Safety Companion

Policy CM S-13 & PROC_CM_S-13A

Use of a Safety Companion for Safety for At-Risk Patients

Revised : 10/19/2013 ck, 03/25/2014 ck, 05/15/2014 ck, 08/18/2014 ck, 3/6/15 ck, 1/18/2016 ck
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What is a Safety Companion?

• Specially trained clinical staff, designated to provide observation of a patient at risk for safety due to:
  • Suicide ideations or attempts
  • Self-Abusive/Danger to Others
  • Unable to follow safe instructions
  • Interferes w/ non-vital medical care
  • Wander (Risk for Elopement)

• LPN, HCT, SCA, HA/UST, MHTA, MOA (In-pt)
SC Required Education

- Safety Companion Course
- Fall Education (CHOP)
- Restraint Education (CHOP)
- Safe Patient Handling (MOD Basic)
- CPI Non-Violent Crisis Intervention (CPI Class)
  - within 3 months of hire (8hrs)
  - yearly refresher course (4hrs)
- Safety Companion annual update (following CPI Refresher)
- Safety Companion/Restraints/Falls annual updates (Patient Safety Fair)
SC Responsibilities

- Provides direct physical and therapeutic patient care consistent with job training while maintaining patient respect and dignity

**Communication RN ↔ SC:**
- SC Receives report and reviews Electronic Medical Record WORKLIST w/ RN within 30 minutes of beginning assignment.
- SC communicates observations to RN every shift and with any change in patient condition

**Communication SC ↔ SC:**
- Gives/receives verbal report using Safety Companion Observation Record (SCOR)

- Documents per policy on the SCOR
SC Responsibilities, cont…

- Communicates any concerns that may affect SC need or level
- Be alert & aware of all patient activity and avoid any distractions
- No eating or drinking at the bedside
- No Sleeping or “resting your eyes”
- No personal activities (including but, not limited to: reading, studying, cell phone use (calls or texts) or use of other electronic devices
SC Responsibilities, cont…

• Face the patient, depending on the safety companion level
• Limit interactions with all other staff
• The distance between the SC and patient is determined by the RN
SC Activities w/ Patient

• Engage patient in activities according to plan of care in collaboration w/ RN

• Activity Cart
  • Community: 3 East Classroom room 3241
  • Downtown: 1328B hallway

• Provide competent physical/therapeutic care and ADL’s consistent with job title/role

• Offer diversion activities with direction of RN

• Walk patient around unit if stable – “Get up & Go Program”

• Redirecting patient
RN Role & Responsibility (non-suicidal patient)
RN Safety Assessment & Evaluation Plan

- Complete a “Safety Assessment” each shift and PRN to determine **NEED & LEVEL** of SC (**Safety Companion Decision Tree**):
  - Electronic Medical Record

- The score total will *help to objectively* determine if a **nursing order** for a SC is recommended
RN Evaluates Need and Level SC
Safety Companion Decision Tree (PROC_CM_S-13A, Attachment A)

**Suicide ideations or attempts**
- Policy CM S-09
- Suicide Watch/Precautions

**Self Abusive and/or Danger to Self or Others**
- 5 points
- Interferes with Vital Medical Devices (coherent pt., ET, Trach tube, PICC, etc.)
- Fall Risk with Injury
- Policy UUH CM F07

**Unable to follow safe instructions**
- 3 points
- Incoherent pt. or getting out of bed when shouldn’t, unable to redirect pt behavior, etc.

**Interferes with Non-Vital Medical Care**
- 2 points
- Coherent pt., pulling or dislodging NG, feeding tube, Foley, IV

**Wanders – Risk for elopement**
- 1 point
- Leaving room or unit without notification, etc.

**Possible interventions**
- Orientation strategies
- Consider discontinuing tubes and drains
- Personal items within reach
- Family involvement
- Use STOP door barrier
- Move closer to communication station
- Use of wander alarm

**Interferes with Non-Vital Medical Care**
- Reinforce unit boundaries
- Use abdominal binder
- Assess adequate pain control
- Chair alarm or Bed alarm
- Ambulation
- Diversion activities
- Low to floor bed
- Use of floor mat
- Geri sleeve – cover lines

**Suicide Watcher = 1:1**
- Is sitter use a value to the outcome?
- Is sitter the most effective way to use staff?
- Is family included in PLAN?

