COUNTY OF LOS ANGELES DEPARTMENT OF HEALTH SERVICES
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Policy & Procedure Title:	DHS Care Companion Program		
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PURPOSE:

To describe the process of assessing and providing ongoing supervision and nursing care utilizing a Care Companion (CC). This policy delineates the roles and responsibilities of the DHS nursing staff and CCs.

DEFINITION(S):

Care Companion: A trained interdisciplinary (ID) staff member or family member responsible for supervising a patient for a specified period of time to ensure their safety.

POLICY:

It is the policy of the Department of Health Services (DHS) to provide safe and therapeutic observation of patients in accordance with patient's needs and standards of quality patient care. DHS hospitals and facilities will utilize appropriately trained CCs when necessary to provide observation for patients who may require protective supervision and interventions during specified times to ensure their safety. Interventions may include: Continuous observation by a CC, fall prevention interventions, restraint use, and/or other interventions, as indicated.

Family members who have obtained appropriate training may assist with the patient's care which must be documented in the electronic health record (EHR). Staff remain accountable for the documentation and care.

A physician order is not required to initiate or discontinue the use of a CC.

Key Point: CC for patients on Suicide Precautions Category 3 must not be discontinued until the patient is reassessed by a physician in consultation with psychiatrist/ psychologist/clinical social worker.

PROCEDURE:

A. Assessing Patients

Registered Nurses (RNs) may initiate the process of obtaining a CC as follows:

1. Assess all patients for risk requiring consideration of a CC.
2. Utilize the *Guideline to Determine Need for Care Companion Algorithm* to determine CC need (see Attachment A).
3. Consult the Supervising Staff Nurse (SSN)/Charge Nurse/designee if interventions trialed are unsuccessful. The SSN/Charge Nurse/designee must review all CC requests every shift.

B. Requesting a CC:

1. The primary RN will follow the *Care Companion Request Process* (see Attachment B) and complete the *Care Companion Request Form* (CCRF) (see Attachment C).

2. The RN completes the CCRF and submits it to the Administrative Nursing Supervisor (ANS) Office two hours prior to the start of the next shift. All supportive activities e.g., interventions trialed and proven unsuccessful, must be documented in the EHR notes section.

3. If the patient meets CC criteria, the RN will place a CC order in the EHR. Once the order is placed, the RN will receive a task list reminder every shift to review the continued need for a CC.

4. The ANS will review the CCRF to determine the level of CC need and patient's priority of need score (see Attachment B). Patients may be co-horted when appropriate.

5. Patients who score at Highest Risk (#4) on the Priority of Need Scale will be deemed a priority.

6. If the ANS is unable to provide a CC, unit management will collaborate with available resources to ensure patient safety.

7. Patients with similar CC needs may be co-horted when appropriate.

C. Discontinuing a Care Companion (CC):

1. The RN utilizes documentation, interdisciplinary communication, and *Guideline to Determine Need for CC Algorithm* to determine if CC use must continue.

2. If it is determined at any time that the CC can be discontinued, the RN must discontinue the CC order.

3. The RN will contact the ANS to advise that the CC is no longer required.

4. The RN will complete the CC Discontinued section of the CCRF and submit it to the ANS (see Attachment C).
   Key Point: CC for patients on Suicide Precautions Category 3 must <u>not</u> be discontinued until the patient is reassessed by a physician in consultation with psychiatrist/ psychologist/clinical social worker.

D. Roles/Responsibilities

1. **<u>Registered Nurse:</u>** The RN has primary patient responsibilities and will:
   a. Assess patient to determine if CC criteria has been met.
   b. Consult SSN/Charge Nurse/designee before initiating or discontinuing a CC.
   c. Initiate and document interventions' (see *Guideline to Determine Need for CC Algorithm*) success or failure in the narrative section of the Interdisciplinary Plan of Care (IPOC) in the EHR before requesting or discontinuing CC.
   d. Provide specific patient information to CC including but not limited to:
      - Obtaining, monitoring, and documenting vital signs.
      - Reporting changes in condition
      - Calling for assistance
      - Skin care, Activities of Daily Living (ADLs) assistance, diet, diagnostic testing/therapy schedule, and any other precautions.
      - Obtaining needed equipment
   e. If the patient's family will be assisting with CC responsibilities, provide education regarding the need for constant observation of the patient's condition and precautions that must be maintained to ensure the patient's safety. Provide the family with the *Care Companion Patient Family Education Fact Sheet* (see Attachment D) and document the education and provision of the fact sheet in the patient education section of the EHR. Provide additional educational material based on the patient's specific CC needs.
   f. Consult CC hourly and as needed on patient's condition or needs.
   g. Reassess continued CC need every shift.
   h. Provide CC break relief

i. Discontinue CC when patient's behavior improves or interventions prove successful.
Key Point: CC for patients on Suicide Precautions-Category 3 must <u>not</u> be discontinued until the patient is reassessed by a physician in consultation with psychiatrist/psychologist/clinical social worker.

