



Massachusetts
Organization of
Nurse Executives

***Strategies in Managing and Reducing
the Use of Patient Sitters
Best Practices Webinar***

February 25, 2010



Massachusetts
Organization of
Nurse Executives

Coordinated by MONE's Management of Practice Committee

Moderated by:

Pat Noga, RN, PhD(c), MBA, NEA-BC

Chair, Practice Committee

Senior Director, Massachusetts Hospital Association



Presenters:

- ◆ Deborah Wilson, MSN, RN, CRRN
Clinical Nurse Specialist
Shaughnessy Kaplan Rehabilitation Hospital

- ◆ Elisa Scher, RN, MSN
Manager, Cancer Services
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Presenters:

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Director of Education, Patient Care Services
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- ◆ **Alexandra Penzias, RN, M.Ed., MSN, CEN**
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Management of Practice Committee

Purpose:

To analyze issues impacting the management of nursing practice for purposes of enabling members to make proactive responses to emerging health care trends and/or necessary reactive decisions to current practice issues.

To provide recommendations to the MONE Board and its membership in response to identified practice needs and topics.

Resources

- [Strategies to Minimize the Use of Sitters](#)
- [Journal Abstracts: Strategies to Minimize the Use of Sitters](#)
- [Nurse Manager Scope Document](#)
- [Pressure Ulcer Resources](#)
- [Opportunities to Improve Pressure Ulcer Prevention & Treatment](#)
- [Special Report - Palliative Wound Care](#)
- [PUP Training & Sharing Best Practices Webinar 9/10/07](#)
- [PUP Training & Sharing Best Practices Webinar 9/13/07](#)
- [Best Practices for Falls Prevention](#)
- [Strategies on Fall Prevention](#)
- [Falls Resources for Specialty Groups](#)
- [Patients First Falls Webinar 2008](#)
- [TRANSFORMING THE PRACTICE - 2007](#)



Resources on MONE website:

- ◆ *Journal Abstracts: Strategies to Minimize the Use of Sitters*
- ◆ *Summary: Strategies to Minimize the Use of Sitters*
- ◆ *Survey Results: Strategies to Minimize the Use of Sitters*

www.monedev.org/management_of_practice_committee.aspx

<http://www.patientsfirstma.org/features/2009/>



Sitter/Observer Care Planning & Interventions

Deborah L. Wilson MSN, RN, CRRN
Clinical Nurse Specialist
Shaughnessy-Kaplan Rehabilitation Hospital



About Shaughnessy-Kaplan

- Shaughnessy-Kaplan Rehabilitation Hospital is a 160-bed private, non-profit hospital located in historic Salem, Massachusetts
- Shaughnessy has 120 long-term care hospital (LTAC) beds and a 40-bed transitional care unit (TCU), sometimes referred to as a skilled nursing facility (SNF)
- Shaughnessy-Kaplan provides inpatient medical & rehabilitation services at the acute, sub-acute and skilled nursing levels of care
- We provide outpatient therapy services in six north shore communities - Salem, Marblehead, Lynn, Peabody, Middleton and North Andover



Our Sitter/Observer Challenges

- Sitters implemented without interdisciplinary team input
- Lack of central oversight of sitter use
- Sitter care planning & interventions inconsistent
- Sitter/Observer instruction needed

How we started

- Fall reduction team developed the sitter/observer care plan
 - Literature review
 - Assessed tools
 - Rehabilitation specific
- Interdisciplinary Collaboration
 - Staff nurses & Rehab Aides
 - Therapists
 - Nursing leadership

Behaviors requiring assessment & care planning

- Anxiety
- Unsociability
- Nervousness
- Restlessness
- Depression
- Uncooperative
- Fall Risk

Behaviors requiring observation & intervention

- Wandering
- Impaired memory
- Confusion
- Agitation
- Impulsive behavior
- Removal of medical device
- Injury to self or others
- Delirium
- Suicide

Questions to Ask

- What is clinical and behavioral indications for a sitter/safety observer?
- Has the organic cause been identified and adequately treated?
- Are there medications that could be given to treat patient's confusion?

