Care Companion Guidelines

Purpose- the purpose of a Care Companion (CC) is to carefully watch a patient so they do not fall or injure themselves. These guidelines are to help guide the CC to know what to look for and how to react to patients as they are being observed.

1. The CC stays in close proximity of the patient at all times. Ideally this means line of sight of the patient.
2. The CC should give their entire attention to the patient
    a. Do not leave the patient unattended for any reason.
    b. Do not engage in any activity that will prevent you from closely observing the patient for example- reading, looking at your phone, watching TV, etc.
    c. Do not sleep or rest your eyes.
    d. Do not have personal items.
3. Patients must be watched carefully to prevent them from falling or injury.
    a. If a patient has an identified need – the CC must call the RN or CNA to assist- potential needs include:
        i. Pain
        ii. Bathroom
        iii. Positioning in the bed
    b. If a patient has a request for an item in the room – the CC can assist the patient- needs include:
        i. The patient's cell phone
        ii. Book
        iii. Dietary items
4. Notify the nurse with any problem for difficulties, or if you need to leave the patient. Utilize the call light system to contact the nursing station and or primary nurse. You may call the nurse directly utilizing the nurses' hospital issued cell phone.
5. Do not leave the patient for personal time- breaks, etc. until another staff member relieves you. Please do not take longer than your allotted time as this affects the staff's ability to help other patients.
6. No documentation is required to complete this role.
7. The CC will give a verbal report of the patient's status to the oncoming CC or person relieving them.

I have read and understand the above CC guidelines related to keeping our patients safe. I will adhere to these expectations to help ensure effective handoff communication and safety for our patients.

_____ _____

Staff Name Staff Signature

_____

Date and Time

AT THE FOREFRONT
UChicago Medicine
Ingalls Memorial

Ingalls Memorial Hospital
Policies, Standard Work, and Guidelines

☒**Policy** ☐**Standard Work** ☐**Guideline**

Name: Discharge; Against Medical Advice
Number: PCS-022
Issue Date: Click here to enter a date.
Reviewed Date: 6/10/2020

Policy:

1. Ingalls Memorial Hospital recognizes the right of a competent adult to leave the Hospital against medical advice.

2. Minors do not have the right to leave against medical advice. Their parents may not remove them from the Hospital against medical advice if removal would create a substantial risk of physical injury to the minor or otherwise prevent the minor from receiving medically indicated treatment as necessary for the minor's well-being. Please consult: Abuse- Treatment and Reporting of Suspected Child Abuse and Neglect PCS Policy-043

Definitions:

1. **Adult** – For purposes of this policy, an individual who is eighteen (18) years of age or older.

2. **Competent** - An adult who, in the judgment of a physician, has decision-making capacity to understand the risks and consequences of leaving the Hospital against medical advice, the benefits of remaining in the Hospital, and any available alternatives.

Procedure:

1. When a patient expresses a desire to leave the Hospital against medical advice, a physician should assess whether the patient has the requisite decision-making capacity to understand the risks of leaving, the benefits of remaining in the Hospital, and any available alternatives.

a. Consultation with a psychiatrist where appropriate may be helpful, but is not required.

b. Consultation with the Ethics Consultation Service may be helpful, but is not required.

2. Competent Patient - If the physician determines that the patient has decision-making capacity according to the criteria set forth above, the physician:

a. Should document the conversation with the patient, his/her conclusions about the patient's decision-making capacity, and the reasons for that conclusion in the patient's medical record.

b. Should encourage the patient to remain in the Hospital. If the patient has consented to release of confidential medical information to family members or others, these individuals may be contacted to discuss the patient's wishes and to enlist their assistance.

c. Discuss with the patient and any others to whom the patient has authorized release of medical information, the risks and consequences of a discharge against medical advice, the benefits of remaining in the Hospital, and any available alternatives. These discussions should be documented in the medical record.

d. Should inform the patient that the Hospital has no obligation to re-admit a patient discharged against medical advice.

e. Should inform the patient that some insurance companies may refuse to pay for some or all care provided to a patient who is discharged against medical advice, and that in such a case the patient will be responsible for payment.

f. Should complete the Form 522, "Release for Leaving Hospital Against Medical Advice (AMA), which is attached and obtain the patient's signature and place the form in the medical record. If the patient refuses to sign the form, the physician should document this fact, and place the partially completed form, in the medical record.

g. May provide the patient with prescriptions and discharge instructions if clinically appropriate and in the best interest of the patient.

h. May assist with transport if reasonable to their destination.

3. Patient Is Not Competent - If the physician believes that the patient is not competent and cannot make an informed refusal of treatment, the physician should not permit the patient to be discharged against medical advice. The physician may have an obligation to keep the patient against his/her wishes in order to protect the patient from serious harm. The incompetent patient may be kept in the hospital if the surrogate decision maker authorizes continued hospitalization, if a court or legal guardian authorizes continued hospitalization, or if the patient meets the criteria for involuntary psychiatric admission.

- The physician may contact the Ethics Consultation Service, Psychiatry, Risk Management, or Legal Affairs to discuss alternative approaches.

4. Patient Presents Danger to Himself or Others - If the physician believes that the patient presents a danger to himself or others, a Psychiatry consult may be obtained. If the patient has explicitly stated an intention to harm another, the Security Office shall be notified, and the patient should not be permitted to leave the Hospital. When the name of a potential victim is known, reasonable efforts should be made to notify that person.

5. If the patient leaves the hospital and is deemed not competent, confused, a risk to themselves, a risk to others, has an active petition and or certificate, and or the staff member has concerns related to their departure, the appropriate Nurse Manager/APCM/Hospital Operations Administrator (HOA) should be notified immediately. The Risk Manager on call should be notified immediately. An Occurrence Report should be completed. A notation of the incident should be included in the electronic health information record.

6. When a patient leaves the hospital without the knowledge of the hospital personnel and is deemed competent, after thorough search of the surroundings, the appropriate Nurse Manager/APCM and HOA, should be notified immediately. The attending physician and family should then be called by the Primary RN or Nursing leadership. The local police may be notified by the Security Department after discussion with the HOA. A notation of the incident should be included in the electronic health information record and an Occurrence report should be completed.

Refusal of Transport via Ambulance

Ambulance transport for hospital admission is not required for all patients. Physician clinical decision will determine the need for ambulance transport. A notation of the decision by the physician for ambulance transport should be included in the electronic health information record.

If a competent adult requires ambulance transport and is not a risk to themselves, a risk to others, does not have an active petition and or certificate, yet refuses the recommended ambulance transport, the following should be completed:

a. Documentation of the conversation with the patient, his/her conclusions about the patient's decision-making capacity, and the reasons for that conclusion in the patient's medical record.

b. Should encourage the patient to be transported by the ambulance. If the patient has consented to release of confidential medical information to family members or others, these individuals may be contacted to discuss the patient's wishes and to enlist their assistance.

c. Discuss with the patient and any others to whom the patient has authorized release of medical information, the risks and consequences of a refusal of ambulance transport, the benefits of ambulance transport, as well as the risk of death if applicable. These discussions should be documented in the medical record.

d. Should complete the Form 2859. "Release for Refusing Ambulance Transport to a Higher Level of Care", which is attached and obtain the patient's signature and place the form in the medical record. If the patient refuses to sign the form, the physician should document this fact, and place the partially completed form, in the medical record.

Cross- References:

Ingalls Policy PCS-043 Abuse- Treatment and Reporting of Suspected Child Abuse and Neglect

Interpretation, Implementation, and Revision:

Patient Care Services and Risk Management are responsible for the interpretation, implementation, and revision of this policy.