**Consider SC Level**
- Review SCOR, RN Notes & Discuss with Caregiver Team

**Safety Assessment Score ≥ 4**
- Behavior Same or Increase
- SC Level = 1:1 Renew Nursing Order
- Question: Cohorting, Distance SC, Purposeful Rounding Update Order

**Safety Assessment Score < 4**
- Discontinue SC
- Document Reason for SC & Update Nursing Order

**Interventions Successful**
- Attempt Other Interventions
- All Interventions Unsuccessful
- Consider SC Level

**Document & Monitor Effectiveness of Interventions**

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Safety Companion Scoring

Self Abusive/Danger to Self or Others 5 points
Unable to follow safe instructions 3 points
Interferes with non-vital med. care 2 points
Wanders 1 point

Total = ________________

If total points ≥ 4: Consider use of a Safety Companion

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Our own data has demonstrated that an increase in the use of a SC has not correlated with a decrease in patient falls. Additionally:

“The most difficult challenge associated with this practice change was shifting the mindset of the nursing staff. Ordering a sitter for any patient situation out of the ordinary was no longer an option. Staff were surprised to learn that presence of a sitter did not necessarily translate into a decrease in falls or other quality metrics. Rather, it was the intentional presence of the nursing staff that was pivotal to the successful reduction in sitter use.”

RN Needs to determine further:

- Does the use of a SC add value to the patient outcome?
- Is the SC the most effective way to use resources (staff members)?
- Has the family been included (non-suicidal)?
- What is the appropriate SC level for the situation?

**GOAL:** To provide a safe environment for our patients in the most efficient manner while preserving our resources.
RN determines the level of SC needed

1. 1:1
2. Cohorting (2:1)
3. Distance Safety Companion
4. Purposeful Rounding Companion
HIGH RISK patient requires 1:1 constant visual, arms reach observation for immediate or impulsive behavior that may be harmful to self or others

- Assaultive/Aggressive behavior
- Interferes with Vital medical Devices (ET, Trach or PICC)
- Actively psychotic experiencing visual, auditory and/or command hallucinations
- Acute detox with seizures or delirium tremors
- 3 or 4 point restraint or Twice-As-Tough Cuff Stretcher/Quick Release
- Fall risk with injury when other interventions are not effective
Cohorting (2:1)

Two patients who do **NOT** require constant visual observation but require a SC in the room

- Remain with both patients in the same room
- Both patients:
  - may have similar conditions and/or symptoms
  - must be responsive to verbal directions
  - cannot be agitated, suicidal or require a great deal of physical care, etc.
- SC must communicate to the RN assigned to the patient if needs extended periods of time with one patient (toileting, bathing, walking, etc)
Distance Safety Companion

Direct observation is possible at all times within 20 feet of patient (approximately length of 2 stretchers)

- For patients that might have had 1:1 SC Level and now trying to decrease SC Level to promote more freedom
- Direct observation but does not have to be constant
- Provides the patient with a little sense of privacy/independence
SC Purposeful Rounding

Frequent (> hourly) rounding on a select group of patients as determined by the needs of the patient and RN

- Charge Nurse determines the minimal rounding time for each patient
- The SC should not have > 3 patients total and no other unit assignments
- Inquire about the 5P’s (Pain, Positioning, Potty, Possessions & P.O.)
- At the same time: Respond to Questions, Reassure that they are there to help and will return frequently (the 2R’s)
- End with “Is there anything else I can do for you? I have the time.”
- Any patient concerns are reported immediately to RN
Once the RN determines a SC is needed

- RN will notify the PSL/Shift Coordinator who reviews alternatives attempted/reassess alternatives
- Upon agreement, RN enters **Nursing Order** (renewed daily)
- PSL/Shift Coordinator notifies Nursing Supervisor, Unit Manager, and MD/LIP

*If Medical Staff orders a SC, RN will reassess need/alternatives and collaborate with MD*
RN Role & Responsibility…

• **Gives verbal report to SC within 30 minutes of assignment**
  • Be specific about behaviors, interventions
  • Use Electronic Medical Record SBAR tab and SC Observation Record (SCOR) form ([F81973](#))
  • Check in on SC periodically
RN Role & Responsibility…

Ensures SC is relieved for Meals & Breaks:
  • PSL/Shift Coordinator schedules coverage
  • Minimally every 4 hours