Questions to Ask

- Have less restrictive behavioral management alternatives been tried?
 - Rehab psychiatry
 - Activities
 - Group therapy
 - Pet therapy
 - Recreation therapy
 - Think creatively

Questions to Ask

- What will need to change for the patient to have the observer discontinued?
 - Maintain safe behaviors
 - Remains in bed/chair
 - Calls for assistance
 - Leaves lines alone
 - Calm > 75%



Nursing Responsibilities

- Identify safety-risk behaviors
- Discuss with interdisciplinary team, nurse manager & nurse aide
- Implement sitter care plan
- Document behaviors requiring a sitter plan of care
- Select sitter/observer interventions

Sitter/Observer Care Plan

- Permanent part of medical record
- Care Plan includes
 - Reason for sitter/observer
 - Location of sitter
 - Behavior to report
 - How to obtain assistance
 - Interactions allowed

Sitter/Observer Care Plan

- Care Plan Includes
 - Visitation
 - ADL instructions
 - Activity level
 - Accompanying patient off the unit
- Suicide precautions (if appropriate)
- Sitter/Observer Reminders



Nursing Responsibilities

- Verify sitter understanding of plan
- Schedule breaks and meal coverage
- Communicate plan to inter-disciplinary team
- Update plan of care
 - daily clinical rounds
 - weekly team rounds
- Keep family informed



About Our Sitters/Observers

- Rehabilitation Aides
- Unit Service Aides
- Orientation & Training
 - Recognizing & responding to aggressive behavior
 - De-escalation techniques
 - Sitter/Observer role & responsibilities
 - Documentation requirements

Sitter/Safety Observer Care Plan: Reason for Observation

- At risk to harm self or others
- Wandering/At risk for leaving
- Attempts OOB/Pull at lines
- Suicidal
- Other: _____

Sitter/Safety Observer Care Plan: Location of the Sitter

- At arm's length from bedside
- Foot of bed
- In doorway facing patient

**Patient Must Be In View
At All Times**

Sitter/Safety Observer Care Plan: Behavior to watch for and report

- Agitation/Confusion
- Attempts to get out of bed
- Attempts to leave the room
- Harmful behavior toward self
- Harmful behavior toward others
- Other: _____

Sitter/Safety Observer Care Plan: How to obtain assistance

- Call light for non-urgent help
- Use staff assist/emergency call

**Please let the nurse know
immediately if you have any
concerns about the patient**

Sitter/Safety Observer Care Plan: Interactions with the patient

- Visitors allowed
- Visitors must check with the nurse
- Activity level
- Light/general conversation
- Activities (play cards, read to patient)
- Quiet/decreased stimulation



Important Reminders

- Always remain alert/awake. If you are sleepy, tell the nurse
- Listen carefully to the nurse's instructions. They are for your safety and the patient's safety
- Keep your attention on the patient
- Do not leave patient alone unless you are specifically relieved

Important Reminders

- Do not wear potentially dangerous items like hanging jewelry or neckwear
- Keep long hair pulled back and away from patients reach
- Do not become overly friendly or involved with the patient
- Avoid sharing personal information or opinions
- Negotiate your break with the nurse at the start of the shift

Patient Safety Interventions

- Check List for Observer/Sitter
 - Document patient behaviors
 - every 15 min
 - Verify patient interventions
- It is a part of the Sitter Care Plan
- Nurse directed
- Hand off communication between observers (scheduled breaks)



Hand Off Communication

- Licensed Nurse reviews interventions with each assigned Sitter/Observer
- Staff initial and sign the document
- Nurse reviews observer documentation
- Nurse signature at the end of shift

Family Involvement

- Ask Family to
 - Describe baseline level of functioning
 - Bring familiar objects
- Encourage family to
 - Visit and participate in care
 - Sit quietly with patient to encourage calm rest or sleep
- Educate family about safety factors

