Safety Companion

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

- Define the role of the Safety Companion
- Define levels of Safety Companion
- Differentiate between RN and Safety Companion responsibilities
- Discuss proper documentation for Safety Companion
- Differentiate between Non-suicidal and Suicidal Precautions
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

LPN, HCT, SCA, HA/UST, MHTA, MOA (In-pt)
RN Role & Responsibility (non-suicidal patient)
The **RN** will complete a “Safety Assessment” **every 8 hours** and PRN to determine a **NEED & LEVEL** of SC via the **Safety Companion Decision Decision Tree**.

- The assessment and level will be documented in the EMR.
  - The score total will *help to objectively* determine if a **nursing order** for a SC is recommended.
Safety Companion Decision Tree

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 CM F07

and/or

Severe Behavioral or Cognitive Issues (impaired judgment, agitation, impulsivity)

Consider SC Level

- Safety Assessment Score ≥ 4
  - Behavior Same or Increase
  - SC Level = 1:1 Renew Nursing Order
  - Document Reason for SC & Update Nursing Order
  
  NO
  
  YES

- Safety Assessment Score < 4
  - Interventions Successful
  - Attempt Other Interventions
  - All Interventions Unsuccessful
  - Consider SC Level

Unable to follow safe instructions
3 points

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

Possible Safety Interventions

- Orientation strategies
- Discontinuing tubes/drains
- Personal items within reach
- Family involvement
- Use STOP door barrier
- Move closer to communication station
- Use of wander guard
- Video Monitor

- Reinforce unit boundaries
- Abdominal binder
- Assess adequate pain control
- Bed alarm or Chair alarm
- Ambulation
- Diversion activities
- Low bed
- Fall mat or floor pad
- Geri sleeve – cover lines

- Limit interaction/stimulation
- Patient Safety Rounder
- Evaluate medications
- PT/OT Consult
- Soft hand mitts
- Self-Releasing padded belt
- Toileting
- Use of Restraint
- Environmental Modifications

Interferes with Non-Vital Medical Care
2 points

- Coherent pt, pulling or dislodging NG, feeding tube, Foley, IV

ASK SC:

- Is the SC use a value to the outcome?
- Is the SC the most effective way to use staff?
- Is family included in PLAN?

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

Total =____________

If total points ≥ 4: Consider use of a Safety Companion
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
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)
  - Another staff member will observe one patient while the Safety Companion addresses other patient needs.
Direct observation of the patient 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
Frequent (more than hourly) rounding on Purposeful Rounding patients ONLY as determined by the needs of the patient and RN

• Clinical Leader/Charge Nurse/Shift Coordinator determines the minimal rounding time for each patient.

• The SC will be assigned NO more than three (3) patients and will have NO other unit assignments other than “Purposeful Rounding”.

• The safety companion documents each rounding time on the Safety Companion Observation Record (SCOR) for each patient assigned.

• Inquire about the 5P’s (Pain, Positioning, Personal Needs, Possessions & P.O.)
SC Purposeful Rounding (cont.)

• 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 the RN caring for the patient and/or the Clinical Leader/Charge Nurse/Shift Coordinator.
Once the RN determines a SC is needed

- **RN**
  - Notifies the Clinical Leader/Charge Nurse/Shift Coordinator
  - Together they review alternatives attempted

- **Upon agreement**
  - RN enters Nursing Order stating the LEVEL of Safety Companion
  - SC Nursing Order expires in 8 hours

- **Clinical Leader/Charge Nurse/Shift Coordinator**
  - Notifies the Nursing Unit Manager and, Nursing Unit Director or Administrative Supervisor of the order.

- **Nursing supervisors and/or Nurse Managers are encouraged to rotate SC assignments on the same unit every 4 hours.**
Additional Alternative Option: Patient Safety Rounder

- The Clinical Leader/ Charge Nurse/Shift Coordinator
  - Determine at the beginning of each shift the need for a Patient Safety Rounder and communicate need with the staffing office.

- Will attend unit safety huddles each shift.

- Will round continuously on up to 12 patients attending to their immediate needs.
• Have no other assignment other than “Patient Safety Rounder”
• Document rounds in the electronic record as rounds are completed
• Report any concerns immediately to the unit Clinical Leader/Charge Nurse/Shift Coordinator.
Overview of Changes
Changes have been made in Epic for charting on Safety Companion needs and use in the Daily Cares/Safety flowsheets so that documentation will reflect policy. In addition, there is a change to the icon seen on the Unit Manager for those patients that have a safety companion.

