The Use of Sitters in the Acute Care Hospital Setting
An Integrative Review

A Topic Summary of the Evidence

**Question:** “What is the quality and consistency of the evidence for the use of sitters in the acute care hospital setting?”

**Answer:** The proper utilization of sitters, constant observation (CO), and CO alternatives can enhance the acute care practice environment as it addresses the diverse issues of patient safety, patient rights, patient/family satisfaction, and human dignity.2,10

➤ Based on the reviewed evidence, the following recommendations are offered for consideration:

- **Staff Nurses**
  - Understand the difference between custodial care by the sitter and professional nursing care of the patient requiring CO.1,7,10,12
  - Complete a comprehensive sitter orientation program and attend regular updates.2,4,8,11
  - Use expert nursing assessment, as well as CO/sitter tools and guidelines, to tailor CO and CO alternatives.4,7,10-12
  - Use culturally sensitive and role-specific guidelines to orient family functioning as sitters.8,11
  - Separate delirious or agitated patients requiring one-to-one sitters in order to decrease incendiary and provoking behaviors.8
  - Ensure that default systems are in place for fall prevention when using a sitter program.2,5

- **Sitters**
  - Use the terms “constant observers” or “therapeutic companions” to imply a more active role.6
  - Provide for a safe patient environment by clearly understanding the roles, expectations, behaviors, and responsibilities of nurses, sitters, sitter-based patient care, and CO.1,4,7,8,10,12
  - Complete a comprehensive sitter orientation program and attend regular updates.1,2,4,8,11
    - Sitters should be trained to understand their part in risk reduction and safe patient care.1
    - Formal educational programs are vital for describing sitter expectations and their understanding of the role behaviors.4
  - Document clearly and specifically, as based on identified patient behaviors, using sitter tools and guidelines.7,11,12

- **Nurse Educators**
  - Develop and present a comprehensive evidence-based sitter program on a regular and ongoing basis, with the incorporation of key elements (See page 8).1-4,7,8,10-12

- **Nurse Managers**
  - Promote multidisciplinary collaboration when CO and its alternatives to CO are implemented as a method of ensuring environmental and interpersonal patient safety.7,10
  - Ensure decision making is nursing department based in order to trigger the prompt responses required for CO and patient safety.10
  - Pilot CO assessment tools on select inpatient units to assess feasibility and functionality before including in guidelines.12
  - Encourage nurses to find alternatives to CO by making them aware of unit-based CO costs.1,10

- **Nurse Executives**
  - Create a system which includes risk management and outcome measurement to monitor the consistency and validity of CO decisions and the impact of improvement.1,10
  - Consider Human Resource strategies (e.g. offering on-the-job sitter orientation and training programs) to support a safe patient environment.12
  - Use a collaborative interdisciplinary programmatic approach to design, implement, monitor, and evaluate a sitter-based CO program (See Appendix E, Sitter Programmatic Model).1,4,6-8,10,12,10
The Use of Sitters in the Acute Care Hospital Setting
An Integrative Review
A Topic Summary of the Evidence

Question: “What is the quality and consistency of the evidence for the use of sitters in the acute care hospital setting?”

Introduction: The practice of “sitting” ensures that a “sitter” remains at the bedside of a hospitalized patient. Sitte-based constant observation (CO) of patients is a strategy used to establish a safe patient environment by protecting high-risk patients from injuring themselves or others. However, scarce healthcare resources demand that the use of CO and one-to-one sitters be determined by an accurate assessment of when, where, and how sitters should be used. A January 2009 integrative review examined the quality and consistency of the research evidence for the use of sitters in the acute care hospital setting. A December 2011 update of this review sought to capture the current literature on this clinical topic.

Electronic Database Search Strategies: A January 2009 integrative review was conducted via multiple electronic databases from 1998-2009 using search terms of “sitter(s)”, “hospital”, “acute care”, “inpatient”, “falls”, “use of sitters” and “constant observation”, either alone or combination. A total of 158 hits yielded 7 articles. Reference links resulted in 1 additional 1997 article. 8 total articles were reviewed and 7 selected as relevant. A November 2011 update on this clinical topic was conducted via electronic databases (Pubmed, Ovid, Proquest, Science Direct, Cochrane Library, Mosby’s Nursing Consult, Yahoo) using the search terms “sitters”, “acute care”, and “constant observation”, from 2008-2011 and open years. The database search yielded 69 hits, with 15 articles pertaining to the clinical area of inquiry. 5 articles were selected as relevant and added to the 2009 body of evidence for a total of 12 citations (Appendices A, B, and C). The strength of the research evidence ranged from insufficient to fair, with a final grade of insufficient. Result limitations include the lack of valid and reliable sitter-focused tools, as well as few research studies examining this area of clinical practice.

