



Massachusetts Organization of Nurse Executives

Strategies to Minimize the Use of Sitters: Survey Results

This survey was completed as part of The Massachusetts Organization of Nurse Executives (MONE) 2009-2010 charges for the Management of Practice Committee. The committee was charged with compiling best practices and resources on patient sitters or patient observers. The committee reviewed, discussed and drafted a three-question survey to be distributed to all Chief Nursing Officers (CNOs) in Massachusetts and Rhode Island. The MONE Board reviewed and approved the survey prior to distribution. The purposes of the survey were to illustrate present best practices on sitter use while keeping patients safe. Surveys were distributed via an electronic link to Survey Monkey on August 4, 2009 with a completion deadline on August 21, 2009. Eighty-eight surveys were distributed, and thirty-seven nurse leaders responded for a response rate of 42 percent.

Question One: "Rank the 5 most successful strategies in use at your organization that reduced the use of sitters while keeping patients safe." The reported ranks are as follows:

- Equipment Usage: 65% of the responses indicated equipment usage, including low beds, tent beds, closure beds for children, safety footwear, memory belts, video monitoring and bed/chair alarms.
- Rounding: 59% of the responses indicated rounding with several references to specific duties such as toileting, pain assessment, positioning, nourishment, location of assistive devices and management of environment of care.
- Family presence /participation: 35% of the responses indicated family, family presence, and family participation in care.
- Patient location: 32% of the responses indicated patient location, such as "close to the nursing station," cohorting or "sharing of sitters", and observers who can see more than one patient at a time.
- Frequent checks: 16% of the responses cited frequent checks ranging from every 15 minutes to every 30 minutes for patients at high risk.
- Staff education and role development: 14% of the responses cited staff education and role development such as Nurses Improving Care for Healthsystem Elders, (NICHE), including GENESIS protocols, continuing education programs, and gerontological nursing certification.

Additional strategies noted by the respondents include:

- Use of guideline criterion for sitter usage as well as an assessment tool for identifying patients at risk; guidelines and algorithms including registered nurse (RN) ability to discontinue sitter orders (instead of physician approval).
- Administration approval with and without case review; psychiatric consult; consultation of a clinical nurse specialist (CNS); assessment and re-evaluation of sitters every 2-4 hours, shift-to-shift or daily.
- Medication management; alcohol withdrawal protocols; electronic requisition to track and trend sitters; use of non-clinical sitters, flat sitter rates, and light duty staff as alternatives to more expensive staff.
- Use of activities for patients; use of a delirium room with specific admission and discharge criteria (staffed with a certified nursing assistant [CNA], and is overseen by a geriatrician and geriatric-psychiatrist).
- Use of huddles; revision of fall programs; fall risk signage; and color-coding patients at risk.

Question Two: “Comment on effective administrative strategies to reduce sitter utilization while keeping patients safe.”

- Administrative approval and oversight: 53% of responses indicated administrative approval and oversight on sitter resource allocation. Some organizations reported additional oversight with psychiatrist or geri-psychiatric CNS. Administrative practices included formal initiatives with a program coordinator; policy and procedure for clear outline on sitter use; approval process with forms; review of prior events to ensure alternative strategies are used; case review tools; and decision trees for sitter vs. observation checks.
- Tracking of sitter usage: 25% of responses cited tracking of sitter usage. Tracking systems included sitter case review ranging from every two hours to daily. Case reviews are reported to be re-evaluated by supervisors, managers, directors, CNS, staffing office and daily multidisciplinary teams. Reviews were completed using a variety of assessment and tracking tools, and written order/discharge sheets were reported in 32% of the responses. 22% of organizations responded with use of a sitter documentation tool.
- Budgetary monitoring: 25% of the responses indicated budgetary monitoring. Cited examples include graphs provided to managers on monthly sitter use, explanation in monthly variance reports, separate cost center for sitters, and weekly budget meeting to discuss number of sitter occurrences. Resources for sitters included contracts with a security company with flat rate for sitters, utilization of college students and non-clinical staff. One organization reported allocated full time equivalents (FTEs) for sitter pool.

Miscellaneous strategies included equipment utilization, sitters for psychiatric/behavioral health patients only, communication book, and full support for hourly rounding.

Question Three “What are your measures of success?”

The overall measures of success were primarily reported in three categories:

- Change in fall rates and patient/staff injury rates: 65% of responses denoted decreased fall rates. Although most responses did not include how the rates were measured, one organization measured with National Database of Nursing Quality Indicators (NDNQI) data and another organization used a Fall Review Team/Nursing Council. Purposeful hourly rounding was noted to have significant impact on fall reduction, call bell response time and increase patient satisfaction.
- Patient/staff satisfaction: 39% of responses denoted increases in patient, family and nurse satisfaction. Examples included decreased volume of concern calls from families; improvement in Press-Ganey Patient Satisfaction Survey results; “more thoughtful process by nursing staff in assessing patient needs” for a sitter; improved process for tracking patient needs at time of admission and at discharge; reduction in restraint use and restraint free-culture.
- Cost indicators: 31% of responses denoted reductions in sitter costs. Although many programs were too new to assess measures of success, most organizations reported decrease in sitter FTEs, and overall reduced sitter expenses. Other measures of success included a decrease in length of stay, decrease in hours per patient day (HPPD), “increase in productivity statistics” and a report of a decrease in pressure ulcer rates.

In conclusion, this document represented a summary of results of a survey of chief nursing officers aimed at presenting best practices of sitter use while keeping patients safe, and illustrated several strategies to minimize the use of patient sitters or observers.