

# YOUR HOSPITAL

## Sitter Care Module

- Keep with flowsheet until patient discharged, complete all lines
- Document Progress Note for any variances
- Place completed form in Medical Record, front of Progress Notes.

Outcomes A = Accomplished V = Variance (requires progress note)	A	V	N/A	Date Initials
1. Patient has not harmed self/others.				
<b>Processes</b>				
1. Assessment.				
a) Write order for "Psych consult per Policy."				
b) Implement CIWA flowsheet if at risk of alcohol withdrawal				
• Start Ativan Protocol based on protocol eligibility				
2. Interventions.				
a) Relocate patient closer to Nurses' station.				
b) Schedule prn medications ATC.				
c) Activate bed alarm.				
d) Institute toileting schedule (offer q2hrs, assist q4hrs).				
e) Reduce/eliminate environmental hazards.				
f) Reduce stimulation, i.e. TV off				
g) Provide dim lighting				
3. Teaching.				
a) Teach/reinforce pt./family safety measures.				
b) Inform pt./family plan of care.				
c) Inform pt./family of psych consult per policy.				
d) Family/S.O. willing to help w/ alternatives; list:				
4. Restrictive Interventions (alternatives fail and/or are inappropriate).				
a) Implement "Patient Restriction Care Module."				
5. Sitter (if restraint worsens behavior or is inappropriate).				
a) Use HH employee first choice (includes overtime).				
b) Use Agency employee if unable to obtain HH employee.				
c) Introduce self to sitter.				
d) Provide report to sitter.				
e) Review "Continuous Observation Activities List" with sitter.				
f) Instruct sitter to review "Basic Skills" and "Responsibilities".				
g) Instruct sitter to use "Observation and Care" flowsheet.				
h) Assign breaks for sitter.				
i) Reduce/eliminate restraint device.				
j) Document behavioral reason for continuous observation.				
k) Collaborate with psych to discontinue sitter.				
6. Notify Psych Liaison Nurse if any variances (x52633).				

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