Integrative Review Results: The terms “patient attendants”, “therapeutic companions”, or “constant observers” imply a more active role than the traditional term of “sitters”. Although sitters traditionally offer a “safety net” for at-risk hospitalized patients, it can often result in costly and fragmented nursing care. Current sitter practices involving CO vary from hospital to hospital, different practice settings, and the individualized needs of each patient. Various tools are used in an effort to provide safe and cost-effective patient care given by licensed and unlicensed sitter personnel. The confusion regarding nurse versus sitter roles and responsibilities represents a practice gap that can lead to uncoordinated nursing care, patient/family dissatisfaction, and possible patient injury. Although family members have often assumed the sitter role, they too are unclear of their responsibilities in patient care and should not be used as a substitute for nursing staff. Family members providing CO is problematic from an ethical and medico-legal perspective, as it implies that responsibility for patient safety has been transferred from the nursing staff to family.

CO practices involve issues of patient safety, cost containment, staff training, and responsibility. The evidence described a variety of CO providers such as RNs, nursing assistants, family, security staff, and volunteers. There are no defined industry standards for the use, efficiency, or financial measurers of sitters. Reliable evidence regarding the effectiveness of the use of sitters in maximizing patient safety and satisfaction remains elusive. Performance improvement was useful in displaying the results of a nursing quality team’s interventions, but did not provide direct evidence that sitter-based CO improves patient outcomes. Currently, there is no research to suggest the use of CO reduces the risk of patient harm related to the risk for falling or self harm.

Conclusions: Evidence-based sitter orientation programs can potentially reduce the anxiety and confusion resulting from unclear role expectations. Although collaborative multidisciplinary decision-making is crucial to determining sitter/CO interventions, the final decision-making process should remain centralized within the nursing department. Nursing centralization is essential in providing the timely responses needed for safe and fiscally responsible patient care. Nursing leaders must strike the proper balance between safe patient care and support for the nursing staff while also maintaining organizational fiduciary responsibilities. A hospital-based monitoring system could aide in assessing the costs, validity, consistency, and potential legal liability of CO decisions. The use of a collaborative interdisciplinary programmatic approach would facilitate the design, implementation, monitoring, and evaluation of a sitter-based CO program. Direct observation remains an inconsistent and expensive means ensuring patient safety requiring rapid human intervention. Patients needing sitters typically require frequent observation, rather than continuous one-on-one monitoring at the bedside. Complete elimination of sitter’s costs may be difficult to obtain. Development of infrastructure, policies, and procedures, minimum sitter use, and maximum sitter effectiveness may be a more realistic goal. Wide-ranging interventions with significant organizational impact include the development of CO standard policies, procedures, and decision tools, with nurse managers and staff nurses tailoring the need for CO and CO alternatives through the use of educational programs, specific tools, guidelines, and accurate nursing assessments. The proper utilization of sitters, CO, and CO alternatives can enhance the acute care practice environment as it addresses the diverse issues of patient safety, patient rights, patient/family satisfaction, and human dignity.

The Use of Sitters in the Acute Care Hospital Setting  
An Integrative Review  
A Topic Summary of the Evidence

Key Summary of the Evidence

➢ Nursing Leadership $^{1,7,10}$
  o The formality of a sign-off by nurse managers or other leadership level nurses engages nurse managers to take responsibility for the overall safety environment, as well as the cost expenditure$^1$
  o On MS units, there is a lack of collaborative decision making between nurses, physicians, patients, families, and case managers about whether to initiate, continue, or discontinue CO $^{10}$
  o Decentralized decision making is needed to trigger the prompt response required within the nursing department $^{10}$
    ➢ Nursing assessments establish the need for interventions with patients needing CO $^{10}$
  o Collaboration with assistive personnel fosters cohesive teamwork with the same vision: environmental & interpersonal safety $^7$

➢ Sitter Strategies $^{1,4-8;10}$
  o Achieve a safe environment for at risk patients via one-to-one sitter or constant observation (CO) $^{1,7}$
    ➢ Sitter role varies with the needs of each patient $^6$
  o Sitters are often nonclinical personnel without hands-on clinical care as their primary task $^7$
  o Define sitter expectations in order to avoid assuming sitters can “do everything” $^{4,7}$
  o Sitter documentation should be clear & specific, rather than generic notes of “sleeping” or “restless” $^7$
    ➢ Specify identified patient behaviors identified (e.g. biting IV tubing, pulling at restraints, attempting to get out of bed)$^7$
  o Sitters have a marginal impact on patient falls, patient satisfaction, and harming themselves $^{1,4,5,10}$
  o Sitters offer a “safety net” and supplement nursing care for elderly patients experiencing delirium and agitation $^{6,8}$
  o Ensure proper sitter orientation to sitter role & responsibilities, as well as providing ongoing team support during the shift $^8$
    ➢ Sitters may be ineffective if they are poorly oriented to responsibilities and not supported $^8$
  o Sitter Orientation includes $^8$:
    ➢ Specific patient behavior requiring interventions $^8$
    ➢ Symptom recognition $^8$
    ➢ Use of restraints $^8$
    ➢ Principles of therapeutic communication $^8$
    ➢ Patient Containment $^8$
  o Decreasing Use of Sitter Strategies: $^1$
    ➢ Reduction of underlying risk $^1$
    ➢ Patient placement/location $^1$
    ➢ Education $^1$
    ➢ Infrastructure $^1$
    ➢ Administrative changes $^1$
    ➢ Use of policies/procedures and decision tools $^1$
  o If possible, CO provider should be of the same gender as the patient, particularly where issues of past sexual abuse or religious modesty are relevant $^5$
    ➢ CO may be perceived by patient as a further traumatic event $^5$