Attachments:

Attachment A: Release for Leaving Hospital Against Medical Advice (AMA)
Attachment B: Release for Refusing Ambulance Transport to a Higher Level of Care

AT THE FOREFRONT
UChicago Medicine
Ingalls Memorial

Patient Label

RELEASE FOR REFUSING AMBULANCE TRANSPORT TO A HIGHER LEVEL OF CARE

I, _____ (*Name of Patient*), have been instructed by Dr._____(*Name of Physician*) that as a result of my current medical condition, it is recommended that I be transported by ambulance to a health care facility that can provide a higher level of care. The physician has fully explained to me the reason for this recommended method of transportation, its risks and benefits including, but not limited to_____ and the potential consequences of not consenting to ambulance transport, **including but not limited to a deterioration of my medical condition and/or death**. I have had the opportunity to ask questions about my medical condition and the recommendation for transport, and my questions have been answered to my satisfaction. Without formal discharge by a physician, and against the medical advice of the physician, I am refusing ambulance transportation.

I understand that my failure to follow the physician's advice may seriously affect my health, and may result in serious injury or death. By signing below, I accept full responsibility for my decision to refuse ambulance transport, and any consequence of my refusal. I hereby release the hospital, its agents, employees and independent members of its medical staff and their assistants who were in any way connected with my care, from refusing transportation by ambulance to a higher level of care.

I acknowledge that I have read and understand this form and that all blank spaces on this document have been completed prior to my signing.

Signature:_____ Date:_____ Time: _____
(Patient or Legally Responsible Person) (Relationship)

Witnesses:

Name (Printed): _____ Relationship to patient: _____

Name (Printed): _____ Relationship to patient: _____

FOR COMPLETION BY HOSPITAL PERSONNEL:

On_____, _____
(Date) (Patient or Legally Responsible Person) (Relationship)

_____refused transportation by ambulance (signed above Statement and Release)
_____refused to sign the above Statement and Release

Signed:_____ _____
(Hospital Personnel) (Date)

Name (Printed):_____
(Hospital Personnel)

_____
(Signature of Interpreter)

Date:_____. Language: _____.

AT THE FOREFRONT
UChicago Medicine
Ingalls Memorial

Release for Leaving Hospital Against Medical Advice (AMA)

I, _____ (*Name of Patient*), have been told by Dr._____(*Name of Physician*), that it is medically necessary for me to stay in the hospital. The physician has explained the recommended treatment/procedure, its risks and benefits, and the probable consequences of not receiving the recommended treatment/procedure and leaving the hospital, **including but not limited to a deterioration of my medical condition and/or death**. I have had the opportunity to ask questions and they have been answered to my satisfaction. Without formal discharge and against the advice of the physician, I refuse further medical care and treatment and wish to leave the hospital.

I understand that my failure to follow the physician's advice may seriously affect my health. By signing below, I accept full responsibility for my refusal and for what may happen because of my refusal. I release the hospital, its agents, employees and independent members of its medical staff and their assistant who were in any way connected with me as a patient, from liability for any ill effects from leaving the hospital against medical advice.

I acknowledge that I have read and understand this form and that all blank spaces on this document has been completed prior to my signing.

Signature: _____ Date: _____ Time: _____
(Patient or Legally Responsible Person) (Relationship)

Physician Signature: _____ Date: _____ Time: _____

If the physician is unavailable for signature, the RN may sign as a witness. The RN must have contacted the physician and confirmed that the physician spoke to the patient about the patient's refusal of further medical care and treatment and wish to leave the hospital against medical advice.

RN Signature: _____ Date: _____ Time: _____
After speaking with: Dr._____(*Name of Physician*)

If patient is unwilling to speak to physician, the RN must complete the following:

I, _____ (*Name of Patient*), have been told by my registered nurse _____, that it is medically necessary for me to stay in the hospital. I am refusing to wait to speak with my physician, Dr. _____(*Name of Physician*), to discuss the risks and probable consequences of my leaving against medical advice.

Signature: _____ Date: _____ Time: _____
(Patient or Legally Responsible Person) (Relationship)

If the Physician or RN is unable to obtain patient's signature, complete the following *(circle one)*:

1. Patient refused to sign.
2. Patient eloped. Unable to obtain signature.

Physician/RN Signature:_____ Date: _____ Time: _____

If interpreter is utilized, complete the following:

Interpreter Signature: _____ Date: _____ Time: _____
Language: _____

AT THE FOREFRONT
UChicago Medicine
Ingalls Memorial

Fact or Fiction?
The Facts about Decisional Capacity/Competent Adults

Competent Adult - An adult who, in the judgments of a physician, has decision-making capacity to understand the risks and consequences of decisions related to his/her healthcare.

Decisional Capacity: An adult (over the age of 18 or an emancipated minor) that has the ability to make their own health care decisions.

MYTH

Only psychiatry services can determine a patient's decisional capacity/competency.

FACT

Any Attending Physician can determine decisional capacity/competency. If decisional capacity/competency is in question, ensure that clear documentation on determination of decisional capacity/competency is documented in the EMR.

MYTH

If a patient is seen/admitted for a psychiatric concern or has a psychiatric history, they are deemed non decisional and incompetent

FACT

Just because the patient is being seen/admitted for a psychiatric concern or has a psychiatric history, this **DOES NOT** mean they are not decisional/competent. The physician should determine the patient's decisional capacity/competency. This should be completed on a case by case basis. If decisional capacity/competency is in question, this should be documented in the EMR by the physician.

MYTH

A patient **MUST** have a COVID test prior to admission

FACT

While we should strongly encourage a COVID test for each and every admission, we should **NEVER** restrain a patent to obtain a COVID test or to complete any other testing medically unnecessary regardless of their decisional capacity/competency.

**If the patient refuses COVID testing, admit to an appropriate unit as a patient under investigation. Ensure documentation reflects this refusal and the receiving MD and RN are aware.

MYTH

If the RN is unsure of the patient's decisional capacity, they should just go with their gut.

FACT

Any questions regarding decisional capacity should be escalated to the Attending Physician for further evaluation and discussion.

If there are any questions regarding decisional capacity or competency, do not hesitate to reach out to Risk Manager on Call at 3939 or via the paging directory.

Office of Risk Management

June 2020

AT THE FOREFRONT
UChicago Medicine
Ingalls Memorial

I acknowledge that I have received this policy. Name: _____

B H 0 0 0 9

Restraint Checklist (Inpatient, ICU, Rehab, ED, Wyman Gordon)

- ☐ Initial order timed when restraints applied Time: _____
- ☐ 4 Hour re-order Time _____**(Violent Restraints Only)**
- ☐ Initial order indication
- ☐ Attending notified
- ☐ Call Code 10 (Violent Restraints Only)
- ☐ Notify Risk Manager On-Call (1111) **(Violent Restraints Only)**
- ☐ Notify Charge RN
- ☐ Monitoring flowsheet initiated (Q15/Q2)
- ☐ Document "Appropriate Restraint Management" on Plan of Care
- ☐ Guardian/Family notified
- ☐ Occurrence report completed
- ☐ Leadership notified (Supervisor, Manager, HOA)
- ☐ MD face to face completed **(Violent-1hours; Non-violent-8 hours)**
- ☐ Monitoring Flow Sheet completed
- ☐ RN completed hourly assessments
- ☐ RN completed Release Note Time _____**(Violent Restraints Only)**

Additional for Wyman Gordon Patients

- ☐ Episode placed in Crisis Intervention Log
- ☐ Restriction of Rights Completed
- ☐ BH Administrator on call notified of any restraint used
- ☐ BH Administrator on call notified for any injury to patient or staff
- ☐ Patient debriefing completed
- ☐ Staff briefing completed and placed in Director of Nursing Mailbox

