Solution: Constant Observation for Suicidal Patients

Organization: Johns Hopkins Hospital  
Type: Acute Care

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**IDENTIFICATION:**

**Goal:** To maximize effective use of sitters for constant observation of psychiatric patients

There have been major strides in the reduction of use of restraints and seclusion to control behavior in psychiatric settings. This project sought to understand effective use of sitters and improve communication between providers, staff and sitters.

There is little data nationally on sitter use for psychiatric patients, especially for those with suicidal ideation. Definitions of constant observation and variability in prescribing are non-standardized, leading to the potential for misunderstanding of patient care needs. This project started with the implementation of an FMEA to identify potential failure modes and implement tests of change to maximize effective communication.

**PROCESS:**

The QI team leader carried out observation of current processes and interviewed RN and Observer staff.

An FMEA involving physicians, residents, nurses, sitters and QI staff met to create an FMEA. The group was split into five teams to consider Ordering, Observation, Observer Activities, Assessment and Handoffs. From the list of issues identified there was a common theme that related to the effectiveness of handoffs between providers and RN Staff, RN Staff and Observers. A process flow chart was created to visualize key processes needed to ensure complete communication pathways among staff.

**SOLUTION:**

The team created a Patient Support Sheet to identify behaviors the Observer should be looking for and a report back sheet for the Observers to note unexpected behaviors for the RNs to review. The RNs increased required interactions to 2 hourly to improve timeliness and effectiveness of communication.

A review of one month of form usage (N=186 Observations) was completed. 70% patients were on Constant Observation, 30% were on 1:1 observation. 39% expressed issues of suicidal ideation. 24% were also on open bathroom observation. 33% were considered dangerous to self or others. Results showed that 78% of observations had written feedback from the Observer, which resulted in changes to patient, follow up. There was an 85% compliance with RN 2hrly interactions with observers.

Next steps include comparing data from the Support sheets with the medical record to ascertain whether the whole medical team received appropriate information about patient changes. Also
there will be follow up interviews with staff for feedback about the new process. Other units on the Psychiatry service are considering a change to the new system.