What’s New?

1. New row in the Precautions group for documenting on the Patient Safety Rounder.
2. Combined Safety Companion charting into one group.
3. see the Row Information in the Details Report to determine whether or not a Safety Companion may be warranted based on the auto-calculated score.

4. If Initiated is chosen for the Safety Companion cascading row, 2 more rows populate to document what level of safety companion is in place, and what are the indications for having one.
**RN**

- **Gives verbal report to SC within 30 minutes of assignment**
  - Be specific about behaviors, interventions
  - Use Electronic Medical Record SBAR tab and (SCOR) form \((F81973)\)
  - Check in on SC periodically
- **Ensures SC is relieved for Meals & Breaks:**
  - Unit Clinical Leader/Charge Nurse/Shift Coordinator schedules coverage
  - Minimally every 4 hours

**Safety Companion**

- **Communication RN ↔ SC:**
  - SC receives report and reviews Electronic Medical Record WORKLIST w/ RN within 30 minutes of beginning assignment.
  - Document SC Level/Suicide Code and RN signature on Safety Companion Observation Record (SCOR) Form \((F81973)\), signifies RN/SC handoff
  - SC communicates observations to RN every shift and with any change in patient condition, behavior, affect, interactions or visitors.
  - Communicates any concerns that may affect SC need or level
- **Communication off-going SC ↔ on-coming SC:**
  - Gives/receives verbal report using Safety Companion Observation Record (SCOR) Form \((F81973)\)
• Family may serve as alternative to a SC
  • Determined by the RN and family members
  • Patient/family/care givers education on expectations
  • Only intervals of time
  • Documented in Electronic Medical Record & (SCOR) form (F81973)

• Continue to assess need for SC every 8 hours 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
SC Responsibilities

- Document observations on SCOR form (F81973) at least once per hour

- Be alert & aware of all patient activity and avoid any distraction

- No eating or drinking at the bedside

- Do not bring personal items into the patient’s room (backpack, purse, coats, etc.)

- No Sleeping or “resting your eyes”

- No personal activities (including but, not limited to: personal reading and/or studying, cell phone use {calls or texts} or use of other electronic devices)

- 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

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

• **Activity Cart**
  - Community: Administrative Hallway – 1st Floor
  - 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 Documentation – Every 8 hours

- Clinical justification & score
- Contributing factors
- Safety interventions attempted along with patient response & outcomes
- LEVEL of Safety Companion utilized in Medical Record
- Patient’s Plan of Care
- Patient/Family/Caregivers safety education
- RN → Safety Companion Handoff on SCOR form *(F81973)*
  - RN Signature
  - SC Level/Suicide Code

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For your own safety…

• Remove items from around your neck
• Tuck in shirt ties, no hooded sweatshirts
• No hanging jewelry, cloth handbands
• 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)
• A safety companion order is a Nursing Order

• The Registered Nurse may discontinue a provider’s order for a safety companion if the patient does not meet criteria.

• If a Licensed Medical Provider requests or writes an order for a safety companion, the Registered Nurse needs to perform a “Safety Assessment” prior to safety companion implementation.
The Suicidal Patient
Policy CM S-09, Suicide Precautions
Placing Patient on Suicide Precautions

• RN will place patient who exhibits active suicide thoughts and/or behavior, or who is admitted for attempted suicide
  ➢ Charge Nurse notifies Administrative Supervisor of 1:1 Suicide Watcher (SUWA)
• Covering MD will evaluate & determine need within 1 hour of implementation = order via EMR
  ➢ MD order is required to discontinue
• Psychiatric consult is ordered by MD to determine continued need
  ➢ Psychiatric Consultation Service – see patient daily
  ➢ STAT Psychiatric Consultation Service – for elopement/AMA
Room Preparation

- Place sign on door indicating visitors need to report to nurse’s station prior to entering room (F87612)
- Remove all sharp objects
- Remove telephone
- Limit linen
Room Preparation (cont.)

- Use paper trash can liners or limit plastic liner to 1 trash can
- Remove unnecessary cables, cords, shoe laces and equipment
- If patient transfer – communicate precautions
- Confirm window latches are secured and locked
1:1 Suicide Watcher (SUWA) means

• Constant visual observation, within-arms-reach, **visual observation of hands at all times** (including but not limited to: bathing/showering, toileting, sleeping, test/treatment)
• NO personal belongings except for quality of life items (glasses, dentures, hearing aids, etc.)
• Visitor belongings in room lockers/cupboards – nothing at bedside
1:1 Suicide Watcher (SUWA) means (cont.)