➢ Sitter Guidelines, Protocols, and Tools $^{1,4-6,8;10;12}$
  o Clear, comprehensive decision tools and standard policies & procedures are needed to support the CO decision-making process $^{1,10}$
    ➢ Develop a sitter program model clearly outlining staff nurse and sitter responsibilities $^{1,10}$
    ➢ Provide clear instructions for the sitters, including a brief patient history, as well as specific patient behaviors and symptoms $^{10}$
The Use of Sitters in the Acute Care Hospital Setting
An Integrative Review

A Topic Summary of the Evidence

- **Policies and Procedures to Heighten the Efficacy of a Sitter Program:**
  - Document reflecting hospital’s policy defining appropriate sitter use
  - Document reflecting appropriate discontinuation of a sitter
  - Procedure by which an employee can request a sitter
  - Job description clearly defining expectations for behavior and responsibilities
  - Document delineating the role of the nurse from the role of the sitter
  - Clear definition of chains of command
  - Written evaluation process for sitters that adequately documents ability of sitter to carry out those responsibilities defined job description

- **Develop culturally sensitive guidelines that include written expectations about family members in acute care setting**

- **Provide safe patient care via CO by using sitter guidelines and assessment tools to structure safe patient environmental and interpersonal strategies**
  - (See Observation Assistant-Sitter Request Form, Harding, 2010; Specialized Adult Focused Environment (S.A.F.E.), Nadler-Moodie et al., 2009; Sitter Training Tests, Ragaisis & Wedler, 1997; Sitter Roles & Responsibilities, Segatore & Adams, 2001; and Patient Attendant Assessment Tool, Tzeng et al., 2008)

- **Use assessment tools to objectively categorize which patients are at risk**
  - Tools such as the Patient Attendant Assessment Tool (PAAT) can provide guidance for assessment of patients’ needs for sitters, with the goal of decreasing the use of sitters (See Tzeng, H.M., Chang-Yi, Y., & Grunawalt, J., 2008)
  - PAAT includes instructions for tool use, tool itself, & list of suggested alternatives to use of sitters
    - Tool includes risk factors & a score for each risk
    - PAAT helped improve the fill/request rates for sitters
    - Unable to conduct validity & reliability analyses of PAAT retrospectively
    - Unable to systematically evaluate the compliance of nurse with PAAT instructions

- **Patient Falls in the Acute Care Setting** (*conflicting evidence*)
  - 2 categories emerged for patients who would benefit from CO:
    - Those assessed to be a high fall risk to fall
    - Patients in psychiatric crisis who experience suicidal ideation, acute mania, and severe depression
  - Clinical nurses should patiently and constantly remind patients and family about fall prevention topics
  - Build collaborative relationships and establish frequent communication between staff nurses, patients, and companions (family members, privately hired aides, sitters) about an individual patient’s risk for falls as a key strategy in preventing fall-related injuries

- **Family visitors cannot replace nurses in effectively preventing patient falls**

- **Use family visitors, sitters, or volunteers to prevent inpatient falls**

- **Use retired nurses as fall prevention care givers in inpatient units**

- **When more personnel (nurse, nursing assistant, and sitter) share the caring for a patient, negative outcomes such as patient falls can be aggravated**

- **There is no rationale to provide sitter service without a definitive positive relationship of sitter use and patient outcome (reduction in patient falls)**
  - Actual productive sitter hours had no correlation to the fall rate
  - The sitter utilization case was unable to provide correlation of sitter use to decreased fall rates, elopement, or assault behaviors

- **No research has shown that sitters effectively impact fall rates or injuries from falls**
  - In part, this might be because of the great variations in personnel and training of sitters across institutions
  - Sitters who are nursing assistants are included in the skill mix, which has been shown to affect fall rates
The Use of Sitters in the Acute Care Hospital Setting
An Integrative Review
A Topic Summary of the Evidence