Signature: _____

AT THE FOREFRONT
UChicago Medicine
Ingalls Memorial

BH2069 - Seclusion and Restraint One Hour

Seclusion and Restraint

Medical-Surgical-Critical Care Violent Restraint

One Hour Face to Face Evaluation

RN

Initiation of Intervention:	**Date:**	Time:

Type of Intervention:	**Reason for Hold:**
☐ Soft Restraint ☐ Seclusion ☐ Violent (Specify) _____	Prevent Harm to: ☐ Self ☐ Other ☐ Escort ☐ Others (Specify)

Describe behaviors and/or events leading up to seclusion or restraint:

Patient reaction to intervention:

MD

☐ **Attestation** – Reviewed events Agree with need to continue restraints

☐ **Assess:** I affirm I've completed (F2F) face to face evaluation,
Key findings are:

_____

☐ **Progress Note Completed.**

Name:	**Signature:**	**Date:**	**Time:**

Form#2857 (2/2020)

AT THE FOREFRONT
UChicago Medicine
Ingalls Memorial

BH0067 - RN Seclusion or Restraint Note

Department of Patient Care Service Restraint Note

Patient Name:	Date of Intervention:	Time of Intervention:
Type of Intervention: o Physical Restraint o Seclusion o Violent Restraint		

Clinical Justificaiton for Initiation of Seclusion or Restraint

Describe all specific incidents or behaviors that led to the patient being secluded or restrained:

Patient was imminently dangerous to o Self o Others as evidenced by:

Describe the least restrictive measures that were tried prior to seclusion or restraint

- o Therapeutic Limit Setting
- o Active Listening
- o Reducing Stimuli
- o 1:1 Verbal Interaction
- o Offering Voluntary Time Out
- o PRN Medications
- o Physical Exercise / Recreation
- o Drawing
- o Snack / Drink
- o Calming Exercises
- o Journal Writing
- o Music or Television
- o Other patient identified intervention (specify):

Describe the measurable and observable behavioral criteria for discontinuation:

Patient will no longer be a danger to self and others as evidenced by:
- o Patient is physically calm and able to cooperate with redirection
- o Patient is no longer threatening and displays behavioral control
- o Other, describe:

o These criteria have been reviewed with the patient in terms the patient can understand

Does the patient have any complaints of pain or injury? o No o Yes (describe)_____

Any signs of respiratory distress? o No o Yes (describe)_____

Special considerations such as disability, asthma, history of seizure? o No o Yes (describe)_____

History of physical, sexual or emotional trauma? o No o Yes (describe)_____

Does the restraint or seclusion pose an undue risk to the patient's health? o No o Yes (describe accommodations made to minimize risk)

Was the patient and/or room checked for contraband? o Yes o No (why?)

Qualified RN was called to perform 1 Hour Face to Face Evaluation: o Yes (who?) Date/Time of Call:

Was patient's family/parent/guardian/other notified? o Yes (who?)

(Always notify the parent or guardian of minors) o No (why?)

o N/A (none identified by adult pt.)

Plan of Care: Safety

- Direct observations at all times
- Security measures explained to patient/family
- Redirect patient to calm state
- Monitor food/fluid intake

Expected Outcome: Patient remains free of injury

RN Printed Name:	RN Signature:	Date/Time

Release Note

Date of Release: Time of Release: Total Time of Intervention:

Describe the patient's behavior at the time of release from seclusion or restraint:

Describe the patient's physical condition at the time of release from seclusion or restraint:

Does the patient have any complaints of pain or injury at the time of release? o No o Yes (describe below)

RN Printed Name:	RN Signature:	Date/Time

AT THE FOREFRONT
UChicago Medicine
Ingalls Memorial

B H 0 0 6 8

Patient Care Services
Seclusion/Restraint Monitoring Flow Sheet

Type of Intervention: o Physical Restraint o Seclusion o Violent Restraint

Time in_____ Time out_____ Time in_____ Time out_____ Time in_____ Time out_____

Physical Hold 15 minutes or less? o Yes o No Reason for Hold: o Prevent harm to self/others o Escort to o Other

The patient is to be observed and monitored on a continuous basis during the utilization of seclusion or restraint. Documentation is to occur every 2 hours or more frequently as appropriate to physical, emotional and safety needs or as condition changes. Vital signs are to be monitored every 2 hours unless contraindicated by patient's condition or more frequently per physician order.

Each of the following areas need to be evaluated every 2 hours:

Date/Time	BP:	Pulse:	Resp:	Pain or Injury? *Describe:* o Yes o No

Skin Integrity		Respiratory Status: o WNL o Hyperventilating o Labored Breathing
		o SOB o Other (specify) _____
Circulation ROM		Position or Restraint non-restrictive to lung expansion o Yes o No
		Staff Intervention:
Patient's Current Behavior		Staff Printed Name:
		Staff Signature with credentials:

Can seclusion or restraint be safely discontinued? o Yes (if yes complete reference note) o No

Date/Time	BP:	Pulse:	Resp:	Pain or Injury? *Describe:* o Yes o No

Skin Integrity		Respiratory Status: o WNL o Hyperventilating o Labored Breathing
		o SOB o Other (specify) _____
Circulation ROM		Position or Restraint non-restrictive to lung expansion o Yes o No
		Staff Intervention:
Patient's Current Behavior		Staff Printed Name:
		Staff Signature with credentials:

Can seclusion or restraint be safely discontinued? o Yes (if yes complete release note) o No

Date/Time	BP:	Pulse:	Resp:	Pain or Injury? *Describe:* o Yes o No

Skin Integrity		Respiratory Status: o WNL o Hyperventilating o Labored Breathing
		o SOB o Other (specify) _____
Circulation ROM		Position or Restraint non-restrictive to lung expansion o Yes o No
		Staff Intervention:
Patient's Current Behavior		Staff Printed Name:
		Staff Signature with credentials:

Can seclusion or restraint be safely discontinued? o Yes o No

AT THE FOREFRONT
UChicago Medicine
Ingalls Memorial

Department of Patient Care Services
Precaution Flow Sheet

Date:_____ Precautions: (circle all that apply)

Observations (circle one)
Check every 15 min
Line of Sight
Line of Sight–common areas
1:1

Elopement Seizure
Suicide Sexual
Assault Arson
Falls Homicide Precaution
Other:_____

Location Key:

R-Room DR-Dining Room
NS-Nurse's station BR-Bathroom
H-Hall OTV-Open TV Room

OH-Off Unit IC-In Conference
QR-Quiet Room

Activity/Behavior Key:

1. Awake
2. Calm
3. Crying
4. Eating
5. Flat
6. Group
7. Hyperactive
8. Lying Down
9. Mild Agitation
10. Non-responsive
11. Pacing
12. Phone
13. Quiet
14. Refusing to participate
15. Responding to internal stimuli
16. Restraints
17. Severe Agitation
18. Showering
19. Sitting
20. Spit Hood
21. Standing
22. Talking
23. Verbal aggression/threats
24. Walking
25. Watching TV
26. With visitors
27. Yelling
28. Other_____

Time	Location	Activity/ Behavior	Initials	Time	Location	Activity/ Behavior	Initials	Time	Location	Activity/ Behavior	Initials	Time	Location	Activity/ Behavior	Initials	Printed Name/Signature/Credentials	Initials
0000				0600				1200				1800					
0015				0615				1215				1815					
0030				0630				1230				1830					
0045				0645				1245				1845					
0100				0700				1300				1900					
0115				0715				1315				1915					
0130				0730				1330				1930					
0145				0745				1345				1945					
0200				0800				1400				2000					
0215				0815				1415				2015					
0230				0830				1430				2030					
0245				0845				1445				2045					
0300				0900				1500				2100					
0315				0915				1515				2115					
0330				0930				1530				2130					
0345				0945				1545				2145					
0400				1000				1600				2200					
0415				1015				1615				2215					
0430				1030				1630				2230					
0445				1045				1645				2245					
0500				1100				1700				2300					
0515				1115				1715				2315					
0530				1130				1730				2330					
0545				1145				1745				2345					

SAFETY ATTENDANT VERSUS CARE COMPANION
4/20/2020

Safety Attendant

- 1:1 observation with patient who is suicidal, homicidal, or certified.
- Order must be placed in chart.
- SA documents every 15 minutes on flowsheet.
- Immediately intervenes if patient tries to harm self/others/leave by verbally de-escalating patient and notifying primary nurse.