- MUST wear hospital SAFETY gowns, pants & socks (EXCEPTION: 2N)
  - DT= Linen Services & CC= Environmental Services
- Patient restricted to room unless medical team give the “OK” (PEDS = stoplight)
- No outside food allowed, order disposable precautions via EMR (PEDS = stoplight)
RN Responsibilities

• Assess patient behavior, thoughts, ideations q8h - document EMR

• Give verbal report to SUWA within 30 min of assignment
  ➢ Behaviors & interventions
  ➢ Review environmental risk assessment items NOT removed from room
  ➢ Document Observation Level (Obs. Level)/Environmental Risk Assessment (ERA) q8h
    (F81973)
Adults are NOT permitted off unit for any non-medical reason (PEDS – Stoplight)

Explain to the patient & family about these safety precautions

- Lock belongings – no outside food – pt. dress code – room restriction
SUWA Responsibilities

• **NO** other patient assignment during 1:1 Suicide Watcher/SUWA

• Communication (F81973)
  - Off-going SUWA & On-coming SUWA, document
  - Receives verbal report from RN within 30 min of assignment
  - Verbalize to RN every shift: patient condition, behavior, affect, interactions and visitors.
  - Immediate attention (STAT RN): Verbal threats/yelling, level of alertness, pulling IV/tubes, refusal to comply
  - Report to RN when patient is leaving the unit for medical reasons
• Constant visual observation, within-arms-reach, **visual observation of hands at all times** (including but not limited to: bath/shower, toileting, sleeping, test/treatment)

• Use Vocera conference feature to join unit

• Document q15min via Observation Record (**F81973 = part of medical record**)  

• Stay with patient at ALL times: tests, toileting, bathing and showering
SUWA Responsibilities (cont.)

• Stay alert & avoid distractions – be aware of patient activities
• Disposable precautions: account for ALL plastic utensils
• May step out of room, remaining just outside at physician request ONLY (examining patient)
• No eating, drinking, sleeping and resting of eyes
• No personal items or activities into patient’s room (coat, purse, cell phone)
SUWA Responsibilities (cont.)

• When possible SUWA & patient = same gender
• Request immediate assistance = harm to patient/staff/visitor
• **Continuously** monitor/document RISK ITEMS in room *(see Appendix A)*

<table>
<thead>
<tr>
<th>O2 meter/tubing</th>
<th>Toxic Substances</th>
<th>Thermometers</th>
<th>Soda Cans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cords Of Any Kind</td>
<td>Otoscope</td>
<td>Linen</td>
<td>Pens/Pencils</td>
</tr>
<tr>
<td>Wire baskets</td>
<td>Ophthalmoscope</td>
<td>Plastic Bags</td>
<td>Mirrors</td>
</tr>
<tr>
<td>Suction Gauge</td>
<td>BP Cuffs</td>
<td>Glass/Sharp Items</td>
<td>Bed/Stretcher</td>
</tr>
<tr>
<td>Blinds/Curtains</td>
<td>Stethoscope</td>
<td>Clothes Hangers</td>
<td>Chair/Sofa</td>
</tr>
</tbody>
</table>
Risk Items:
1. BP Cuff
2. Stethoscope
3. SCD Tubing
4. Extra Dirty Linen
5. Chair
6. Bed Frame
7. Telephone
8. Call Bell
9. IV Pump
10. Privacy Curtain
11. Suction Gauge
12. Over-bed Table
13. Bed-Side Stand
14. Air Conditioner
15. Blinds
16. Extra Telephone
17. Wire Basket
Psychiatric Inpatient Unit (4B and 5 West): Refer to unit specific policy PSY S-05 Suicide Precautions.

Patients who intubated and on a continuous sedative drip will require a 1:1 SUWA during any period of holding or weaning the continuous sedative drip. The Observation Record must be completed. (F81973)

Pediatric ICU: An RN or unlicensed personnel will act as the 1:1 SUWA while the patient is intubated and sedated. The Observation Record must be completed. (F81973)
Correction Officers (State & County)

- May assume responsibility for 1:1 SUWA constant observation (no nursing staff required).
- Required to document every 15-minute observations in the DOCCS log book or the County Jail log book on admitted patients including admitted inmates in the ED awaiting placement.
- A copy of the log will be obtained by the nurse caring for the patient every 8 hours & attach to Observation Record Form (F81973).
- Nursing will place a patient sticker on the copy of the log and document “Constant Observation by DOCCS/County Jail Officer”.

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