



Patient Sitter Orientation

Patient safety and comfort is very important to us. As a sitter, you play an important role in keeping our patients safe. The following provides helpful information to assist you during shift.

General Guidelines:

1. The patient must be observed at all times and never left alone. To keep the patient safe, it is important that you remain awake and alert.
 - Use the call light to summon staff for assistance, break times, needed equipment. Do not leave the room.
 - While the doctors are in the room, you may step out into the hallway. You must stay in the room while visitors or family members are in the room unless you are told otherwise by the nurse.
2. The bedside telephone is for patient and family use only.
 - You may use the telephone only in an emergency or if there is a delay in response to the call light.
 - You may call:
Unit desk number (enter it here): _____
Security 6-2311 (if you feel you are in danger or if the patient is attempting to elope)
3. Please turn off all personal cell phones or pagers. Use of these devices in the patient room is not permitted. Personal cell phones or pagers may be used only during your break. You may bring personal reading material to use when patient is sleeping and all duties are completed.
4. All sitters have a 30-minute lunch break during their shift. Other staff are scheduled to stay with the patient when you are on break. For 12-hour shifts, two 15-minute breaks are allotted in addition to the lunch break. Eating or drinking in the patient room is not allowed.

Communicating with the Patient:

The patient's illness (or sometimes their age) may cause them to be confused, uncooperative or even harm themselves. As a result, they may have little control of what they do or say. This is why a sitter is needed.

It is important to respect the patients by speaking to them in a calm and friendly tone. Raising your voice may cause the patient to become upset.

- Avoid arguing with the patient
- Remain calm

In certain circumstances, you may be required to take action to prevent a patient from harming themselves prior to the nurse's arrival. An example of this may be holding the patient's hand to prevent them from pulling out a tube or line. If the patient is doing something that may cause harm (e.g. climbing over the bed side rails), attempt to stop these actions by giving brief, clear instructions. Repeat this up to 3 times (over one minute) in a firm, yet quiet manner. Be sure that you have the patient's attention. Make eye contact when possible. If the patient persists in this harmful behavior, contact the nurse right away.



On the Unit:

When arriving on the unit, please let the charge nurse know that you are there. Shortly thereafter, the nurse will talk with you. The care needed for the patient will be discussed at this time. **Before starting your shift, please verify with the patient's nurse:**

- Your break time
- Special patient needs
- Vital sign schedule (if you are not trained in taking vital signs, please tell the nurse)
- Patient activity (e.g. up to bathroom with help, bed rest)
- Any concerns you have about caring for the patient

Responsibilities:

Your duties will include the following:

1. Keep the patient safe by observing the patient at all times:
 - When the patient is using the toilet or showering, leave the bathroom door open at all times so you can see the patient. The outer door to the patient's room may be closed for the patient's privacy. If the patient refuses to leave the bathroom door open, contact the nurse. The nurse will then select other care options (e.g. use of a commode or bathing at the bedside).
 - If you see any object in the room that patients may use to harm themselves or others, contact the nurse right away. This may include knives, scissors, matches, lighter, cord, rope, plastic bags, or pills (not given by the nurse).

Patients At Risk For Falling: You may be asked to monitor and ensure the safety of a patient who is at risk for falling.

- A surgical procedure or medical condition that impairs their strength or balance
- Confusion caused by medication, dementia or unfamiliar surroundings
- Poor eyesight
- Medical equipment such as IV pumps, tubes, drains or orthopedics devices such as casts or splints

2. Vital signs are generally taken once a shift; if it is required more often, the nurse will advise. Others may note this for you in the patient's online chart.
 - This includes temperature, pulse, respirations, blood pressure and pulse oximetry (ox)
 - Contact the nurse right away if the patient's:
 - temperature is above 101.5
 - pulse is above 100 or is below 60
 - respirations are above 24 or are below 12
 - blood pressure is above 160/90 or below 90/50
 - pulse ox is below 93%



3. Intake and output (I & O): Please tally up any fluids the patient has had.
 - Record any urine the patient has had on the patient's eraser board or on a piece of paper so staff can enter into the computer.
 - Empty Foley catheters and measure output; if you are unsure how to empty Foley catheters, please consult the nurse.
 - Again, please report these totals to the PCT or nurse so they may record it in the chart.
4. Assist the patient during meals. If the patient is coughing after drinking liquids or is having a hard time swallowing or chewing, please let the nurse know right away.
5. Please do not attempt to walk the patient to the bathroom by yourself unless you have verified this with the nurse.
6. Please check the patient every hour if they are diapered or incontinent to see if they need to be changed. If so, please carefully clean the area. Report any skin breakdown to the nurse.
7. Make sure the patient is turned and repositioned in bed every 2 hours. If you need help to do so, please call a staff member.
8. Bathing is done every morning and as needed. The patient may require more frequent bathing:
 - After meals
 - If incontinent
9. You may be asked to leave if you fail to comply with the above guidelines and your agency will be notified.
10. **Talk with the nurse if you have any questions about the above information or feel that you cannot fulfill these outlined duties.**

Care of Patients Who Are Restrained:

Restraints are used on a variety of patients for many different reasons. Some of those reasons may include confusion, agitation, violent or aggressive behavior, to prevent the patient from pulling out tubes or lines and prevention of harm to the patient or others. Before restraining a patient, other attempts to use alternative measures such as disguising or covering tubes and lines, reorienting the patient to their environment, medication or pain management, and staff or family supervision should be made.