j. Review CC documentation in the EHR every shift, check to continue or discontinue CC use in appropriate box, and document signature, date, and time reviewed. RN will review and sign in the EHR at the end of the shift.

k. Provide CC shift change report.

2. **<u>SSN/Unit Charge Nurse:</u>**
   a. Consult with primary RN assigned.
   b. Adjust nursing assignments to provide CC.
   c. Notify ANS/Nurse Manager (NM) of CC need.
   d. Assess patient, in coordination with the primary nurse, every shift to determine continued CC need.
   e. Ensure the CC has meals/breaks relief.

3. **<u>Administrative Nursing Supervisor</u>**
   a. Review CCRFs 2 hours before start of next shift.
   b. Score each patient's Priority of Need based on the 1-4 rating scale (see Attachment B).
   c. Assign CCs based upon Priority of Need scores and coordinate with unit management on a plan of care if CCs are not available.
   d. Maintain a log of all patients requiring a CC.

4. **<u>Care Companion (CC)</u>**
   a. Report to SSN I/Charge Nurse/designee on assigned unit.
   b. Receive hand-off communication from primary RN.
   c. The CC should remain within close contact of patient and maintain an unobstructed view of patient at all times. If the CC is unable to remain with or within view of the patient, CC will notify primary RN so an alternate CC can be assigned.
   d. When patient is leaving the unit for therapies or other tests, communicate level of supervision needed to next accountable caregiver.
   e. Ensure environmental safety.
   f. Remain alert at all times. Use of cell phones, watching TV, reading other than with patient, or eating is not permitted.
   g. Provide rehabilitation nursing care such as:
      - Assist with meals/fluid intake, complete dietary menus, and provide snacks.
      - Assist with toileting. Accompany the patient to and remain with the patient in the bathroom.

- Remain with the patient during transport for tests/procedures.
- Assist with ADLs and ambulation.
- Position/transfer to/from chair or bed
- Take vital signs and report significant finding(s) to the primary nurse.
- Provide rehabilitative and/or distraction activities.
- Report behaviors and other pertinent clinical observations to the primary RN.
- Engage patient in ID activities.
- When assigned patient is in therapy, contact SSN/Charge Nurse/designee for additional duties.
- Complete required CC documentation in the EHR.
- Provide hand-off report to the incoming CC.

ATTACHMENTS/FORMS:

Guide to Determine Care Companion Need (Attachment A)
Care Companion Request Process (Attachment B)
Care Companion Request Form (Attachment C)
Care Companion Patient/Family Education Fact Sheet (Attachment D)

REFERENCE(S)/AUTHORITY:

Bock, T., J. (2016). Patient care sitter reduction and fall safety improvement. *Doctor of Nursing Practice (DNP) Projects, 79*, pg 1-114. Retrieved from https://repository.usfca.edu/dnp/79

Rochefort, C., M., Buckeridge, D., L. & Abrahamoqicz, M. (2015). Improving patient safety by optimizing the use of nursing human resources. doi: 10.1186/s13012-015-0278-1

Tom, Colman. (2016). Improving patient safety through patient safety aide (sitter) competency education. *Nursing Thesis and Capstone Projects, 256.* Retrieved from: http://digitalcommons.gardner-webb.edu/nursing_etd/256

DHS Policies
311.101 – DHS System-Wide Fall Prevention Program
321.100 – Violent and Non-Violent Restraint & Seclusion

Rancho Los Amigos National Rehabilitation Center (RLANRC)
Administrative Policy B806 – Suicide Precaution
Administrative Policy B814 – Violent and Non-Violent Restraints
Administrative Policy B814.3 – Code Gold Behavior Response Team
Administrative Policy B868 – Care Companion
Nursing Clinical Policy/Procedure C211 – Care Plan Process and In-patient Documentation