Care Companion

- May provide observation for up to 4 patients at a time who are NOT suicidal or homicidal.
- Examples of appropriate indications for care companions: pulling at lines, confusion, fall prevention.
- No order for care companion needed nor should order be entered into chart.
- Care companions do not document on flowsheets or in patient's chart.
- Intervenes by verbally reorienting/deescalating patient and notifying patient's primary nurse if additional interventions are required.

RN/Safety Attendant/Care Companion SBAR Report Tool

Room_____ Patient Name_____ Age_____ Sex: (Circle One) M/F

Nurse Name & Extension_____ Charge Nurse Name & Extension_____

ID Band On: ((Verify band on and circle once verified) YES

You are sitting with this patient in the capacity of a: (circle either 1:1 Safety Attendant or Care Companion and reason):

1:1 Safety Attendant: The reason for sitting with this patient is:

(circle one) Suicidal/Homicidal/Certified Care/Other_____

You will need to document every 15 minutes on the paper flowsheet

—-or——

Care Companion: The reason for sitting with this patient is:

(circle all applicable) confused/fall prevention/pulling at lines/tubes/drains/wandering

You will not need to document on a flowsheet

S (Situation): Food Allergies_____ Code Status_____ Diagnosis_____

Mental Status_____ Restraints: (circle one) Y/N Precautions_____

Isolation_____ Fall Risk: (circle one) Y/N Turn Schedule_____

B (Background): Pertinent Medical History_____ Blood Sugar Frequency_____

Vital Sign Frequency_____ Calorie Count (circle one) Y/N Daily Weight (circle one) Y/N

Activity_____ TEDS/SCDS (circle if applicable) O2 Device_____

A (Assessment): Significant Events/Data/Information/Patient and Family Preferences_____

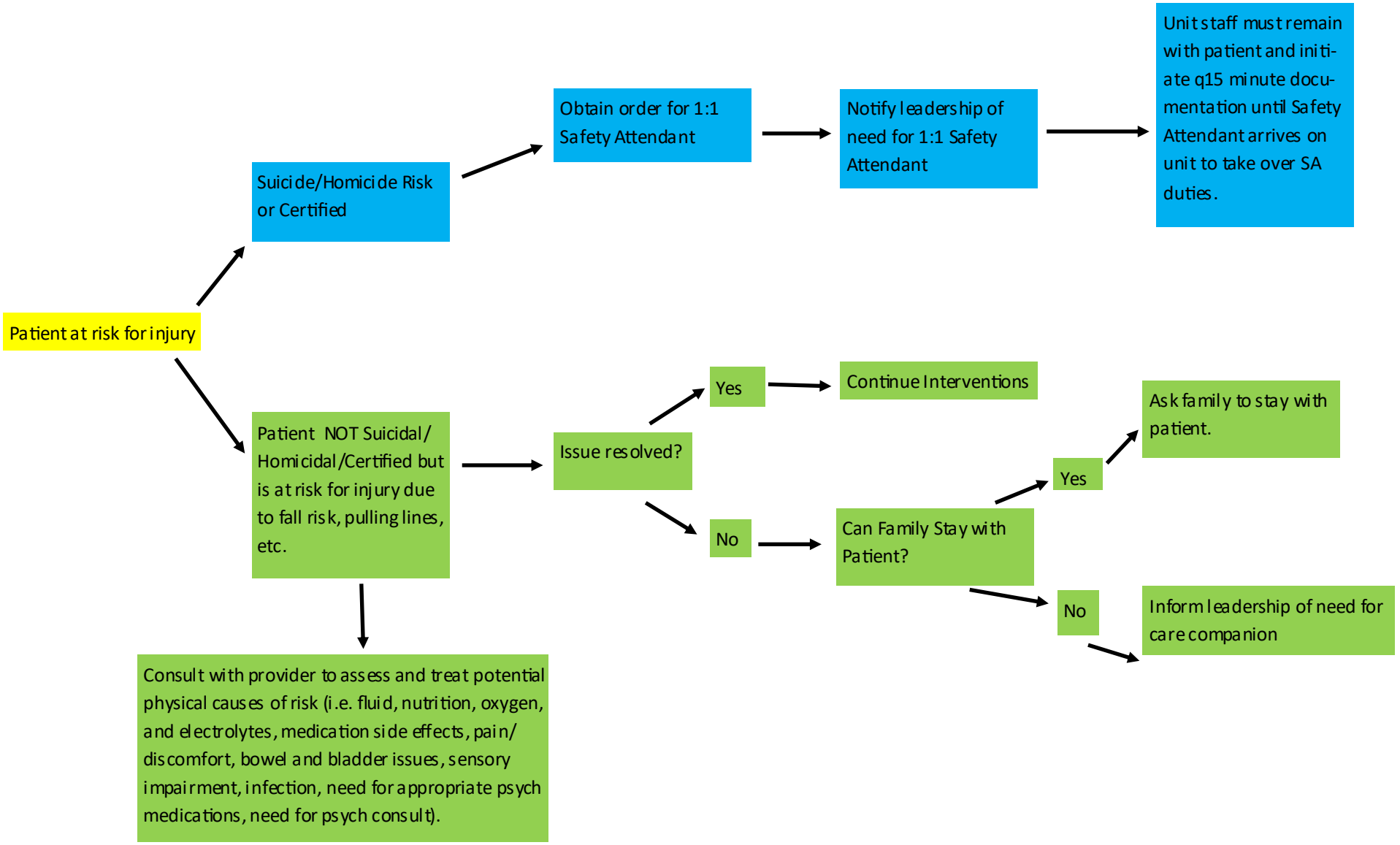
_____

_____

R (Recommendation): What should the oncoming shift know about this patient?

_____

_____


Patient at risk for injury
Suicide/Homicide Risk or Certified
Obtain order for 1:1 Safety Attendant
Notify leadership of need for 1:1 Safety Attendant
Unit staff must remain with patient and initiate q15 minute documentation until Safety Attendant arrives on unit to take over SA duties.
Patient NOT Suicidal/ Homicidal/Certified but is at risk for injury due to fall risk, pulling lines, etc.
Issue resolved?
Yes
Continue Interventions
No
Can Family Stay with Patient?
Yes
Ask family to stay with patient.
No
Inform leadership of need for care companion
Consult with provider to assess and treat potential physical causes of risk (i.e. fluid, nutrition, oxygen, and electrolytes, medication side effects, pain/ discomfort, bowel and bladder issues, sensory impairment, infection, need for appropriate psych medications, need for psych consult).