- Possible causal factor in fall phenomenon may be that other risk-minimizing tools (e.g. bed checks monitors) are deemphasized when sitters are used.
  - If sitters steps away or break in sitter coverage, other systems are not in place & falls occur.
  - Ensure default systems for fall prevention are in place when using a sitter program.
- Fall risks can be decreased by:
  - Increased nursing observation and vigilance to ensure patient safety.
  - Proactive nursing assistance with toileting, hydration, and movement.
- Use of soft limb holders decreased after PAAT adoption, but the rate of fall injuries did not decrease.
- Most common fall prevention interventions (per nurse manager phone interviews; N=140):
  - Bed alarms (90%)
  - Rounds (70%)
  - Sitters (68%)
  - Relocating patient closer to the nurses’ station (56%)
  - Physical restraints (29%)
  - Ambulation (10%)

- Patients Experiencing a Psychiatric Crisis in the Acute Care Setting:
  - 2 categories emerged for patients who would benefit from direct observation:
    - Those assessed to be a high fall risk to fall.
    - Patients in psychiatric crisis who experience suicidal ideation, acute mania, and severe depression.
  - Sitter PI Project Results:
    - The sitter utilization case was unable to provide correlation of sitter use to decreased fall rates, elopement, or assault behaviors.
    - There was no relationship between ED or inpatient volume and actual sitter use.
  - No elopements or assaultive behavior documented for patients in psychiatric crisis with a sitter.
  - There is currently no research data to demonstrate that CO is effective in reducing the prevalence of suicide or violence in the general hospital.
    - General hospital studies have confirmed CO is frequently ordered for management of confusion/agitation and suicide prevention. However, reduction of self harm has not been demonstrated through the use of this intervention.
  - CO should be reviewed at least daily by the consultant psychiatrist in order to monitor the patient’s coping strategies and to assess the ongoing need for CO.
  - Nursing staff use for CO may be less stigmatizing than using security staff.
  - Staff’s professional background may be less relevant than personality and physical characteristics which allow physical/emotional containment for patients at risk of harm to self or others.
  - Modern CO practices on psychiatric units include maintaining an arm’s length distance between staff and patient.

- Patients and Family:
  - Education re: risk should also be shared with family to involve them actively in safety of loved one.
  - Negative and Positive CO Effects:
    - One study found 28% of patients rated CO in negative terms.
    - Stigmatizing effect of CO.
    - Family feelings of anger or distress regarding patient may be displaced toward staff providing CO.
    - Trend for older patients to view CO as punitive, especially in those with a history of substance abuse.
    - Younger patients tended to rate CO more positively.
      - Some even described the interaction with CO staff as a therapeutic experience.
The Use of Sitters in the Acute Care Hospital Setting
An Integrative Review
A Topic Summary of the Evidence

- Patients who benefit from CO include, but aren't limited to:
  - Agitated, highly anxious
  - Withdrawing from alcohol or other substance intoxication
  - Posing as a danger to others
  - Harm from others
  - Experiencing behavioral disturbances, psychosis, psychiatric crisis, or personality disorders
  - High fall risk
  - Delirium or dementia
  - Pulling at medical machinery; dislodging significant lines, tubes, or catheters
  - Neurologically impaired
  - Vision or hearing impairments
  - Acutely suicidal
  - Elopement

Sitter patients typically require frequent observation, rather than continuous, bedside, one-on-one monitoring.

- Family Participation (*conflicting evidence)
  - Involving family visitors in patient care may provide psychological support, but cannot replace nurses in effectively preventing patient falls
  - Qualifications & roles of family members, family-paid aides, and economic burdens to families should be addressed, rather than replacing nursing staff and saving nursing costs for inpatient in-services
  - Understand what roles of family members are expected to play in inpatient care, as well as what kinds of activities nursing staff expect them to perform, before setting up an open visitation policy which invites family members to participate in patient care
  - Develop a culturally sensitive guideline for patients, family, hospital administrators, nurses and physicians that include written expectations about family members in acute care setting
  - Relatives may be the most astute observers of behavior and best able to ground the patient in reality
  - Family members may be calming to the patient
  - Family members should be oriented to the plan of care, diagnosis, supportive interventions, and staff appreciation
  - Approach family members with a CO cost-sharing program
  - The public image of Taiwan hospital systems suggest a lack of trust in hospital-based medical care
  - Families often worry that loved ones would not receive good care if they were not present

- Nursing Strategies (*conflicting evidence)
  - As nurse accountability shifts toward assessment & delegation, it is imperative for nurses to be aware of the obligations inherent in managing the environment
  - Early assessment and management of patients’ disorientation through the use of night light, pictures or presence of family members may minimize the need for CO
  - Staff member should request another staff member provide CO they need to leave room
  - *Environment: 6 patient beds: 2 beds per room in close proximity, two across from each other, and one next door
  - Staffing configuration: 1 nurses, 1 diversional partner, 1 nurse’s aide who successfully completed specialized training program
  - CO is often considered a task that enables the nurse to “check off” patients with little thought for how s/he could supplement sitters activities with purposeful interactions
  - The formality of a sign-off by nurse managers or other leadership level nurses may make nurses consider sitter alternatives
  - Nurses may need to spend more time coordinating care, which can result in fragmented workflow and impact safe hospital stays
  - As nurses are accountable for both patient and sitter, it is essential they understand the responsibilities between licensed and unlicensed nursing staff
The Use of Sitters in the Acute Care Hospital Setting
An Integrative Review