Family may serve as alternative to a SC
  • Determined by the RN and family members
  • After patient/family education
  • Only intervals of time
  • Documented in Electronic Medical Record
RN Responsibilities cont…

Continue to assess Need for SC every shift and w/ changes
  • D/C as soon as no longer indicated
  • Use lower level of SC when possible (“weaning”)

Communicate and collaborate with all health care team
  • Other RN’s, SCs, Medical Providers, FAMILY

• Proper Documentation
RN Documentation – EACH SHIFT

• Safety Companion Evaluation Plan, including:
  • Clinical Justification/score
  • Contributing Factors
  • Safety Interventions attempted along with patient response & outcomes
  • Level of Safety Companion utilized

• Patient’s Plan of Care

• Patient/Family/Caregivers safety education

• RN → Safety Companion Handoff on SCOR (# 81973)
SC Documentation

- Safety Companion Observation Record (SCOR)
  - Patient activities & behaviors every hour
    - Suicide Patients every 15 minutes
  - Signature upon handoff and receipt of plan (SC → SC)

- Purposeful Rounding patients – varies according to the rounding time for that patient
Observation Record, Safety Companion/Suicide Precaution Form F81973

****Reflects time behavior was observed, NOT time note is written
Interventions for the Confused Patient

- Detect and Treat the underlying cause
- Nutritional consult
- Hydration
- Administer O2
- Treat infections
- Use of visual/hearing aids
- Consistent caregivers
Interventions, cont…

- Reduce noise, adjust lighting
- ↓ clutter
- Encourage family presence
- Provide familiar belongings
- Frequent, gentle reorientation x 3
- Activity – ambulation, range of motion exercises, ADL’s
- Stimulation – activities, talking, reminiscing
Interventions, cont…

**Medications:**

- Manage pain with non-pharmacologic methods (ice/heat)
- Be familiar with common side effects of medications (especially anticholinergic meds in elderly patients)
- Review and monitor response to medications
- Go slow with new meds
- Obtain a pharmacy consult
Increasing Agitation

- Move patient from situation (to quiet area)
- Redirect their attention
- Clearly communicate information - explain what you are doing, any delays
- Calm but firm approach
  - “I want to help but I need you to…”
- Be consistent - Involve other staff in communication and plan...but 1 person talks to patient
- Identify a trusted person who can be with the patient
For your own safety...

Remove items from around your neck
Tuck in shirt ties
No hanging jewelry
Don’t discuss personal information
Keep track of utensils, etc.
Back off, wait it out
For your own Safety…

Keep yourself between the patient and an exit

May need to obtain help – a neutral person may be able to diffuse the situation

Staff abuse is unacceptable (physical or verbal)

• Take steps to protect your safety
• Notify your supervisor
• Contact University Police as needed and complete the required injury/occurrence forms as needed
• Refer to Workplace Violence Prevention Policy Statement (Policy W-04)
The Suicidal Patient
Policy CM S-09, Suicide Precautions
Suicide Precautions

RN can initiate Suicide Precautions
  • Active suicidal thoughts and/or behaviors or
  • Admitted following an attempted suicide

• RN notifies MD – who evaluates **within one 1 hour**
  - who then writes an order to continue or not

• A psychiatric consult must be ordered by the MD to further determine need to continue

• MD order is required to D/C
Suicide Precautions: Additional SC Responsibilities

- CONTINUOUS OBSERVATION
  - The patient is NEVER left alone
  - ALWAYS 1:1 Suicide Watcher (AKA: Safety Companion)
  - Remain within “arms reach” of the patient at ALL times
    Includes showering/bathing, sleeping, toileting
    When Cleergy present, the Suicide Watcher may continue to monitor pt.
  - Documents observations every 15 min
- Suicide Watcher Voceras to conference for unit for assistance
Suicide Precautions

- Allowed off unit only for required tests/treatment
  - Constant observation must be maintained during transport and in the testing area
- Visitors, Family or Clergy can not serve as a Suicide Watcher
- Remove ALL sharps, shoe laces, belts, cords, potentially toxic substances
- No cell phones, computers, tablets (no electronic devices)
- Notify dietary for plastic utensils
- Check all utensils - accounted for after eating

ALL BAGS BROUGHT IN BY VISITORS MUST BE INSPECTED
Exceptions:

• Special Care Units, where the patient can be constantly observed.