Patient Transportation Standard Work

Process Owner: Patient Transport | **Department: Patient Transportation** | **Revision Date: 4/13/2020**

Work Sequence: Picking Up/Returning Patient

1. Once transporter has called the Interactive Voice Response system IVR (4031) and accepted an assignment, the transporter responds to the assignment with a sense of urgency.
    - There should be no "Cart" assignments that require an assist. If a transporter requires help on a cart job, please call the call center and explain why.
    - If mode of travel is "Bed" Transporter requests assist only if needed once arrived to the unit and it has been established that a second transporter is needed. If you need training on how to move a bed on your own please ask management.
        - Secondary transporter does not go in progress or completes the job due to the primary transporter having full control.
2. Transporter heads to assigned origin with a sense of urgency .
3. Transporter logs into the IVR (4031) and updates status to "In progress" immediately once arrived to the testing site.
4. Transporter informs RN/CA of their arrival. Transporter hits call light on remote and waits until RN/CA arrive to the patient room.
5. Transporter completes hand hygiene before entering and exiting patient's testing site room.
    - Introduce self by following AIDET and proper scripting.
    - Identify patient by name, ask to see the patient ID band and verify the name with your pager.
        - *"Hello Mr. Smith, can I please check you ID band for patient safety?"*
6. Assist with any final preparation of patient within transporter scope.
    - See steps A-C if delayed. If cancelled, follow cancellation scripting.
7. If isolation, follow PPE protocol. Perform hand hygiene.
8. If returning patient back to their room, use call light button to inform patient's care team (consisting of NSA, PCT, RN, Charge RN) of patient's arrival back to their room.
9. Transporter does not leave the patient until (NSA, PCT, RN, Charge RN) arrive inside the patients room and handoff is completed, If delay more than 10 min please notify the Charge nurse or call the NPC at #2773
10. Transporter helps the patient to the bed. Ask for nursing assistance if the patient needs to be transferred.
11. Before leaving, transporter informs patient of their departure by following proper scripting. Please make sure the patient has the call light before leaving.
    - Transporter checks to see if patient has any requests before they leave them.
12. Complete proper hand hygiene practice (washing your hands is a must when the patient is isolation or your hands are visibly dirty). Properly disinfect equipment.
13. **While at destination location**, sign patient into logbook, (Notify RN or Charge Nurse if there is no Logbook available) call in to the IVR(4031) to complete current assignment and listen for next assignment.
    - Do not complete the assignment outside of the patient transportation department.
14. Transporter responds to the next assignment with a sense of urgency.
    - If no jobs pending, continue checking Teletracking every 5 minutes unless you get a page to pick up a job in between the 5 minutes.
        - Do not depend on the pager to tell you when there is a job for you.

Completing assignments outside of the destination or locations specified in the standard work will be considered unsatisfactory work performance with progressive

Inventory: stretcher, wheelchair, PDI Sani wipes, gloves
Cycle Time: 18 minutes or less

Delay Process:
A. Using the IVR system, phone into Teletracking to enter the appropriate delay reason, if one is observed.
B. After 7 minutes of delay, inform clinical care team that transporter will need to cancel (see script below).
C. Notify Call Center (2773) of assignment cancellation.

Cancellation Scripting
Excuse me _(RN)_, I have been on delay for my maximum allowed time of 7 minutes. I will have to cancel this transport request in order to respond to the next patient. Please re-enter the task when your patient is ready for travel. Thank you.

AIDET

A – Acknowledge
I – Introduction
D – Duration
E – Explanation
T – Thank you!

AT THE FOREFRONT
UChicago Medicine
Ingalls Memorial

Environmental Round Standard Operating Procedure

Every time you observe a patient that is on 1:1 suicide precautions, you should be observing for any items that might be a safety risk or be on the contraband list. Environmental Rounds are one of the primary ways to ensure the safety of the patients. It is essential that they be done thoroughly upon admission, every shift, and after each visitor leaves the room. Below are the steps to be taken when doing Environmental Rounds:

- Glove up and have the linen bin with you as well as a paper garbage bag.
- While you are certainly looking for any items on our Contraband List, you should also note any items that you think may create a safety concern and discuss those items with the charge nurse when the Environmental Rounds are completed.
- Patient Room
    - Check all open floor space and window sills, especially for excess gowns or clothing. (Excess gowns, linens, or towels should be placed in the laundry bin.)
    - Be sure to check the window sills and all drawers.
    - If patient has papers/books, lift and shake for any loose/hidden items and restack neatly.
    - Check the storage spaces of the bedside tables.
    - Run your hands over the top and sides of the mattress to check for items between the sheet and the mattress.
    - Pat down pillow to check for items hidden inside.
    - Lift the mattress from multiple angles to check the entire space underneath the mattress.
    - Visually inspect the space between the bed frame and wall, desk and wall and bedside table and wall. If items are visible, remove them and determine if item can remain in room.
    - Check under desks and chairs
    - Visually inspect items in wastebaskets (empty if unable to see all contents).
    - Check behind the room door.
    - Visually inspect ceiling light fixtures, access panels, electrical plates and outlets.
- Bathrooms
    - Check all open floor space in the bathroom and visually inspect the shower area.
    - Visually and by touch- ensure no items are in the toilet paper and paper towel dispensers

- Check the space behind the grab bars.
- Check the light fixture to be sure there is nothing on top.

- Any items/areas needing repairs are to be reported to Unit Secretary for completion of a Work Order.

AT THE FOREFRONT
UChicago Medicine
Ingalls Memorial

Place patient sticker here

Suicide Precautions Environmental Rounds Form

Directions: It is essential that they be done thoroughly upon admission, every shift, and after each visitor leaves the room.

✓ = completed

Safety concerns should be reported to the nurse/nursing supervisor immediately.

Date/ Time									
Contraband Check									
Window sills									
Drawers/ Bedside tables									
Mattress/ Bed frame									
Pillows									
Ceiling light fixtures									
Floor/Baseboards									
Curtains/Window Screen									
Lights/Wall Sockets									
Door/Door Handle									
Bathroom									
Initials									

UChicago Medicine Ingalls Memorial					
Hospital		Section	General		
Reviewed By:	MEREDITH BORAK (IMH NE UCM LEADER)			3/14/2019	
Approved By:	CORRIN STEINHAUER (IMH NE EXEC VP PT CARE SVCS)			03/15/2019	
Title	**Suicide, Homicide and Aggression Screening and Precautions**			Pages	8

PURPOSE:

Ingalls Memorial Hospital is committed to providing a safe environment for patients, visitors, and employees. Early identification of patients at risk for suicide or patients with homicidal ideations is a first step in providing appropriate care and interventions. The purpose of this policy is to delineate the process of identifying patients at risk for self-inflicted bodily harm or suicide, patients with homicidal ideations, and the procedures involved in the implementation of appropriate interventions.

DEFINITIONS:

1. Suicide Precautions: are implemented for patients assessed as being potentially harmful to him/her-self, patients who are actively suicidal, have made a recent suicide attempt, are expressing thoughts of suicide, or present psychotic behavior which may inadvertently cause harm to him/her-self.

2. Homicide, Aggression precautions: are implemented for patients assessed as at risk of assault, aggression towards others, and/or destruction of property.

3. Behavioral Health Unit: Wyman Gordon Center (Locked Unit)

4. Non behavioral Health Unit: All inpatient units including the emergency department

5. Suicide, Homicide, and Aggression Precautions: *One to One Observations:* patient is considered actively suicidal. Dedicated staff member (Safety Attendant) is assigned to remain within arm's reach of the patient at all times.

6. Safety Attendant: is dedicated staff member or qualified personnel, hospital and/or contracted agency personnel.

7. Behavioral Technician: is dedicated staff member specially trained, Wyman Gordon Center only.

8. Constant Observation: constant (24 hours a day) visual observation of patients at risk (provided for patients on suicide, homicide, and aggression precautions and entails staying within 6 feet with continuous full view of the patient at all times including while bathing and toileting).