A Topic Summary of the Evidence

- Make clear distinctions between the custodial care provided by a sitter and the professional nursing care the patient on CO requires 7,10,12
- Staff nurse often lack an understanding of patients' needs and are confused as to "who is responsible for what" 7
- Implement interdisciplinary rounds focused on the need for sitters 1
- Development CNS role responsible for daily rounding on patients requiring sitters to maximize less expensive therapies 1
- Tools such as the PAAT may help nurses assess patients' needs for sitters and better judge whether to request scarce resources for nursing services 12
- Patient Placement to Maximize Safety 1 ("conflicting evidence")
  - *Cohort multiple patients with 1 sitter 1
  - *Do not cohort delirious or agitated patients with one sitter, as their actions may become incendiary and behavior provoking 8
  - Video camera to monitor patient movement (question of privacy) 1
  - Placement close to nurses station 1
  - Placement in public areas 1
- Use psychiatric consults/treatment for symptom & behavior management 5,10
- Research findings are not conclusive as whether better fill/request rates for sitters would lead to fewer restraints being ordered 12

Education 1,4,5,7,9,10

- There is minimal information available in the literature regarding what constitutes appropriate training or essential knowledge/skills for sitters 7
- Providing the development of formal educational programs for sitters was vital for describing expectations of sitters and their understanding of the role behaviors 4
- CO staff should receive work-based training in managing common psychiatric conditions to improve their communication and interaction with their patients 5
- Key areas of information for any sitter training program should include the following 7:
  - Policy & Procedure 7
  - Symptom Recognition 7
  - Risk Assessment 7
- Develop and present a comprehensive evidence-based sitter program on a regular and ongoing basis, with incorporation of the following key elements 1,4,7,8,10-12
  - Standardized sitter guidelines, policies, procedures, and tools 1,4,6,8,10,12
  - Nurse and sitter roles, expectations, behaviors, and responsibilities 1,4,7,8,10,12
  - Family member sitter roles and responsibilities 11
  - Early symptom recognition 7
  - Risk assessment 7
  - Specific patient behaviors requiring interventions 7
  - CO and alternatives to CO 1,10,12
  - Restraints and fall prevention 2,3,12
  - Principles of therapeutic communication 8
  - Patient containment 8
  - Patient behavior-based documentation 7
- Administrative support is needed for staff education to keep nurses competent in the performance of mental status examinations & early recognition and intervention in 10:
  - Suicide intent 10
  - Alcohol/drug withdrawal 10
  - Delirium 10
  - Psychosis 10
  - Impeding violent behavior 10
The Use of Sitters in the Acute Care Hospital Setting
An Integrative Review
A Topic Summary of the Evidence

- **Nursing Staff Education**
  - Alternative interventions, including the use of behavioral interventions
  - Cost to unit of the intervention
  - Regular rounding and interaction with staff/patient by APRNs who educate staff re: need for sitters

- **Organizational Systems**
  - Acute care facilities need systems in place to safeguard the consistency & validity of the decisions being made concerning constant observation (CO)
    - Effective information processing is needed to quickly implement clinical decisions made to protect patients
    - Risk management involvement is essential when the driving concern is the issue of safety and protection against liability lawsuits
  - Create an environment where mutual, collaborative patient care decisions are made across disciplines
  - Promote safe hospital stay via Human Resource strategies (e.g. offering on-the-job training)
    - Expect results to take time – no instant solution
    - Outcomes are often obscure or have no correlation with sitter use
  - The lack of CO alternatives may be due to poverty of thought on the part of decision makers
  - A constraint on the decision making process is the availability of alternatives to CO
  - The development of CO standard policies, procedures, and decision tools is a broad intervention with significant organizational impact
    - However, by putting effort into infrastructure, policies, and procedures, minimization of sitter use and maximization of sitter effectiveness is a more realistic goal
  - Pilot assessment tools related to CO or sitter use on at least 2 inpatient units to assess feasibility & functionality before including in guidelines
  - Incorporate sitter utilization in the average daily census construct for industry comparison

- **Financial Considerations**
  - *Discover the proper balance between safe patient care and nursing staff support for the nursing while maintaining fiduciary responsibilities
    - *Authors of a performance improvement project for patients in psychiatric crisis stated the added expense of sitters was not warranted or justified, as the same patient outcomes (elopement and/or assault behavior) were obtained for the same patient population without a sitter
  - **Constant Observation Cost Saving Interventions (cited in the literature):**
    - Use of less expensive providers and programs
      - Internal staff rather than external agency staff
      - Family members
      - Volunteers
      - Cost-sharing program with family
    - Authorization of CO by a consultation-liaison psychiatrist
    - Consolidating bed space for patients
    - Daily written order renewal
    - Bed enclosure devices
  - Keep CO costs unit-based to:
    - Encourage nurses to find alternatives to CO
    - Hold units accountable
    - Align decision-making with the financial impact
Use the PDSA model to test Specialized Adult-Focused Environment (S.A.F.E.) units to prevent falls with
more cost effective utilization of “sitters”.