Lessons Learned

- Standardize Sitter/Observer Processes
- Assess Sitter/Observer Use
 - Leadership operations huddle
 - Clinical patient rounds
 - Nurse manager
 - Clinical Nurse Specialist
 - Staffing coordinator

Lessons Learned

- Education
 - Staff nurses
 - Rehab Aides
 - Unit Service Aides
 - Staffing coordinator
 - Off-shift supervisors
 - Interdisciplinary team
- Fall Team collaboration

Implications for Practice

- Developed a behavior care plan
- Sensory Carts
- Reduced Fall Rate 2007-2009
 - per 1000 patient days
- LTAC
 - 3.10 - 2.69
- TCU/SNF
 - 4.61 – 2.10

Strategies that Northeast Hospitals is Using to Manage and Reduce the Use of Patient Sitters

Best Practices Webinar

Elisa Scher, RN, MSN



Northeast Hospital Corporation

Beverly Hospital

250 Bed full service community hospital in Beverly, MA



Beverly Hospital at Danvers

Ambulatory surgery and medical day care in Danvers, MA



Addison Gilbert Hospital

50 Bed community hospital in Gloucester, MA



BayRidge Hospital

62 Bed behavioral health hospital in Lynn, MA



What is the Evidence?

- Literature review on the role of the patient sitter shows:
 - Use of the sitter is not cost effective;
 - Does not reduce fall rates;
 - Does not improve patient satisfaction;
 - Little to no guidelines for sitter implementation, usage or discontinuing during hospitalization.
- Sitters are used most often for delirious or suicidal patients, substance abusing patients with behavioral problems and patients that present the risk of elopement.
- ***Conclusion: Use of patient sitters is not an evidence-based practice.***

Addressing the Challenges at NHC

- Labor intensive
 - 8 FTEs or 45 hours per day
 - 2 sitters per shift every day
- Creates Staffing Challenges
 - Sitters take away from direct patient care for the remainder of the patients on the unit, leaving the unit typically short-staffed in this role with other roles needing to pick up the workload
 - This shift in workload impacts negatively patient safety and satisfaction of remaining staff and patients on the rest of the unit
 - Difficulty in staffing on offshifts (particularly nights) leads to increased costs with the need to pay premium dollars to cover the shift.
- Costly
 - Average cost/hour = \$14.77
 - Annualized = >\$240,000
- The use of sitters is often an expectation for physicians, nurses and families.
- Orders for sitters are typically physician-driven



Strategies

- Alternatives to Sitters:
 - Appropriate use of PRN medications
 - Room location
 - Family visits
 - Collaboration with geriatric and behavioral clinical experts
 - Frequent checks by clinical staff (e.g. rounding)
 - Cohorting patients appropriately
- Addressing a Root Cause
 - We have learned that our treatment plans can create problems in the elderly
 - We assessed knowledge and attitude of our nursing staffing regarding care of elderly
 - 35% of all NHC RNs took the Geriatric Intuition Assessment Profile (GIAP) Survey
 - The results provided a baseline level of knowledge and attitude
- Established a Geriatric Resource Nurse Training program
 - 160 nurses have attend 2-day Geriatric Education Training session to become unit-based Geriatric Resource Nurses Created a specialized Geriatric Educator role

Strategies

- A Specialized Geriatric Care Area was created
 - A distinct 10-bed “suite’ within a 28-bed medical unit in a Beverly Hospital general medical unit Johnson 3.
 - The “suite” is actually 10 adjacent beds, mostly semi-private rooms. The suite will be staffed by dedicated clinical assistants who are specially training in care of the geriatric patient and their family.

- Rationale
 - Utilize current evidence-based nursing practice to improve care for our geriatric patient population.
 - Principles identified through NICHE (Nurses Improving Care of Health System Elders).