When a patient is placed in restraints, it does not mean that they need less supervision than other patients. Any type of restraint tied to the bed can loosen easily. Also, these patients need to be assessed frequently to make sure the restraint is not causing any harm to them. The RN must monitor the patient's circulation or skin integrity, movement and sensation every two hours. A sitter can assist the RN with patient's range of motion exercises, hydration with sips of water or juice (if appropriate), toileting, and any other relevant care every two hours as necessary. Please also monitor the areas within the patient's reach to assure that he/she does not have access to items that could cause harm (i.e. sharp objects, matches, lighters, etc.).



Types of restraints used here at Northwestern include:

1. soft restraints
 - mitten restraints
 - soft wrist and limb restraints
 - vest-type or chest restraints
2. locked restraints (always on all four limbs and considered “hard restraint”)

You may be asked to care for a restrained patient. Your responsibility may be to observe the patient every 15 minutes and record this on the flow sheet outside the patient door.

You need to check on the patient and document the results every 15 minutes by signing your initials. You will be making the following observations:

- awake vs. asleep (do not wake the patient every 15 minutes)
- change in the patient’s condition (change in vital signs)
- change in the patient’s mental status
- safety of the patient
- comfort level of the patient
- physical needs of the patient (toileting and fluids)

Notify the nurse of any changes!

Do not remove restraints without permission from the RN caring for the patient!

Care Of A Suicidal Patient:

Patients who have attempted or have expressed a desire to commit suicide must be taken seriously and protected from harming themselves. This is accomplished through a team approach including the RN, unit staff and 1-to-1 monitoring by you. **It is extremely important that you are awake and alert while caring for this patient!**

Follow the care guidelines below and provide a safe environment for them.

- The patient should never be left alone, this includes when the patient is dressing, bathing or using the bathroom. You must have visual contact with them at all times and should be within 4-6 feet from the patient.
- The patient cannot ask you to step out of the room for any reason. If they become agitated, use the call light to get assistance in the room.
- The patient cannot have private time with visitors, nor should you move yourself away from the patient when visitors are present.
- If the patient asks to go for a walk, another member of the staff should accompany you.
- The patient cannot have anything that has the potential to be used to harm them. This could include items such as knives and forks, sharp objects, pins, plastic bags, glass or metal objects, medications of any kind, strings, cords, or unused restraints.
- You should have the ability to see the patients hands at all times.
- Patient should be checked frequently when sleeping, including pulling covers down to check patient.



- Convey attitudes of compassion, empathy and understanding. Do not offer to counsel the patient spiritually or emotionally.
- Allow the patient to talk, but do not offer your judgments or opinions. Do not promise the patient that you will not tell the staff what you have been told.
- Notify the RN of any plans to commit suicide that the patient has shared with you.
- Notify the RN of any strange or unusual behavior. Give a complete and thorough report when being relieved for breaks and when leaving.
- **If an emergency situation should arise stay with the patient and call for help out the door.**

Other Duties:

- 1) If the assigned patient leaves the floor for treatments or diagnostic testing, you are **required and expected** to accompany the patient for the duration of the test. This may alter break times previously agreed upon earlier in the day. Remember that we are here to care for patients and this may require some flexibility.
- 2) You are required and expected to remain with the assigned patient until your relief has arrived.
- 3) You are expected to help the patient **clean up or freshen up once during your shift**. If the patient needs a complete bed bath, and you know the patient is going to an early test or to surgery, you may start as early as 5 a.m.
 - Please do not forget to include oral care when assisting the patient clean up. If the patient is capable to brush without assistance, prepare their toothbrush/toothpaste for them and allow them to brush their teeth. If the patient is not able to brush their own teeth, please assist them in cleaning their mouths and oral cavity.
- 4) Please assist the patient through range of motion exercises, allowing them to move their arms and/or legs. Also, help the patient reposition and turn as often as necessary to prevent skin breakdown.
- 5) Please change linen at least once a day, and more frequently as needed. Straighten linen as often as necessary.
- 6) You are expected to communicate with the RN caring for the patient throughout your shift.
- 7) It is also helpful to pass on any information that may be useful to your relief.

Thank you for caring for our patients!



Sitter Orientation Quiz

1. It is an expectation of a patient sitter that (s)he will:
 - a) Arrive on time and ready for work
 - b) Have respect for the patient, families and significant others at all times
 - c) Adhere to NMH unit procedures
 - d) All of the above

2. It is important for patients who are on suicide precautions to at least have privacy when using the washroom or making personal phone calls
 - a) True
 - b) False

3. The assigned patient has fallen out of bed. You ring the call light to notify the nurse and return the patient safely back to bed and make them comfortable.
 - a) True
 - b) False

4. If the assigned patient is sleeping quietly, it is ok for you to:
 - a) take a nap yourself
 - b) eat your dinner in the patient's room
 - c) phone one of your friends
 - d) read a book

5. The responsibilities of a patient sitter include all of the following except:
 - a) taking vital signs
 - b) keeping track of intake and output
 - c) assisting patient with bathing and freshening up
 - d) replacing tube feedings

6. Which of the following are examples of restraints:
 - a) soft limb
 - b) mittens
 - c) hard limb
 - d) all of the above

7. Reasons for restraining a patient may include:
 - a) confusion
 - b) agitation
 - c) prevention of harm to self/others
 - d) all of the above



8. Documentation for restraints should include the following (circle all that apply):
- a) ambulation
 - b) toileting
 - c) offering food/water
 - d) skin integrity
 - e) none of the above
9. You are the sitter for Mrs. Smith. She had been agitated before now, but after her nap she is calm and cooperative. You would:
- a) remove the restraint and watch closely
 - b) notify the nurse of change in behavior
 - c) do nothing
 - d) none of the above
10. You may be asked to assist in the following areas:
- a) change of patient linens
 - b) assist the patient with oral care
 - c) both A and B
 - d) only b