- **Plan.** Understand the problem; propose out-of-the-box solutions.
- **Do.** Pilot S.A.F.E. on a medical-teaching unit; hold weekly unit meetings.
- **Check.** Review data and lessons learned; recommend changes.
- **Act.** Implement permanent S.A.F.E. units with PI monitors.

Patient sitter programs should be strengthened.

*Do not cohort delirious or agitated patients with one sitter as a cost-containment measure, as their
actions may become incendiary and behavior provoking.

**Ethical-Medico-Legal Considerations**

- **Ethical Considerations:**
  - The role of family members providing CO for a suicidal patient in the general hospital is problematic from an ethical and medico-legal perspective.
    - Implies hospital transfers responsibility for patient’s safety to family.
    - Problematic from a logistic perspective since it requires adequate manpower operating on shifts with a full explanation of inherent risks.

- **Medico-Legal Considerations:**
  - “Duty of Care”: Israel judicial decisions require treating hospital to exercise a duty of care toward a patient with a known risk of self harm (suicide attempt) and include CO in situations where there are acute concerns.

**Future Research**

- There is limited research in CO; the following topics for research have been suggested:
  - Qualitative Research: understand the patient’s experience in order to develop CO alternatives from a patient’s point of view & to involve patient in CO decision making.
  - Quantitative Research: determine actual costs of CO to hospital, unit, patient, family, 3rd party payers.
  - Report or Case Studies of successful alternatives used in place of CO.

- Evidence-based intervention research is needed to further illustrate the cost-effectiveness of sitter or volunteer components of a fall prevention program.

- Further investigation on the optimum combination of staffing patterns & infrastructure for safe hospital stay in the inpatient setting.

- Further research is needed to determine the true effectiveness of direct observation as a mitigating tool to prevent falls or self-harm to patients in psychiatric crisis.

- Reaction of patient and provider to CO is a subject that requires further research.

- Ethical practice prevents the implementation of a study involving random allocation of CO in a clinical setting.
  - However, a study comparing the frequency of critical events of harm to self or others occurring in two general hospitals which differ in CO provision would provide some data to support the efficacy of CO.
The Use of Sitters in the Acute Care Hospital Setting
An Integrative Review

A Topic Summary of the Evidence

Appendix A – 2009 Electronic Database Search Methodology

<table>
<thead>
<tr>
<th>Key Web Search Terms</th>
<th>Search Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitters, sitter, hospital, acute care, inpatient, falls, use of sitters, constant observation (1998 to 2008)</td>
<td>Ovid Medline</td>
</tr>
<tr>
<td></td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key Web Search Terms</th>
<th>Search Results</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5</td>
</tr>
</tbody>
</table>

Contextual/Reference Links Relevant Articles: 1 (1997)
Web Search (Yahoo) Relevant Articles: 0
Total 2009 Articles Reviewed: 8

Total Relevant Articles Included in 2009 Review: 7
Appendix B – 2011 Electronic Database Search Methodology

Integrative review search topic: The Use of Sitters in the Acute Care Hospital Setting: An Update of the 2009 Integrative Review
Date(s): November 2011

<table>
<thead>
<tr>
<th>Database</th>
<th>Key Word(s) Used</th>
<th>Total References Identified (hits)</th>
<th>Relevant References</th>
<th>Total Duplicates</th>
<th>Articles Selected for Review</th>
<th>Articles Excluded</th>
<th>Final Total Relevant References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: Pub med</td>
<td>Sitters + Acute Care</td>
<td>2</td>
<td>2</td>
<td>1 (2009 Review)</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Years: 2008-2011</td>
<td>Constant Observation + Acute Care</td>
<td>10</td>
<td>2</td>
<td>1 (2009 Review)</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Name: Ovid</td>
<td>Sitters + Acute Care</td>
<td>1</td>
<td>1</td>
<td>1 (Pub med)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Years: 2008-2011</td>
<td>Constant Observation + Acute Care</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Name: Proquest</td>
<td>Sitters + Acute Care</td>
<td>2</td>
<td>2</td>
<td>1 (Pub med)</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Years: 2008-2011</td>
<td>Constant Observation + Acute Care</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Name: Science</td>
<td>Sitters + Acute Care</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Direct Years: 2008-2011</td>
<td>Constant Observation + Acute Care</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Name: Mosby’s</td>
<td>Sitters + Acute Care</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Nursing Consult</td>
<td>Constant Observation + Acute Care</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Years: Open</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Created by Cecelia L. Crawford, RN, MSN, ©Kaiser Permanente SCAL Nursing Research Program, January 7, 2009; Modified May 2011, updated December 2011
# The Use of Sitters in the Acute Care Hospital Setting
## An Integrative Review
### A Topic Summary of the Evidence

