

Massachusetts Organization of Nurse Executives

Strategies to Minimize the Use of Sitters

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Sitters (also referred to as “Patient attendants” or “companions”) represent a significant expense to many hospitals across the nation. Particularly in this difficult economic climate, it becomes extremely important for hospitals to try to minimize these often non-reimbursable costs to the extent possible. To this end, a review of some of the more current literature regarding strategies to minimize the use of sitters was completed.

Healthcare facilities utilize sitters to attempt to maximize patient safety. Common risks that the use of sitters addresses include suicide risk, risk of harm from others, risk of falls, elopement risk and risk of dislodging significant lines or tubes.

While strategies for decreasing the use of sitters have appeared in several articles, there seems to be no panacea (Evans, 2008). Reliable evidence regarding the effectiveness of the use of sitters in maximizing patient safety and satisfaction remains elusive (Tzeng, Yin C, & Grunwalt, 2008) (Boswell et al., 2001). Strategies fall into several categories: reduction of underlying risk, patient placement/location, education, infrastructure and administrative changes, and the use of policies/procedures and decision tools.

Strategies to minimize the risk of falls have been shared throughout the industry. The MONE document “Strategies in Fall Prevention” suggests many such strategies (Litchfield, 2008). Other strategies for the reduction of the underlying risk include the use of distraction and relaxation techniques and the frequent review of the need for lines and tubes (Kratz, 2008) (Salamon & Lennon, 2003).

Several facilities outlined practices regarding patient placement that maximize safety. Some articles suggested cohorting multiple patients with one sitter (Salamon & Lennon, 2003) (Torkelson & Dobal, 1999) (Worley & al., 2000) (Wright, 2006) (Nadler-Moodie, et al, 2009). The use of a video camera to monitor patient movement has been suggested but brings up questions of privacy (Torkelson & Dobal, 1999). Placement close to the nursing station for high-risk patients (Worley & al., 2000), and placement in public areas are common suggested strategies (Salamon & Lennon, 2003) (Nadler-Moodie et al, 2009).

Education is a common theme within several articles. In order to provide safe care, the sitters themselves are carefully trained to understand the part they play in the reduction of risk. Education regarding risk should also be shared with the family in order to involve them actively

in the safety of their loved one (Tzeng & Yin, 2007). Suggestions for staff education included education regarding alternative interventions (Salamon & Lennon, 2003) (Torkelson & Dobal, 1999) (Heyman & Lombardo, 1995), the cost to the unit of this intervention (Worley & al., 2000), and the use of advanced practice nurses who educate staff regarding the need for sitters by doing regular rounding and interacting with staff and patients (Linck & Phillips, 2004) (Heyman & Lombardo, 1995).

Infrastructure change suggestions include:

- the movement of costs to the individual unit in order to hold them accountable and to align the decision-making with the financial impact (Torkelson & Dobal, 1999) (Heyman & Lombardo, 1995);
- outcome measurement evaluating the impact of improvements (Salamon & Lennon, 2003);
- the use of internal staff rather than the more expensive agency staff (Salamon & Lennon, 2003) (Worley & al., 2000);
- interdisciplinary rounds focused on the need for sitters (Salamon & Lennon, 2003);
- the development of the role of a CNS responsible for daily rounding on patients requiring sitters in order to maximize less expensive therapies; and,
- several facilities suggested that the use of family members or volunteers in either the role of sitter or as a cost-sharing partner can be successful (Tzeng & Yin, Using family visitors, sitters, or volunteers to prevent inpatient falls, 2007) (Worley et al., 2000).

Certainly, a broader intervention, which can have a significant impact at the organizational level, is the development of standard policies, procedures, and decision tools. Nurses in some hospitals utilize tools or decision algorithms that help them to assess the patient needs and make suggestions for alternative interventions (Tzeng, Yin C, & Grunwalt, 2008) (Heyman & Lombardo, 1995). The formality of sign-off by the nurse manager or other leadership level nurses may make the nurse consider her alternatives, but also engages the nurse manager to take responsibility for the overall safety environment, as well as the cost expenditure (Salamon & Lennon, 2003). Policies and procedures heighten the efficacy of a sitter program.

Suggestions include:

- a document reflecting the hospital's policy defining the appropriate use of sitters, as well as the appropriate discontinuation of a sitter (University HealthSystem Consortium, December 2007) (University HealthSystem Consortium, December 2007);
- a document reflecting the procedure by which an employee can request a sitter (Salamon & Lennon, 2003) (University HealthSystem Consortium, December 2007);
- a job description which clearly defines expectations for behavior and responsibilities (Torkelson & Dobal, 1999) (University HealthSystem Consortium, December 2007);

- a document delineating the role of the nurse from the role of the sitter (Torkelson & Dobal, 1999) (University HealthSystem Consortium, December 2007);
- clear definition of chains of command (University HealthSystem Consortium, December 2007); and
- a written evaluation process for sitters that adequately documents the ability of the sitter to carry out those responsibilities defined in his or her job description (University HealthSystem Consortium, December 2007).

The minimization of the cost of sitters is a high priority in the minds of many senior leaders in healthcare facilities. By examining the various practices of fellow institutions, complete elimination of these costs throughout the institution may remain elusive; however, by putting effort into the infrastructure, policies and procedures around sitters, minimization of their use and maximization of their effectiveness is a more realistic goal.

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