9. Contraband: potentially harmful items prohibited at all times.

10. Elopement: The unauthorized departure of a patient from a hospital unit, care area, or the IMH grounds.

POLICY:

All patients who present with emotional, behavioral, and/or substance abuse problems at the time of admission or triage will undergo a suicide risk screening.

The Suicide, Homicide, and Aggression Precautions will be implemented for all patients at risk as identified by suicide screening, patient statement, collateral contact statement, nursing assessment, integrated assessment, psychiatric evaluation, and /or physician order. Patients expressing suicidal ideation will be immediately placed on 1:1 observation pending further evaluation.

RN may initiate Suicide, Homicide, and Aggression Precautions when indicated however, an order from the attending physician or attending psychiatrist must be obtained within one hour.

An order from attending physician or attending psychiatrist is needed to initiate suicide, homicide and aggression precautions.

- Physician orders suicide precaution at a level of intensity deemed appropriate based upon assessment of suicide risk. Nursing staff shall place the patient on a level of observation commensurate with the level of risk as ordered by the physician.

    a. Suicide Precaution: One to One Observation (severe)
    The individual is considered actively suicidal. A dedication staff member is assigned to remain within arm's reach of the patient at all times.

    b. Suicide Precautions: Line of Site (moderate)
    A staff member keeps the patient within visual observation at all times. The patient is not permitted to be in an area where staff is not able to directly see them. This intervention must be noted in the medical record and on the proper form.

    c. Suicide Precautions: 15 minute checks (mild)
    Staff makes visual contact with the patient and confirms that the patient is safe and in no physical distress at frequent rand random interval not to exceed fifteen (15) minutes apart. Whenever possible, verbally interact with patient to assess safety and well-being.

An order from attending psychiatrist is needed to discontinue suicide, homicide and aggression precautions.

All patients who are placed on suicide and/or homicide precautions shall have psychiatric consultation/evaluation within 24 hours of initiation of consult request. An order for a psychiatric consult needs to be entered.

All patients placed on Suicide, Homicide, and Aggression Precautions will have a suicide assessment screen completed by the Assessment and Referral (A&R) personnel or psychiatrist within 24 hours of initiation of precaution by calling extension # 6411.

It is the responsibility of safety attendant to ensure a constant level of observation and intervention per order.

PROCEDURE:

1. 1:1 Precautions with safety attendant assigned.

2. All patients' belongings should be removed from the patient's room, labeled, and stored away from the patient's room in a secured area on the unit. RN should document in clinical note location of secured

belongings. All belongings will be returned to the patient or family upon discontinuation of suicide precautions/constant observation.

3. Consideration should be given to stripping the room of potentially dangerous furniture and/or furnishings.

4. A safety attendant or qualified personnel is to carry out any activity for the patient that uses a potentially harmful object and ascertains that the object is then removed from room. Consideration should be given to postponing any potentially dangerous activity (e.g., shaving) until the patient is more stable.

5. Patient visitors, upon arrival to the room, should be directed by the Safety Attendant to check in with the patient's RN at the Nurse's Station prior to visitation with the patient. Visiting may be restricted in certain instances.

6. Belongings brought in by visitors should be secured by staff, these belongings should be given back to the visitor to take home when visitation is completed or the belongings should be secured with the patient's other belongings outside of patient room until discontinuation of suicide precautions/constant observation or the patient is transferred or discharged.

7. Safety Attendant or qualified personnel performs an environmental assessment at the beginning of each shift and after visitors leave to ensure no contraband has been brought.

8. Safety Attendant or qualified personnel accompanies patient to diagnostic tests and treatments. There should be no disruption of in the observation and documentation process during diagnostic tests and treatments and the safety Attendant or qualified gender appropriate personnel should remain under constant observation whenever possible including toileting.

9. Safety Attendant or qualified personnel and gender appropriate Safety Officer accompany all patients that are being transported to Wyman Gordon Center.

10. RN documents suicide, homicide, and aggression precautions in the medical record every shift.

11. Safety Attendant or qualified personnel documents suicide, homicide, and aggression precautions every 15 minutes in the flow sheet. Once the flow sheet is completed for the 24 hour duration it is given to RN to place in the patient's medical chart. A new 24 hour period flow sheet is initiated each day at midnight.

12. Food trays are to have disposable plastic dishes and eating utensils (no knives allowed). This includes guest trays. No metal cans are allowed.

13. Use only paper trash bags - no plastic bags should remain in patient room.

14. In the event that a patient attempts suicide, the psychiatrist, primary physician and Manager/Director/designee, are to be notified immediately. After hours the AC will be contacted.

15. In the event that a patient on suicide or homicide precautions elopes the psychiatrist, primary physician Manager/Director/designee, Security, and Police are to be notified immediately. After hours the AC will be contacted.

16. Upon psychiatrist order for discontinuation of suicide or homicide precautions, RN should enter a clinical note indicating suicide or homicide precautions were discontinued.

17. Contraband is not permitted. Refer to attachment C-Contraband.

ATTACHMENTS:

A. Safety Attendant Guidelines
B. Patient Observation Flow Sheet
C. Contraband

Attachment A: Safety Attendant Guidelines

SAFETY ATTENDANT GUIDELINES

1. The Safety Attendant observes and stays in close proximity of the patient at all times. Ideally, this means line of sight of the patient. The Safety Attendant is to have visual contact with the patient AT ALL TIMES and remain within 6 feet.

2. Your entire attention is to be given to the patient.
   a. Do not engage in conversation with the other patients.
   b. Do not leave the patient unattended for any reason.
   c. Do not engage in any activity that will prevent you from closely observing the patient.
   d. DO NOT SLEEP.

3. Patients must be watched carefully to prevent them from obtaining items with which they could use to harm themselves or others.
   a. Observe closely at meals for confiscation of knife, fork, or spoon. Plastic utensils should be used by patient.
   b. Be aware of items which could be potentially harmful to the patient.
   c. All patient belongings should be secured outside the patient's room.
   d. Visitors should be directed to check in with the RN at the Nurse's Station prior to visitation.
   e. All items brought in by visitor should be secured and given to RN. Food items should be searched for potentially dangerous items before given to the patient.
   f. Patient Care Safety Attendants should not have personal belongings/items near the patient.
   g. Cell phone use for personal purposes is not permitted

4. Notify the nurse with any problems or difficulties, or if you need to leave the patient. Utilize the nurse call light to contact the Nursing Station and/or the primary nurse. You may also call the nurse directly utilizing the nurse's hospital issued cell phone.

5. DO NOT leave the patient for personal time until another staff member relieves you. Please do not take longer than your allotted time. This affects the staff's availability to other patients and activities.

6. Safety Attendants will complete patient observation flow sheet in 15 minute intervals documenting patient's behavior.

7. The Safety Attendant will give a verbal report of the patient's status to the on-coming Safety Attendant and the nurse assigned to the patient.

Your adherence to these expectations will help ensure effective hand off communication and safety for patients, visitors, and staff.