<table>
<thead>
<tr>
<th>Database</th>
<th>Key Word(s) Used</th>
<th>Total References Identified (hits)</th>
<th>Relevant References</th>
<th>Total Duplicates</th>
<th>Articles Selected for Review</th>
<th>Articles Excluded</th>
<th>Final Total Relevant References</th>
</tr>
</thead>
</table>
| **Name:** Cochrane Library  
Years: 2008-2011 | Sitters + Acute Care              | 0                                 | 0                   | 0                | 0                            | 0                | 0                               |
| **Name:** Cochrane Library  
Years: 2008-2011 | Constant Observation + Acute Care | 3                                 | 0                   | 0                | 0                            | 0                | 0                               |
| **Name:** Yahoo  
Years: Open | Sitters + Acute Care              | 50                                | 7                   | 3 (2009 Review) 1 (Pub med) | 3                | 1                         | 2                               |
| **TOTALS**                | **69**                            | **15**                            | **5 from 2009 Review 4 from Pub med** | **6**            | **1**                        | **5**          |

**Total New Articles Included in Updated Integrative Review: Database (5) + Contextual Links (0) = 5**

**Inclusion Criteria:** Sitter(s), constant observation, observation assistant(s)/attendant(s), acute care hospital setting

**Exclusion Criteria:** Health care professionals other than sitter(s) and/or observation assistant(s)/attendants(s); interventions other than constant observation; health care settings other than acute care (Psychiatric units, rehabilitation units, skilled nursing facilities, convalescent homes, etc);

**Relevant Articles included in 2009 Review: 7**  
**Relevant Articles included in 2011 Update: 5**  
**Total Relevant Articles included in 2011 Review: 12**

---

Created by Cecelia L. Crawford, RN, MSN, ©Kaiser Permanente SCAL Nursing Research Program, January 7, 2009;  
Modified May 2011, updated December 2011
### Appendix C – Evidence Levels

<table>
<thead>
<tr>
<th>SCORE</th>
<th>LEVELS OF STUDIES</th>
<th>RELEVANT ARTICLES</th>
<th>ARTICLE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Systematic Reviews/Meta-Analysis of Randomized Controlled Trials</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Large Sample Randomized Controlled Trials</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Small Sample Randomized Controlled Trials</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Non-random, Controlled Prospective Studies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Non-random, Controlled Retrospective Studies</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5</td>
<td>Cohort Studies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Case-Controlled Studies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Non-Controlled, Clinical, Descriptive Studies</td>
<td>3</td>
<td>10,11,12</td>
</tr>
<tr>
<td>2</td>
<td>Case Studies</td>
<td>3</td>
<td>4,6,7</td>
</tr>
<tr>
<td>1</td>
<td>Expert Consensus, Manufacturers Recommendations (Literature Reviews)</td>
<td>4</td>
<td>1,3,5,8</td>
</tr>
<tr>
<td>0</td>
<td>Anecdotes</td>
<td>1</td>
<td>9*</td>
</tr>
</tbody>
</table>

**Total Articles** 12

(*Qualitative research study)
Appendix D – 2009 Bibliography


The Use of Sitters in the Acute Care Hospital Setting
An Integrative Review

Risk Identification & Assessment
- Objectively categorize at-risk patients
  - Admission, every shift; clinical status change
  - Initiate, continue, discontinue CO
  - CO request procedure

Risk Reduction
- Coordinated nursing care
- Prompt & timely response
- Symptom recognition

Rescue
- Psychiatric crisis consultation
- Accountability for patient safety
- Safety net system for 24/7 CO

Protection
- Falls program, CO guideline & assessment tools

CO Strategies
- Rounding & assessment
- Patient/family involvement
- CO request procedure
- Staffing configuration
- Therapeutic communication
- Patient placement, location, containment
- Culturally sensitive & role specific guidelines
- Toileting, hydration, & movement assistance
- Frequent observation vs CO
- Patient-sitter gender matching
- Nursing staff rather than security staff
- Default safety net systems for 24/7 CO

Nursing Staff
- Education
  - Role expectations & behaviors
  - Sitter-based patient care
  - Policy & procedure
  - Early symptom recognition
  - Risk assessment
  - Restraints & falls prevention
  - Rounding
  - CO & CO alternatives
  - Patient containment
  - Behavior-based documentation
  - Cost to nursing unit using CO