Strategies

■ Goals of the Geriatric Suite:

- Reduce the incidence of Geriatric Syndromes e.g. functional decline, falls, skin breakdown, incontinence, nutritional and sleep problems called.
- Provide specialized care for patients suffering from an acute medical problem combined with depression, delirium and/or dementia.
- Improve outcomes by reducing the use of restraints, catheters, and inappropriate medications and/or medication dosages.
- Improve patient, family and staff satisfaction
- Reduce length of stay and re-admissions
- Utilize specific geriatric order sets avoiding potentially inappropriate medication use in older adults (“Beers List”) and requiring PT/OT consult (<http://archinte.ama-assn.org/cgi/content/full/163/22/2716>: Fick, DM, et al. Updating the Beers Criteria for Potentially Inappropriate Medication Use in Older Adults. *Arch Intern Med.* 2003;163:2716-2724)
- Standardized nursing care plans to mobilize patient frequently, address toileting and improve ‘socialization’

Strategies

■ Modified Care Model

- Suite lead by Team Leader who has attended Geriatric Resource Nurse Program.
- Registered Nurse/Clinical Associate Care team (pair for 5 patients)
- RNs and CAs have received additional training in geriatric care
- RNs and CAs all had an observational experience on the Addison Gilbert Hospital Senior Adult Unit (SAU)

■ Multidisciplinary Team Involved in Care:

- Hospitalists
- Psychiatry MD Liaison
- SAU Informal nurse-to-nurse consults
- Geriatric educator
- Rehabilitation (PT, OT)
- Pharmacist
- Dietician
- Certified WOCN (Wound, Ostomy, Continence Nurse)