Attachment B: Patient Observation Flow Sheet

UChicago Medicine
Ingalls Memorial

Department of Behavioral Health Services
Precaution Flow Sheet

Date:_____

Precautions (circle all that apply)

Location key:
NS Nurse's station
H Hall
OH Off Unit

Activity/Behavior Key:
1. Awake
2. Calm
3. Crying
4. Eating
10. Non-responsive
11. Pacing
12. Phone
13. Quiet
20. Spit Hood
21. Standing
22. Talking
23. Verbal aggression threats
24. Walking
25. Watching TV
26. With Visitors
27. Yelling
28. Other___

Observations (circle one): Check every
15 minutes Line of Sight
1:1

Elopement Seizure
Suicide,Sexual
Assault Arson Falls
Other_____

DR Dining Room
BR Bathroom
OTV Open TV Room
CTV Closed TV Room
IC In Conference
QR Quiet Room

5. Flat
6. Group
7. Hyperactive
8. Lying down
9. Mild agitation
14. Refusing to Participate
15. Responding to internal stimuli
16. Restraints
17. Severe Agitation
18. Showering
19. Sitting

Time	Location	Activity/ Behavior	Initials	Time	Location	Activity/ Behavior	Initials	Time	Location	Activity/ Behavior	Initial	Time	Location	Activity/ Behavior	Initial	Printed Name/Signature/Credentials	Initials
0000				0600				1200				1800					
0015				0615				1215				1815					
0030				0630				1230				1830					
0045				0645				1245				1845					
0100				0700				1300				1900					
0115				0715				1315				1915					
0130				0730				1330				1930					
0145				0745				1345				1945					
0200				0800				1400				2000					
0215				0815				1415				2015					
0230				0830				1430				2030					
0245				0845				1445				2045					
0300				0900				1500				2100					
0315				0915				1515				2115					
0330				0930				1530				2130					
0345				0945				1545				2145					
0400				1000				1600				2200					
0415				1015				1615				2215					
0430				1030				1630				2230					
0445				1045				1645				2245					
0500				1100				1700				2300					
0515				1115				1715				2315					
0530				1130				1730				2330					
0545				1145				1745				2345					

Form # 2221 (03/13)

Attachment C: Contraband

Anything that can be potentially used by patients to harm themselves or others is considered contraband and is not permitted. The items listed below are examples of contraband.

- Aerosol Cans
- Audio or video tapes
- Battery Operated Gadgets: toys, radio, TV, cell phone, pager/beeper, palm pilots, MP3 Players, cosmetic mirror, or any item requiring a battery to operate
- Belts
- Cans: Soft drink, juice, etc.
- Clippers & Other Manicure
- Equipment: Finger and/or toenail of any size
- Cough Drops or Throat
- Lozenges: prescribed or store bought even if sealed
- Cords: including those in clothing such as sweat pants
- Creams: over the counter or prescribed
- Drugs/Medication including drug Paraphernalia
- Electrical / Electronic Gadgets: toys, hair dryer, blow dryer, curling iron, radio, TV, cosmetic mirror, shaver, computers or any item that has an electrical cord, cell phone
- Explosives
- Food, Candy and/or Gum: homemade or store bought even if sealed
- Glue, Paint, or Cleaning: Behavioral Health Services
- Compound
- Head Coverings: Hats, baseball caps, "doo rags"
- Keys
- Knives: including pocket
- Lighters and/or matches
- Medication: Including over the counter, prescribed, traditional, complimentary
- Mirror: compact or hand
- Needles
- Nude/violent items: including photographs, posters, magazines or books
- Picture frames: glass face or sharp edges
- Personal videogame and music players: including video games
- Products with Alcohol
- Rope and/or String: Includes drawstrings on clothing
- Scarves and/or Bandanas
- Shoe laces
- Sharp Objects: Scissors, hard plastics or other objects that may cut or puncture. Plastic ware including forks, knives and spoons provided by the facility are excluded as sharps and are not considered contraband.
- Smoking Materials
- Spiral Notebooks

- Sunglasses
- Suspenders/overalls
- Telecommunication: Including pagers, beepers, cell phones, palm pilots, walkie-talkies, and lap tops. Behavioral Health Services
- Devices
- Ties
- Weapons or potential weapons: including pins, needles and metal combs
- Wire Hangers

Interpretation, Implementation and Revision: The Nursing Department, Emergency Department, Wyman Gordon Department, and Security Department are responsible for the interpretation, implementation, and revision of this policy.

CROSS REFERENCES:
Search of Unit and Patient Belongings Policy
Elopement Precaution Policy

This Policy was revised in February 2019
Corrin Steinhauer, VP, CNO, Krista Curell, VP Risk Management & Patient Safety, Chris Fishback (ED), Dr. Guneesh Saluja (EM), Doug Kaiser (Security), Elizabeth Smoczynski (A&R), Alan Moy (WG), Susan Klaczak (PCS), Martina Buttilgero (RPS), Meredith Borak (RPS), Dawn Deboer (Education), Roseanne Serafin (Education)

Patient Transportation Standard Work

Process Owner: Patient Transport | **Department: Patient Transportation** | **Revision Date: 4/2/2020**

Work Sequence: Picking Up/Returning Patient from Testing Site

1. Once transporter has called the Interactive Voice Response system IVR (4031) and accepted an assignment, the transporter responds to the assignment with a sense of urgency.
    - There should be no "Cart" assignments that require an assist. If a transporter requires help on a cart job, please call the call center and explain why.
    - If mode of travel is "Bed" Transporter requests assist only if needed once arrived to the unit and it has been established that a second transporter is needed. If you need training on how to move a bed on your own please ask management.
        - Secondary transporter does not go in progress or completes the job due to the primary transporter having full control.
2. Transporter heads to assigned origin with a sense of urgency .
3. Transporter logs into the IVR (4031) and updates status to "In progress" immediately once arrived to the testing site.
4. Transporter informs RN/CA of their arrival. Transporter hits call light on remote and waits until RN/CA arrive to the patient room.
5. Transporter completes hand hygiene before entering and exiting patient's testing site room.
    - Introduce self by following AIDET and proper scripting.
    - Identify patient by name, ask to see the patient ID band and verify the name with your pager.
        - *"Hello Mr. Smith, can I please check you ID band for patient safety?"*
6. Assist with any final preparation of patient within transporter scope.
    - See steps A-C if delayed. If cancelled, follow cancellation scripting.
7. If isolation, follow PPE protocol. Perform hand hygiene.
8. If returning patient back to their room, use call light button to inform patient's care team (consisting of NSA, PCT, RN, Charge RN) of patient's arrival back to their room.
9. Transporter does not leave the patient until (NSA, PCT, RN, Charge RN) arrive inside the patients room and handoff is completed, If delay more than 10 min please notify the Charge nurse or call the NPC at #2773
10. Transporter helps the patient to the bed. Ask for nursing assistance if the patient needs to be transferred.
11. Before leaving, transporter informs patient of their departure by following proper scripting. Please make sure the patient has the call light before leaving.
    - Transporter checks to see if patient has any requests before they leave them.
12. Complete proper hand hygiene practice (washing your hands is a must when the patient is isolation or your hands are visibly dirty). Properly disinfect equipment.
13. **While at destination location,** sign patient into logbook, (Notify RN or Charge Nurse if there is no Logbook available) call in to the IVR(4031) to complete current assignment and listen for next assignment.
    - Do not complete the assignment outside of the patient transportation department.
14. Transporter responds to the next assignment with a sense of urgency.
    - If no jobs pending, continue checking Teletracking every 5 minutes unless you get a page to pick up a job in between the 5 minutes.
        - Do not depend on the pager to tell you when there is a job for you.

Completing assignments outside of the destination or locations specified in the standard work will be considered unsatisfactory work performance with progressive

Inventory: stretcher, wheelchair, PDI Sani wipes, gloves
Cycle Time: 18 minutes or less

Delay Process:
A. Using the IVR system, phone into Teletracking to enter the appropriate delay reason, if one is observed.
B. After 7 minutes of delay, inform clinical care team that transporter will need to cancel (see script below).
C. Notify Call Center (2773) of assignment cancellation.

Cancellation Scripting
Excuse me _(RN)_, I have been on delay for my maximum allowed time of 7 minutes. I will have to cancel this transport request in order to respond to the next patient. Please re-enter the task when your patient is ready for travel. Thank you.

AIDET

A – Acknowledge
I – Introduction
D – Duration
E – Explanation
T – Thank you!