Unit-Based Cost Management
- Encourage CO alternatives
- Daily sitter rounds
- Internal vs external staff
- Cost-sharing with family
- Unit accountability
- Nurse managers sign-off
- Incorporate sitter use into daily census
- Decision-making + financial impact alignment

Documentation
- Use sitter tools & guidelines
- Clear & specific documentation
- Identify patient behaviors (e.g. biting IV tubing)

Communication
- Between patient, family, & staff
- Written expectations of family
- Collaborative relationships

Multidisciplinary Collaboration
- Collaborative decision-making across disciplines
- Nursing centralization with clear chain of command
- Cohesive teamwork with shared vision
- Interdisciplinary sitter rounds
- Sitter job description, guidelines, protocols & decision-making tools

Evidence-Based Sitter Program
- Organizational & administrative support
- Worked-based training & education
- Evidence-based sitter and nurse strategies
- Tailored CO and CO alternatives specific to patient need
- Individualized patient population practices

STRATEGIC PROGRAMMATIC INFRASTRUCTURE
Assessment, Implementation, Monitoring, & Evaluation Systems

Appendix E
The Hospital Sitter Constant Observation Programmatic Model:
An Evidence-Based Framework for Risk Reduction & Management

Adapted from Sexton's Falls Reduction Conceptual Framework: An Error Management Model (2008); C. Crawford, RN, MSN; Kaiser Permanente SCAL Regional Nursing Research Program, December 2011


Purpose/intended Audience

Because we want everyone in our communities to have the healthiest lives possible, we are making our
evidence reviews available to the communities we serve to help Californians and others lead healthier lives.

Integrative reviews and evidence summaries are provided as a community service for reference purposes
only, and must be used only as specified in this disclaimer. These documents are intended for use by
clinicians. If you are not a clinician and are reading these documents, you should understand that the
information presented is intended and designed for use by those with experience and training in managing
healthcare conditions. If you have questions about them, you should seek assistance from your clinician.
The information contained in the evidence reviews is not intended to constitute the practice of medicine or
nursing, including telemedicine or advice nursing.

Limitations On Use

These documents have been developed to assist clinicians by providing an analytical framework for the
effective evaluation and treatment of selected common problems encountered in patients. These documents
are not intended to establish a protocol for all patients with a particular condition. While evidence reviews
provide one approach to evaluating a problem, clinical conditions may vary significantly from individual to
individual. Therefore, clinicians must exercise independent professional judgment and make decisions based
upon the situation presented.

Kaiser Permanente's documents were created using an evidence-based process; however, the strength of the
evidence supporting these documents differs. Because there may be differing yet reasonable interpretations
of the same evidence, it is likely that more than one viewpoint on any given healthcare condition exists.
Many reviews will include a range of recommendations consistent with the existing state of the evidence.

All of the Kaiser Permanente integrative reviews and evidence summaries were developed from published
research and non-research evidence and do not necessarily represent the views of all clinicians in Kaiser
Permanente. These documents may also include recommendations that differ from certain federal or state
health care mandates.

Intellectual Property Rights

Unless stated otherwise, all of these materials are protected by copyright and should not be reproduced or
altered without express written permission from Kaiser Permanente. Permission is granted to view and use
these documents on single personal computers for private use within your hospital or hospital system. No
portion of these materials in any form may be distributed, licensed, sold or otherwise transferred to others.

The organizations within Kaiser Permanente retain all worldwide rights, title and interest in and to the
documents provided (including, but not limited to, ownership of all copyrights and other intellectual
property rights therein), as well as all rights, title and interest in and to their trademarks, service marks and
trade names worldwide, including any goodwill associated therewith.

2013 Kaiser Permanente Southern California Regional Nursing Research Program
Nursing.Research@kp.org
No Endorsement or Promotional Use

Any reference in these documents to a specific commercial product, process, or service by trade name, trademark, or manufacturer, does not constitute or imply an endorsement or recommendation by Kaiser Permanente. The views and opinions expressed in these documents may not be used for any advertising, promotional, or product endorsement purposes.

Disclaimer of All Warranties and Liabilities

Finally, although Kaiser Permanente believes that all of the information provided in its documents is accurate, specific recommendations derive from combining the best available evidence. Although we have sought to ensure that the documents accurately and fully reflect our view of the appropriate combination of evidence at the time of initial publication, we cannot anticipate changes and take no responsibility or assume any legal liability for the continued currency of the information or for the manner in which any person who references them may apply them to any particular patient. Kaiser Permanente does not assume any legal liability or responsibility for the completeness, clinical efficacy or value of any apparatus, product, or process described or referenced in the documents. We make no warranties regarding errors or omissions and assume no responsibility or liability for loss or damage resulting from the use of these documents.