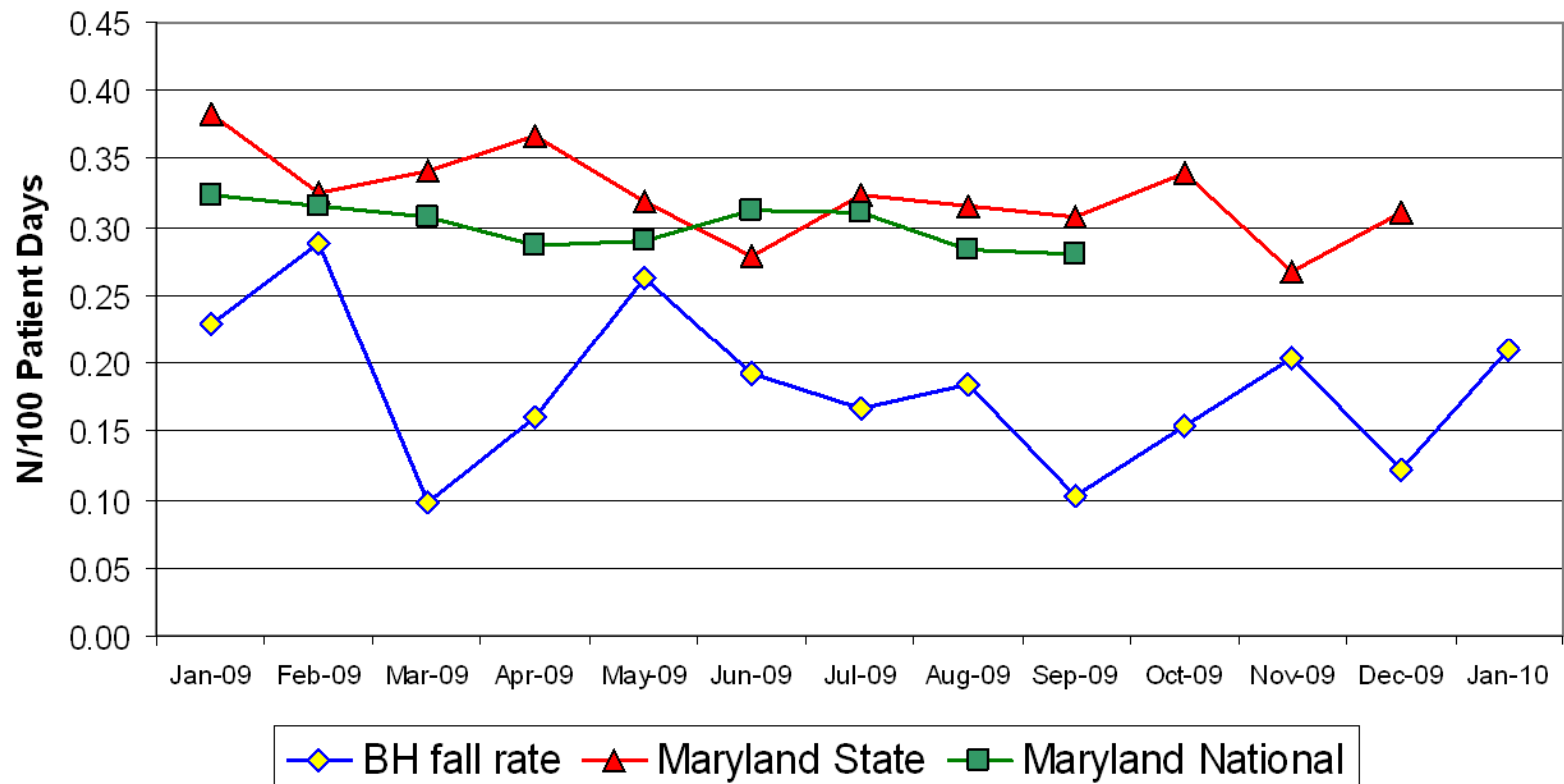
Next Steps for NHC

- Monitor outcomes from new Geriatric Suite
- Shift control of the sitter order from the physician to the nurse.
- Improve communication between the hospitalists and behavioral health clinicians.
- Advance a newly created dedicated patient sitter role job.

Patient Falls

Beverly Hospital Fall Rate Trend (Med-Surg)

(Falls per 100 Patient days)



Tufts Medical Center: Sitter Program Overview

February 25, 2010

Diane M. Gillis, MS, RN, Director of Education, Patient Care Services

Contributions By:

Alexandra Penzias, RN, M.Ed, MSN, CEN, Clinical Educator, Emergency Department

Linda Fisher, RN, MSN, Executive Director

& Patient Safety Aide Task Force Members

Tufts Medical
Center

&

Floating Hospital
for Children
at **Tufts** Medical
Center

- 459 Licensed Beds
- Academic Medical Center –Two full-service hospitals
- Principal teaching hospital for Tufts University School of Medicine
- Pediatric Trauma Level I & Adult Trauma, Level II
- Located in downtown Boston, Massachusetts

Introduction & Background:

Spring 2009 began collating and tracking sitter utilization:

- Non-budgeted FTE variance @ an average of 14 FTE's/biweekly pay period for inpatient units and 2 FTE's/biweekly for Emergency Department (ED)
- Event occurred demonstrating lack of role clarity
- Large sitter pool of various clinical & non-clinical roles, being utilized, often @ overtime rate
- No formalized educational process in place
- 60% of requests for “confusion”

Best Practices: **MONE Management of Practice Committee** **& Literature Review by MONE Research Committee**

Clinical practice best practices:

- ✓ **Reduction of underlying risk**
- ✓ **Frequent checks**
- ✓ **Placing patients close to Nursing Station**
- ✓ **Roles utilized for sitters vary, some include families**
- ✓ **Interdisciplinary communication**
- ✓ **CNS Rounding**
- ✓ **Video camera monitoring**
- ✓ **Cohorting multiple patients**

Organizational Structure:

- ✓ **Hospital policy**
- ✓ **Job description with defined expectations**
- ✓ **Infrastructure & Administrative policies/practices**
- ✓ **Tools to drive process such as algorithms, request forms, etc.**
- ✓ **Nursing Leadership sign-off**
- ✓ **Need for ongoing re-evaluation for sitter utilization**
- ✓ **Unit-based budget for sitters**

Mary Baron, BSN, RN,CCRN,CPA, MOP Presentation
8/28/09

Formation of Sitter Task Force:

- Co-led by Nurse Manager of Central Staffing Office (CSO) & Director of Education
- Representation from all areas that utilize sitters
- Included Psychiatric Consult Team
- Education Specialist responsible for Unlicensed Assistive Personnel (UAP).