Hand-off and Transport Tip Sheet

☑ Change of shift from 6:30-7:30 is a protected time. No patients should be transported during this hour

☑ The ED RN will call to notify the inpatient unit prior to the patient transfer. The charge nurse will also receive the bed assignment via the unit pager. See the nurse to nurse report ED STW

☑ Transportation will press the call light when the patient arrives in the room. The transporter will not leave the patient until a CA or RN arrives and a handoff is complete. See Transportation STW

☑ The transporter will sign the patient in and out of the unit logbook when taking the patient off the unit and after the patient has returned and handoff is complete

☑ The charge RN reviews bed assignment pages received during the shift with oncoming charge RN prior to deleting pages.

AT THE FOREFRONT
UChicago Medicine
Ingalls Memorial

REASSESSMENT TIPS FOR NURSES

REASSESSMENT should be performed to see if symptoms are improving or worsening AND,

- When there are any changes in the patient's condition
- After an intervention is provided
- At transfer of care
- While patients are in restraints (PCS-031 policy)
- When your internal thermometer (gut), tells you something's not right/different
- When patient verbalizes new complaint/concern
- If there's a noticeable change in patient's mood, affect, or behavior (aggressive or passive)

Document your findings regarding the patient's condition, intervention provided, patient's response to treatment provided and follow-up of condition. Significant changes in patient's condition must be reported to the physician and documented.

Reference PCS-016 and PCS-037

Occurrence Reporting & Patient Safety

AT THE FOREFRONT
UChicago Medicine
Ingalls Memorial

Why report?

- To promote a **safety culture** and trigger proactive continuous **quality & safety improvement**
- To obtain help in **resolving** patient care delivery **problems**
- To seek guidance from a risk manager on **when & how to apologize, to disclose and to appropriately document** about an adverse event
- To **notify the Professional Liability** Plan about a patient harm event

How do I report?

For high severity harm events:

- **Page** the Ingalls Risk Manager on Call (RMOC) at pager #3939

The Ingalls Risk Manager on Call is available 24/7.

For lower severity harm events, reporting options include:

- Dialing the Quality/ Risk/Safety Office at **3334**
- Clarity Occurrence Reporting Portal on the Intranet Home Page

What should I report?

Behavioral Issues:
AMA/ Elopement/Aggressive patient

Treatment/Practice Issues
Bed Assignment Concerns
Alarm alert delay or failures
Bedside Procedure Complications
Blood Transfusion Reaction or delay
Code 33, RRT or Stroke Activation Delay
Breach of Patient Confidentiality
Falls & Fall Related Injuries
Hospital Acquired Conditions
Communication & Hand-off Issues
Transportation Delay
Non-compliance with Hand Hygiene and Isolation Policies & Procedures
Unexpected Patient Death

Equipment Management
Device failures
Delay in Treatment due to lack of equipment (i.e. SCD's, IV Pumps, etc.)

Laboratory Issues
Lack of order
Delay in processing
Mislabeled specimen

Environmental Hazards

Surgical/ Anesthesia Related
Retained Foreign Body
Return to surgery
Wrong person/ side/site procedure

Medication Events
Adverse Drug Reaction
Medical Order Errors
Dispensing/Administration Errors
IV infiltration

Labor & Delivery Related
Post-Partum Hemorrhage
Fetal demise
Maternal mortality
Birth trauma

What happens with the report?

Identification of actual or potential harm events

Investigation of no harm events, harm events, near miss events and unsafe conditions

Root Cause Analysis of NQF serious reportable events, adverse events or near misses

Improvements to reduce/prevent future harm events

Apology & Disclosure of serious adverse events or unanticipated treatment outcomes

Reporting of potential compensable events to professional liability protection

Risk Management & Patient Safety Team are delegates of the UChicago Health System Quality Committees. Investigations are protected under the Illinois Medical Studies Act.

No judgments, finger pointing or blame

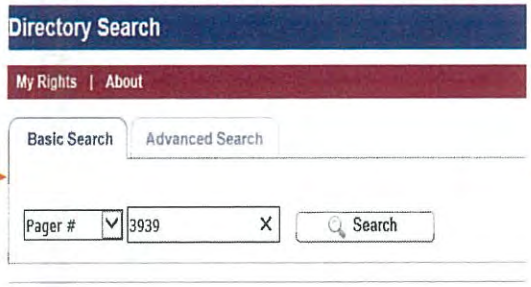
For more information contact Risk Management & Patient Safety at ext. 3334

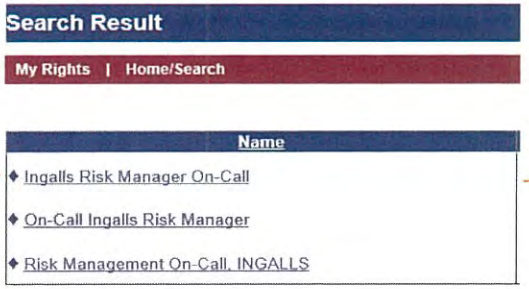
March 2020

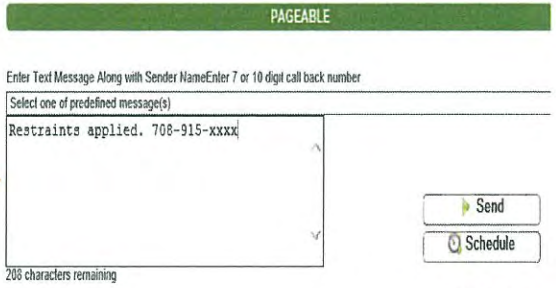
RISK MANAGER ON CALL PAGING INFORMATION
Available 24/7

Effective Immediately: The 10 digit long range number has been disconnected. The pager number for Risk Management is 3939.

- Page Risk Management by:
  - Dialing 5233
    - Enter 3939#
    - Enter call back number followed by #
  - The Enterprise Paging Directory (see below)
    - Double Click on the icon located on desktop
    - Select Pager # on the basic search drop down, enter 3939 and click search
    - Click Ingalls Risk Manager On-Call
    - Type message and call back number in the text box and click send







Risk Management
June 2020

AT THE FOREFRONT
UChicago Medicine
Ingalls Memorial

Risk Management Documentation Tips

	Document only the facts in the medical record- do not point fingers or place blame
	Do not refer to an occurrence report, Risk Management, or anything/anyone not directly related to patient care in the medical record
	All information entered into the occurrence reports is considered protected information
	Do not exchange emails or text messages about patients even if it is through the Ingalls email system (all written information is discoverable prior to privilege being established)
	Do not produce notes or document information on an event outside of the medical record to help you recall the case at a later date- this information is discoverable. Call Risk Management to help document this information and to establish privilege
	If any of the above are being considered, the event likely warrants a call to Risk Management. Dial 708-915-5233 (or x5233 if in-house) enter pager #3939, enter callback number OR use "Enterprise Paging" icon on IMH desktop, enter "Risk" in search bar, select "Risk Management On-Call INGALLS", enter your call back number in box provided, select "send".

Care Companion Tip Sheet

1 to 4

- ☑ May provide observation for up to 4 patients at a time who are NOT suicidal or homicidal
- ☑ Examples of appropriate indications: pulling at lines, confusion, fall prevention
- ☑ There should NOT be an order placed in Soarian for a care companion
- ☑ NO documentation should be completed on the flowsheet or in the patient's chart
- ☑ Interventions include:
  - o *Verbally Re-orienting*
  - o *Deescalation of patient*
  - o *Adhering to wake/sleep cycle (opening blinds, sitting up during day, allowing sleep at night, etc.)*
  - o *Providing fall precautions are in place*
  - o *Distraction techniques*