door
  - Put a sign on the door identifying that patient’s room
  - Make sure the pt is using his/her hearing aids, dentures, and glasses and ensure they are fitting properly
  - Get patients out of bed
  - Remain calm at all times – avoid arguments
  - Keep distractions to a minimum
Dealing with the Behaviour

- Track the pt’s bowel movements and voiding
  - Put the pt on a bathroom schedule individualized to the pt, i.e. every 3 hrs the pt is brought to the washroom to try to void.
- Bring back offservice pts who are high risk for delirium - team approach
- What distraction techniques are we using?
- Provide the pt with meaningful activities to provide distraction. If a patient likes to write provide pen and paper. Some patients enjoy staying busy – folding towels might be an appropriate intervention.
- Don’t confine the pt to the room. Have the pt come out and sit by the nursing station.
- Involve the family in the care of the pt; they know the pt best.
Dealing with the Behaviour

- Pain assessment for confused pts?
- Call bell kept in reach of the pt at all times?
- Pull patients from ICU as soon as they are ready
- Identify yourself at all times
- Try to maintain consistent assignments for these patients
- Make sure the patient stays appropriately hydrated
- Minimize the use of restraints
- Have the family bring in some familiar objects from home
- Avoid overstimulation from too many visitors
- Avoid caffeine
- Maintain a regular routine
- Speak to patient in clear, short sentences
- Offer support to the patient and family
Wandering?

- What is causing the pt to wander?
  - Is the pt bored?
  - Is the pt looking for a washroom?
  - Is the pt trying to sit in the lounge?

- Through the use of the interventions in the “Dealing with the Behaviour” slides we can eliminate some of the wandering behaviour.
What is causing the behaviour?

- Date of last BM reviewed?
- Pain Assessment?
- Distraction techniques?
- How often has the pt been moved?
- Is the pt on a toilet schedule?
- Have we given the pt limits to wander?
- How many elopement attempts has the pt had? Where did he/she go? When did the elopements occur?
- Have we seated the pt at the nursing station?
Falls Prevention

- Morse Fall Scale
- What is the pt’s Falls Risk prior to admission?
- What are the client’s expectations surrounding falls?
  What are the family’s expectations?
- Is the pt living with this risk in the community?
- Medication review?
  (Sedatives & Hypnotics, Antidepressants, Antipsychotics, Antihypertensives, Cardiac Medications, Steroids, NSAIDS, Anticholinergics, Hypoglycemic Agents, etc)
What we discovered about Falls Risk?

- The Morse Fall Scale wasn't always being completed and updated.
- Interventions weren’t being implemented based on the score from the Morse Fall Scale.
- There was little-to-no discussion happening with families surrounding falls risk, what we were doing to minimize falls, and minimize adverse effects when they do happen.
- Pts were deconditioning when in constant care because the observer wouldn’t let them up out of bed.
- After a period of admission we were sending these patients home with little intervention surrounding falls prevention, and sometimes at an increased risk.
- There was a real fear surrounding falls on the units.
Falls Prevention

- Educate clients and families about falls and fall prevention
- Toilet schedules
- Bed alarms
- Q15min surv
- Move the pt closer to the nursing station
- Delirium prevention
- Keep the environment as clutter free as possible
- Mats on the floor next to bed
- Bottom rail kept down – a pt wanting to get up is coming out regardless if the rails are up
- Medication review
Falls Prevention

- Keep the pt as active as possible
- Chair Alarms
- Analyze CSRS regarding falls
- Complete a causative assessment after each fall – identify all the contributing factors
- Ensure adequate lightening in the environment
- Is the pt wearing his/her falls risk bracelet?
- Ambulatory aids
- Footwear
- Helmets
- Implement the various other interventions that are identified on the Morse Fall Scale
Falls Prevention

- Falls Risk Assessment
- Implementation of prevention interventions
- Alternatives to restraints and other restrictive devices
- Multidisciplinary strategies
- Promoting safe mobility
- Pt/family education and involvement
- Risk management including post-fall follow-up

(Falls Prevention Slide Show, LTC, 2012)
Falls Risk

Some patients live with the risk of falling every day. We need to talk to patients and families about their falls risk, and minimize these risks by working with our patients.
Attempted Suicide

- Psych consult needs to be done in a timely manner
Preservation of Medical Equipment

- Does the pt need that line? Perhaps it is contributing to the behaviour.
- What are the consequences of removing that piece of equipment?
- Have we tried a onesie? – Preserves peg tubes
- Have we wrapped the IV?

- Context: In LTC we have patients with ventilators, peg tubes, IV’s, PICC lines, etc that are not constant. What are they doing different?
Evaluation Tools

- Occurrence Reports
- Statistics (Constant Care Hours)
- Education Evaluation
- Review of Client Complaints/Compliments
- Feedback from staff (Nurses, Physicians, etc.)
- Chart Reviews
Challenges/Catalysts for Change

- Managers have to live the change and coach staff.
- Informal champions were chosen and highly developed – these were keen staff that we built an expertise in to develop other staff.
- Can’t focus only on nursing staff.
- Has to be a team effort.
- Consistent approval process.
- After hours managers has to be consistent with process.
- Occurrences need to be debriefed with staff.
- Frontline staff need to take ownership.
- Client quality improvement focus.
- Physician involvement is critical.
- Program specific teams – must contain frontline staff.
- Regional constant care team.
- Staff develop/educate each other/new staff.
Pertinent Policies

- Fall Prevention and Intervention: Adult Acute Care and Long-Term Care – Safety 204(NUR)-2-030
- Destination and Management of Alternative Level of Care (ALC) Patients in Acute Care – Patient-Resident-Client Care PRC-030
- Least Restraint – Patient-Resident-Client Care PRC-080
- Client Surveillance (Acute/Long Term Care) – Safety 204(NUR)-2-020
- Code Yellow – HSC
Further Considerations

- Pain Assessment for confused pts
- Nursing Assessment needs to be updated
- Bed Alarms and Chair Alarms
- Approval process
- Better understanding of Morse Fall Scale for staff
- Change in frame of mind
- What constants are ordered by a physician?
- Type of equipment we’re ordering – low rise beds
- Have we considered hip protectors in our setting?
- Acute care needs an elopement policy similar to LTC’s?
- A standardize tool to identify delirium? – The Confusion Assessment Method?
- Should a floor have a section locked?
- Delirium decision tree?
Questions
Contact Info

- melvin.layden@easternhealth.ca
- 709-777-6943