Goals for Sitter Task Force:

- Update Policy & Procedure for Sitter Utilization with a focus on criteria for utilization and role responsibilities of sitter, and covering Registered Nurse
- Develop standard for training with re-education plan for all sitters
- Reduce sitter utilization by 50% or 8 FTEs/biweekly pay period

What We Accomplished:

- Changed “Sitter” to “Patient Observer” for either *intermittent* or *constant* observation
- Revised request criteria for observer and implemented process requiring Nurse Manager (NM) or off-shift Supervisor sign-off
- Developed Handoff tool for RN to Patient Observer
- Revised shift documentation tools
- Developed training module and required all existing Patient Observers be retrained prior to next assignment:
 - *Central programming*
 - *Self-learning module with post test*
 - *Tracking mechanism on shared drive for communication/assignments*
 - *Incorporated training into central orientation for applicable unlicensed roles*
- Emergency Department developed report/communication tool & piloted impact
- Central Staffing Office Controls such as signed Request Form & assisting with facilitating the re-education of Patient Observers who were Floats or Per Diems.

Evaluating the Impact of Patient Observer Checklists on Safety in the Emergency Department

Alexandra Penzias, Robert Devlin, Catie Carson

Abstract

To improve patient and staff safety in the Emergency Department.

Many patients present to the ED who are at risk of inflicting self harm or causing harm to others. As a means of ensuring patient and team safety, Patient Observers are often utilized for patient monitoring. However, Patient Observers have varying levels of training and are often unfamiliar with elements of caring for patients at risk.

Sample Population

The sample “n” consisted of 48 patients that presented to the ED with known or suspected risk of self injury or injury to others during a 30 day period starting in the end of January, 2009. In our sample: 32/48 (66.7%) were male and 32.3% female. 75% were identified as being at risk of self-harm, and 25% were considered to be at risk of both harm to self and to others.

Methodology

A single page checklist was created to summarize the care of individuals at risk. The checklist is completed by the assigned RN or ED charge nurse, and is reviewed with the patient observer and security officer assigned to the ED. At each transfer of care, the form is reviewed and signed by the responsible staff (RN, UAP, Security Officer).

Nursing, Security and UAP staff were informed of the 30 day pilot study, and the forms were placed at each point of entry to the ED to facilitate early identification of patients at risk, and prompt notification of security. A random survey of Patient Observers, RN's and Security Personnel was performed throughout the pilot study in order to evaluate team perceptions associated with the use of the checklists.

Limitations: Small Sample Size

Results

60 forms were completed and returned over the 30 day trial, reflecting the care of 48 patients. 6 forms were excluded from data analysis. Patients presented with 1-3 risk related complaints. Presenting issues included suicidal ideation (24), general psychiatric complaint (15), Depression (3), Self Injury (2), ETOH/ Drug Ingestion(4), Mental Status Changes/Dementia (5).

Sample “n” by Risk

36 (75%) At risk to themselves

12 (25%) At risk to themselves and others

Sample “n” by gender:

32 (66.7%): Male

16 (33.3%): Female

Patients Identified as Self Risk (n=36), mean age 41.3 yrs

25 (69.4 %) Male

11 (30.5 %) Female

Patient Identified as Risk to Self/Others (n=12), mean age 45 yrs :

7 (58%)-Male

5 (42%)-Female

There were no elopements or falls of at risk patients in the sample*

ED Pilot Study Conclusions:

Our pilot indicated that patients who were identified as being at risk to themselves or others were more likely to be male (than female), middle-aged, and most likely to present with a single or combination of mental health complaints which may pose a risk to physical safety.

A random, informal survey of ED nursing staff, patient observers and security personnel indicated that Patient Observers perceived that the checklists improved their awareness of both the patient condition and their role.

