A Standardized Toolkit for Patient Safety Attendants to Reduce Variability in Practice

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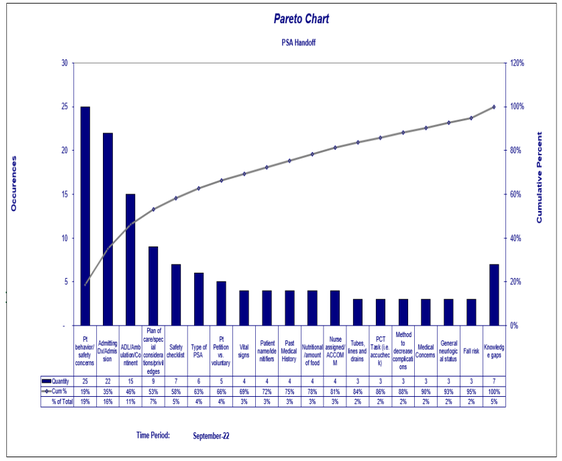
BACKGROUND

There are gaps in the practice of staff caring for patients who require a safety attendant despite policies and procedures in place.

Often referred to as "sitters", patient safety attendants have an instrumental role in keeping patients safe who are identified as danger to self or others (DTS/DTO).

GAP ANALYSIS



	Pt. behavior/ safety concerns	Admitting Dx/Admission	ADL/Ambulation/Continence	Plan of care/special considerations/privileges	Safety checklist	Type of PSA	Pt. Petition vs. voluntary	Vital signs	Patient name/ID/ Allergies	Past Medical History	Nutritional/ amount of food	Nurse assigned/ ACOM/ Id	Tubes, lines and drains	PCT Task (i.e. accuchek)	Method to decrease complications	Medical concerns	General neurological status	Fall risk	Knowledge gaps
Quantity	25	22	15	8	7	6	5	4	4	4	4	4	3	3	3	3	3	3	7
Cum %	19%	35%	46%	53%	58%	63%	68%	69%	72%	75%	75%	81%	84%	86%	88%	90%	93%	95%	100%
% of Total	19%	16%	11%	7%	5%	4%	4%	3%	3%	3%	3%	3%	2%	2%	2%	2%	2%	2%	5%

REVIEW OF THE LITERATURE

Evidence suggests using a comprehensive, evidence-based toolkit has been found beneficial in standardizing practice.

- PubMed and CINHAL databases searched.
- 8 articles related to the PICO question and was rated for strength and quality using Johns Hopkins Evidence Appraisal Tool (n.d)[5].
  - •Overall low to moderate strength and quality (V-B)
  - •Systematic reviews[4,8,10] - 3 (37.5%)
  - •Pilot studies[1,2,] - 2 (25%)
  - •Survey - 1[7] (12.5%)
  - •Descriptive case study[9] - 1 (12.5%)
  - •Literature review[3] -1 (12.5%)

CNS COMPETENCIES

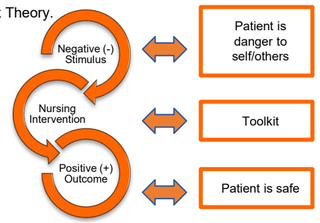
PICO QUESTION

For healthcare providers caring for patients requiring a patient safety attendant, does the use of an evidence-based toolkit compared to current interventions and processes increase patient and staff safety?

THEORETICAL BASIS

Kolcaba's[6] (1974) Comfort Theory.

- Four Components:
  - Physical.
  - Psychospiritual.
  - Sociocultural.
  - Environmental.



METHODOLOGY

DESIGN: Quality Improvement project, DMAIC process

SAMPLE: All nurses and Patient Care Techs (PCTs) experienced in being a safety attendant

SETTING: 595 licensed bed acute care tertiary hospital in urban Southwestern United States

TOOLS/MEASURES: Post intervention survey & utilization report

INTERVENTIONS

- Creation of a toolkit.
- Education for all clinical staff experienced in safety attendant
- Added toolkit to safety attendant onboarding
- Purposeful rounding.

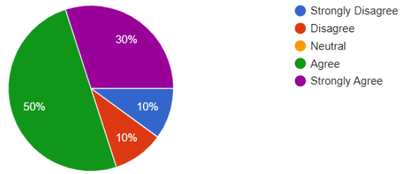
TOOLKIT TABLE OF CONTENTS

Introduction/Program Overview	
Definitions	Workplace Violence Prevention Strategies
Quick Reference Guide (QRG)	Interventions to Try Prior to Initiating Safety Attendant
Patient Safety Attendant Process – SI, Danger to Self/Others, Elopement Risk, Forensic	Checklists
General Safety Principles for Safety Attendant	Delirium Resources
Handoff/ Report Sheet	Policies & Procedures
Transport of Patients To/From Departments	Other Resources/References

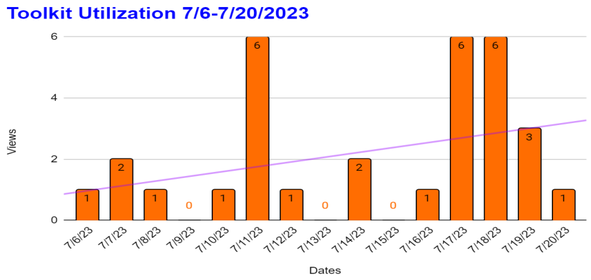
FINDINGS

- **Demographics:**
  - Number of responses (n=20); 3 Patient Care Tech (PCT) (15%), 17 Registered Nurses (RNs) (85%)
  - 12 (60%) have practiced as safety attendant less than 5 years
- **Awareness**
  - 16 (80%) of respondents agreed or strongly agreed to having awareness of the toolkit

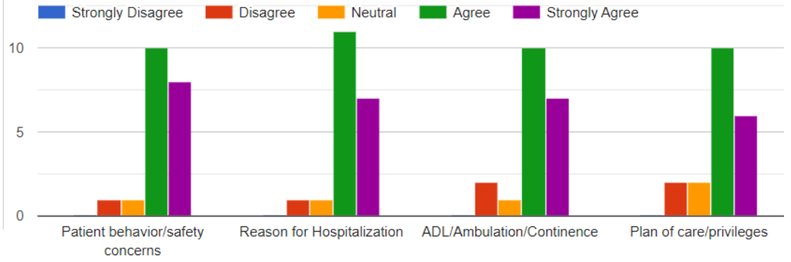
20 responses



- **Utilization**
  - 17 (85%) of respondents stated they have accessed and referenced the toolkit

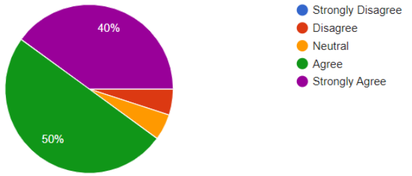


- **Toolkit Content**
  - Handoff Data Addressed



- **Adds Value to Practice**

20 responses



CONCLUSION

Handoff of patient information is critical in order to provide safe patient care. By identifying practice gaps in policy and procedure, and interviews with key stakeholders, a toolkit can provide a resource for nursing and safety attendants to guide standardized practices to keep patients safe.

RECOMMENDATIONS FOR PRACTICE

Identify root causes for patient behavior driving the risk of harm to self/others

Create and promote a toolkit with resources in a centralized location for strategies to care for patients at harm to self/others

Leadership continue to audit safety attendant practice

Continue to monitor patient elopements (patient safety)

Continue to monitor number of workplace violence incidences (staff safety)

REFERENCES

ACKNOWLEDGMENTS

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