Patient Behavior requiring a sitter: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**If Patient is on Suicide Precautions – stop here and follow Suicide Risk Assessment Policy**

**All other sitter cases must have the following areas reviewed and trialed**

**MANDATORY:**

* Screen patients for need prior to requesting a sitter ✓ Review every 4 hours if a sitter is in use
* Renew this approval every shift

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| Criteria | | **Yes** | **No** |
| *Yes = This has been done No = This did not work* | |  |  |
| 1. **Patient Assessment**: All underlying causes reviewed and discussed with LIP and intervened with the following:   \*Oxygenation – check SpO2 level \*Sleep Deprivation  \*Activity Needs \*Pain Control  \*Elimination-Pt offered toileting q 2 hrs. \*Blood Sugar  \*Delirium vs. Confusion  If no, assess all abnormal values and patient needs, and contact patient LIP prior to initiating sitter. | |  |  |
| 1. **Use of Bed Alarm**: Has a bed/chair alarm been used? If no, trial this for 1 shift.   *Exceptions require clearance from Nurse Manager/ Administrative Supervisor* | |  |  |
| 1. **Rounding:** Frequent rounds made in order to provide toileting and other needs.   Document: Days / PM’s - q 1 hr Night - q 2 hr | |  |  |
| 1. **Fall Risk:** Patient’s fall risk score is Moderate to High.   If Low to Moderate, review with Charge RN why sitter is needed. | |  |  |
| 1. **Medications:** Medications reviewed for possible side effects or interactions that may contribute to risk of falling, aggravation, or confusion. (Check Micromedex) If no, contact pharmacy prior to initiating a sitter to clarify side effects. | |  |  |
| 1. **Room Placement:** Patient’s room is near the nurse’s station. If no, move patient closer to nurse’s station for observation prior to ordering a sitter. | |  |  |
| 1. **Family Support:** Family member can partner with staff in watching the patient. If yes, create schedule and confirm times with volunteering family member. | |  |  |
| 1. **Restraints:** *Consider less restrictive measures first per policy* such as: arm boards, netting over tubes, PJ’s, or something to hold. Prior to wrist restraints, apply mittens (also considered restraints) correctly and trial for 2 to 4 hours minimum if appropriate. | |  |  |
| 1. **Patient Cohort:** Two patients can be cohorted to use the same sitter. Assess compatibility (diagnosis, need for sitter, etc.) before combining patients. | |  |  |
| 1. **Sitter Assignment:** Sitter assignment appropriate for non-clinical sitter | |  |  |
| * All of the above must be trialed and if majority of questions 1 to 9 are answered YES, a sitter may be appropriate. * FAX to: Administrative Supervisor / Staffing Office (707) 269-3895 and SUBMIT to Nurse Manager * For assistance with psychiatric assessment contact: BART RN - Daytime #: (707) 407-7722   ***RN Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:***\_\_\_\_\_\_\_\_\_\_\_\_***Time:***­­­­­­\_\_\_\_\_\_\_\_\_\_  ***Sitter Approved:*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***Date:***\_\_\_\_\_\_\_\_\_\_\_\_***Time:***­­­­­­\_\_\_\_\_\_\_\_\_\_ | | | |
| H:\LOGOS\SJH-SJE-color logo.png  **SITTER NEEDS ASSESSMENT** | Patient Identification | | |

(11/16) NO*T PART OF THE PERMANENT MEDICAL RECORD*