Nursing staff stated that the checklist improved their perception of safety in the department and security staff stated that earlier identification of high risk patients has facilitated improved monitoring, and safety.

The major limitation of this pilot was the small sample size. The findings of this pilot indicated that there is further opportunity to evaluate the factors associated with patient risk and the impact of the use of patient observer checklists upon patient and staff safety in the ED. This checklist has been adapted for use in in-patient areas of the facility.

For more information, contact: Alexandra Penzias, RN,M.Ed.,MSN, CEN, ED Clinical Educator

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Spring 2009: Hospital-Wide Implementation

- Implemented revised request form and a structured CSO tracking process to monitor compliance
- Implemented handoff tool and revised shift documentation forms
- Reduced observer utilization to 11 FTEs/biweekly but did not reach goal of 8 FTEs/biweekly
- Implemented re-education process
- Re-drafted policy to reflect changes noted above

Other Organizational Changes That Impacted the Project in 2009:

- New Senior Vice President of Patient Care Services, CNO, with revised leadership structure
- New Executive Clinical Directors (#3)
- Director of Nursing Finance - new role
- CSO Nurse Manager Turnover

What We Learned During Initial Implementation & Where We Are Now Going:

- During Care Delivery Model Community work, staff participating provided information that Patient Observers remained unprepared to support role expectations
- Data demonstrated that we were not achieving our economic goals and the request process remained flawed with 40% requests for sitters being filled without form & established approval process
- New leadership brought renewed perspective and new ideas!
- Observer hours tracked daily on newly implemented Administrative Report

Under New Leadership:

- Re-implemented Task Force led by Executive Clinical Director
- Engaged staff participation: Clinical Care Technician
- Re-engaged Psychiatric Consult Team
- Revised job description and skill requirements
- Developed new title: *Patient Safety Aide (PSA)*
- Utilizing Nurse Manager of Adult Psychiatric Unit to begin daily rounding to review PSA utilization, assess patient needs, utilize opportunity for education, etc.
- Hire and/or train PSA to provide basic hygiene

Next Steps:

- Policy & Procedure to be revised to reflect new changes
- Updating forms to reflect changes:
 - Request Form
 - Handoff Tool
 - Shift documentation tools
 - CSO Tracking Form
- Will continue to track FTEs and codes for PSA request to measure outcomes

Thank you for your attention, may I answer any questions for you?



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Strategies to Reduce Safety Sitter Usage

2/25/10

Joyce Dolin RN,MSM, NE - BC



About Southcoast



**Charlton Memorial
Hospital
Fall River**



**St. Luke's Hospital
New Bedford**



**Tobey Hospital
Wareham**

Southcoast Health System

**800+ physicians & 6,000+ employees
serving 719,000 people in 33 communities dating back to 1884**



Historical Perspective: Sitter Cost

- **FY 2008 – \$2,145,275 = 84.6 FTEs**
- **FY 2009-\$1,244,949 = 48 FTEs**
 - **36.6 decrease in FTEs from FY 08**
 - **42% decrease in cost**
- **FY 2010- Budgeted for \$983,322**
 - **21% decrease in cost from FY09**
 - **54% from FY08**
- **FY 2010 YTD - \$73,000 spent**
 - **22% under budget**
 - **Budgeted 37.89 FTE Actual 26 FTEs**



Best Practice

MONE

Best Practices Research:

**The committee reviewed and
implemented best practices**



Strategies

- Development of specific criteria for sitter usage and sitter request form
- Manager assigned daily to oversee sitter approval and distribution
- Research and purchase of fall prevention equipment- Posey selected
- Development of the roles of Patient Care Observer and Therapeutic Assistant-
elimination of Safety Observation Sitter role



Strategies

- Hourly and 15 minute rounding
- Clustering patients in close proximity for ease of rounding
- Assessment conducted of current Falls Prevention Program
- Literature search conducted – Hendrich II Fall Prevention Program
- Development of “Safety Zone”