• Psychiatric Inpatient Units (4B & 5W)

• All Corrections Officers will assume responsibility for maintaining constant observation of a suicidal inmate (not nursing) – will document on their log and nursing keeps a copy for the patient’s chart
Test Your Knowledge
Safety Companion Decision Tree

Suicide ideations or attempts
- Policy CM S 09
- Suicide Watch/Precautions
  - Suicide Watcher = 1:1
  - Ask SC:
    - Is sitter use a value to the outcome?
    - Is sitter the most effective way to use staff?
    - Is family included in PLAN?

Self Abusive and/or Danger to Self or Others
- 5 points
  - Interferes with Vital Medical Devices (coherent pt, ET, Trach tube, PICC, etc.)
  - Fall Risk with Injury
  - Policy UUH CM F07
  - Severe Behavioral or Cognitive Issues (impaired judgment, agitation, impulsivity etc.)

Unable to follow safe instructions
- 3 points
  - Incoherent pt or getting out of bed when shouldn’t, etc

Interferes with Non-Vital Medical Care
- 2 points
  - Coherent pt., pulling or dislodging NG, feeding tube, Foley, IV

Wanders – Risk for elopement
- 1 point
  - Policy UUH CM E 11 & M 03 for both campuses
  - Leaving room or unit without notification, etc

Possible interventions
- Orientation strategies
- Consider discontinuing tubes and drains
- Personal items within reach
- Family involvement
- Use door barrier
- Move closer to communication station
- Use of wander alarm
- Reinforce unit boundaries
- Use abdominal binder
- Assess adequate pain control
- Chair alarm or Bed alarm
- Ambulation
- Diversion activities
- Low to floor bed
- Use of floor mat
- Geri sleeve – cover lines
- Limit interaction with others
- Limit stimulation as needed
- Evaluate medications
- PT/OT Consult
- Soft mitts
- Self-releasing Padded Belt
- toileting
- Use of Restraint
- Environmental Modifications

Consider SC Level
- Review SCOR, RN Notes & Discuss with Caregiver Team
- Safety Assessment Score ≥ 4
  - Behavior Same or Increase
    - NO
    - YES
  - SC Level = 1:1
    - Renew Nursing Order
- Safety Assessment Score < 4
  - Discontinue SC
  - Document Reason for SC & Update Nursing Order

Interventions Successful
- NO
- YES

Attempt Other Interventions
- All Interventions Unsuccessful
- Consider SC Level
- Document & Monitor Effectiveness of Interventions

QUESTION: Cohorting, Distance SC, Purposeful Rounding Update Order

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Scenario #1

A women is being treated on the Inpatient unit for depression. She tells the nurse, “I don’t see how I can go on. I’ve been thinking of ways to kill myself. I can see several ways to do it.” What is the best initial action for the nurse?

Score = _____
SC Level_____  
Interventions:____________

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Scenario #2

An adult suffering a diving accident and is being brought in by an ambulance intubated and on a backboard with a cervical collar. He is extremely agitated due to O2 deprivation and is trying to extubate himself.

Score = _____
SC Level_____  
Interventions:___________
Scenario #3

An adult patient suffered second-third degree burns over 20% of his body 2 days ago. He is incoherent and agitated most of the time. He tries getting out of bed and restless. His family stays with him during the day and evening hours, but leave shortly after dinner.

Score = ______
SC Level_____
Interventions:__________
Scenario #4

A women who is brought in after a motor vehicle accident has suffered a head injury and possible spinal injury. She is confused and disorientated and is refusing the need for her IV.

Score = ______
SC Level_____
Interventions:____________
Scenario #5

An elderly patient was recently admitted to the hospital because of confusion, disorientation, and negativistic behavior. She has been seen wandering into other patient’s rooms. Her family states that she is in good health. The women asks you “Where am I?”

Score = ______
SC Level_____
Interventions:__________
Scenario #6

- Betty is an 87 year old patient admitted with dehydration due to GI illness. She’s confused but follows directions well. Upon admission, she had explosive diarrhea and made many attempts to get to the bathroom by herself. As she was at an increased risk for falls, a Safety Companion was assigned.

Score = _____
SC Level _____
Interventions: ___________
Betty, cont…

Her diarrhea is now resolved but she is not yet stable enough to return to her extended care facility. What could you consider as some courses of action to be related to a Safety Companion?

Score = _____
SC Level_____ 
Interventions:__________