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Nursing Observation: Essential or Substitutable?

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Over the past decade, the use of patient sitters in hospitals has increased significantly, especially in situations when vigilant observation is deemed necessary for the patient's safety. Prepared primarily as certified nurse's aides, these patient companions, or "one-on-ones," are essentially intended to act as safeguards against harm by stopping or alerting others of potentially dangerous patient behaviors. Initially, hospitals used sitters to watch suicidal or violent patients for signs of impending injurious behavior and to notify staff as needed. Today, in the face of a lack of evidence for their use,[1] sitters are at the bedsides of older hospitalized adults with dementia or delirium who are perceived at risk for falling or treatment disruption.[2]

The use of individuals as supplemental bedside observers to hospital nursing staff is neither new nor unusual. Private-duty caregivers, whether professionally educated nurses or minimally trained nursing assistants, have been regularly employed by patients and their families to supplement existing staff, especially if the patient was deemed in need of additional or constant monitoring. This has been particularly true during periods of change in nurses' roles and environments and nurse workforce shortages. Examination of nursing's shifting role in preventing patient falls from bed provides a salient historical example.

In the 1930s, the nurse's primary intervention for preventing agitated, confused, or other high-risk patients from falling from bed was the use of "careful and continuous watchfulness."[3] This was relatively manageable on hospitals' large wards where handfuls of patients were readily observed from the nurses' central station. With post–World War II changes in hospital architecture from multi-patient wards to semiprivate and private patient rooms; however, nurses' direct and ongoing visibility of their patients' conditions and behaviors was markedly reduced. Along with new technologies and expanding scope of practice, nurses' new duties combined with traditional ones; nurses were expected to interact with patients in a kind and pleasant manner as well as be skilled bedside technicians. These new and growing responsibilities, combined with nurse shortfall, diminished nurses' time and ability to observe their patients and attend to direct care needs. With pressure from legal and health care interest groups, efforts were made to remedy the situation; the adoption of side rails and other physical restraints limited patients' movement from bed until nurses could arrive.[4] This practice continued unabated until well into the 1990s, when Centers for Medicare and Medicaid Services (CMS) and Joint Commission stipulations compelled hospitals to reduce restraint use. Many hospitals, in an effort to comply with new regulations against restraint use and keep patients safe, hired sitters to enforce patients' immobilization, particularly with older patients at risk for falls. This practice has reported negative consequences similar to those incurred with restraints; as well meaning sitters discouraged patients from leaving bed, patients became physically deconditioned and risked skin breakdown. Still, sitters remain consistently utilized in this capacity.

Indeed, the current reliance on sitters to sit, watch, and report on the status of older patients may potentiate hospital costs as well as Medicare costs for rehabilitation services to regain functional losses post-hospitalization. This is because observation is a key element of nursing assessment. Using sitters as observers *only* separates this essential aspect of the nurses' critical thinking process from action, diluting its effectiveness.

In other words, because sitters are "observers" rather than "doers," their presence does little to improve the quality of patient care. Given the climate in which nurses practice today and the projected nurse shortfall that the nation faces in the future, is there a role for hospital sitters with this patient population?

We think there can be. First, existing models that focus on the clinical issues associated with sitter use—fall risk and delirium—need to be implemented. These models employ sitters in more than an observation capacity and have clear parameters as to when they are best utilized and when they can be discontinued. Practice models proved to be most effective employ advanced practice nurses to provide decision support, promote provider-patient/family collaboration, and facilitate comprehensive care planning in a team approach that includes an active role for sitters when needed. Many mirror successful models used with medical-surgical patients with psychiatric comorbidities (suicidal behavior; substance abuse; psychotic, violent, or personality disorders) in which trained sitters provide supportive psychiatric interventions designated within a care plan directed by psychiatric consultants.[5-8] We think sitters can have an equally important function in caring for hospitalized older adults at high risk for falling or treatment disruption by actively promoting function (e.g., ambulation, bedside exercise, therapeutic recreation), comfort (e.g., addressing pain, providing reassurance), and physical care needs (e.g. hydration, nutrition) that can effectively prevent fall-related injury and delirium and limit continued sitter use. Thus, the term "sitter" and its associated scope of responsibility require transformation.

It is time to change current practices that lack supportive evidence or simply don't make sense. Although the expansion of hospital sitter use over the past ten years parallels the growing national shortage of nurses and changes in regulations that impact care of an increasingly older hospital population, their use fragments the essential role of observation from nursing's caring process. Substituting one set of eyes for another, especially with individuals whose skill and preparation is less than those for whom they substitute, is not the answer.

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