Patient Care Observer Role

- Round on up to 4 patients clustered in a small geographic area every 15 minutes focused on patient safety
- Perform patient assistance, ambulation, mobilization activities
- Trained to recognize patient emergency situations and respond appropriately
- Provide assistance to licensed staff in application and removal of restraints
- Communication of patient information



Patient Care Observer Role

- Handoff communication occurs at shift changes, breaks, and meal times
- Current CPR Certification
- Follows fall prevention plan, utilizes bed/chair alarms and uses safe patient handling techniques
- Involved with other unit activities as directed



Therapeutic Assistant Role

- The therapeutic assistant provides care for patients who require 1:1 constant observation or 1:2 continuous coverage.
- Cares for patients who are suicidal, psychotic, experiencing delirium tremors or severely aggressive.
- Performs all of the duties of the PCO
- Obtain pulse, respiratory rate and check circulation and skin integrity



Therapeutic Assistant Role

- Provides therapeutic interactions.
- TA trained in CPI (Crisis Prevention Institute training for nonviolent crisis prevention and intervention.)



Education PCO /TA - Core

Responsibilities in the Health care environment

- Code of Ethics
- Personal Hygiene/Appearance
- Staff Relationships
- Legal Aspects of Care
- Patient Bill of Rights
- The Patient's Environment

Communication Skills

- Verbal, Written, Non-verbal, Barriers



Education PCO/TA - Core

- Safety: bed locks, oxygen, ambulation safety
- Safe Patient Handling
- Fall Prevention
- Restraint Application
- Emergency Response
- Infection Prevention



Additional Education - PCO

Caring for the older adult

- Dementia
- Delirium
- Sensory deficits
- Language Disorders
- Muscular-skeletal disorders

Documentation



Additional Education - TA

Mental Illness

Major Psychiatric Diagnoses

- Schizophrenia
- Bipolar Disorder
- Major Depressive Disorder

Suicide

Care of the patient with psychiatric precautions

Maintaining Safety

Age Specific Patient Populations



Additional Education - TA

Special Situations

- Toileting
- Meal Service
- Psychiatrist / social worker visits

Communication strategies

Special Procedures

- Checking Radial Pulse and respirations
- Observation of skin integrity

Care of the Restrained patient



Budget for PCO/TA

- FY 2010 budget based on the ability to continue to care for the same or greater number of patients, but in a clustered format
- FY 2009 the larger sites (300-400 beds) were providing on average 13 safety sitters per shift.
- FY 2010 3 PCO and 1 TA per shift provide same coverage
- FY 2009 smaller site (80 beds), staffed with 2 safety sitters per shift
- FY 2010 1 PCO and 1 TA can cover 5 patients



Lessons learned

- Needed to cross train the PCOs to be TAs
- Needed the flexibility of the TA role for influx of suicidal and psych / DT patients
- Clustering of patients because of specialties at times was a challenge
- Instituted best practice of one manager monitoring the use and need of Safety Sitters as well as clustering to ensure guidelines are followed
- Frequent rounding initially by management needed to ensure compliance as well as a good understanding of the new program



Where Are We Now?

- Cross trained PCOs to be TAs
- Enhanced our per diem pool to be able to meet the demand of PCO / TAs
- Met 1:1 with staff to ensure an understanding of the program-logistics and rationale behind the process
- Implemented fall prevention rounds to ensure the best plan of care is being used for our patients at risk for falls



Implementation of Safety Zone

- Education
- Explanation of the “Safety Zone”
 - Dementia, Delirium, Depression
- Brochure
- Questionnaire
- Inclusion/Exclusion Criteria
- Shift Re-assessment
- Location



What's Next ?

- Expansion of Safety Zones
- Implementation of fall prevention equipment based on unit needs at all 3 campuses
- Implementation of Hendrich II Fall Prevention Program



Impact on Falls

- 2008 Fall rate 3.62
Number of falls 663
- 2009 Fall rate 3.73
Number of falls 565
- 2010 Fall rate 1st quarter 3.62
Number of falls 127



Questions???????

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