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Bearing Witness: The Lived Experience of Sitting With Patients

Rebecca Schroeder

Regis College, Winchester Hospital

A B S T R A C T

There is abundant literature focused on the practice of using hospital sitters as part of standard patient safety care. However, minimal attention has been paid to understanding the actual experiences of hospital workers as they sit with distressed and often agitated patients. With the overwhelming number of hospitalized patients who require sitters, attention must be paid to the healthcare workers' perspective. In this study a phenomenological approach was used to elicit the perceptions of these hospital sitters. Themes which emerged from the participant's lived experiences of sitting included: Accepting them, It's not about me, You're not alone, Taking it to heart, Lifts me up, and Supporting role, with an overarching focus of Bearing witness. Nursing implications for this study suggest that using advanced practice psychiatric nurses in med–surg settings may help to support the hiring and training of skilled sitters and lead to improved psychological nursing care. In addition, identifying health care workers who best "fit" the sitter profile may promote the role from one of safety surveillance to one of therapeutic engagement.

Medically ill hospitalized patients often present with confused or agitated behaviors that require close nursing management and oversight. These problems exist for several reasons including delirium, dementia, substance intoxication and/or mental health problems (Dewing, 2013; Harding, 2010). The use of constant observation by sitters has become standard practice in many institutions. This practice is sometimes referred to as sitting, specialing, constant observation or one-on-one sitting (Harding, 2010; Tzeng & Yin, 2007). This practice differs from institution to institution but essentially consists of prolonged and continuous surveillance of a patient as an intervention recommended for those deemed at risk to themselves or others (Dewing, 2013; Rausch & Bjorklund, 2010; Tzeng, Yin, & Grunawalt, 2008). It is generally carried out by paid, unlicensed paraprofessional health care workers although occasionally volunteers or family may also be used (Rochefort, Ward, Ritchie, Girard, & Tamblyn, 2012; Tzeng & Yin, 2007). By definition, special observation or sitting requires engagement between the person assigned to observe and the person being observed, yet little is known about this relational experience. Sitting and being present with a confused or behaviorally disrupted patient may at times be difficult. In addition it may carry associated risks for the sitter if the patient is impulsive or when assaultive behavior is involved. Despite this highly charged environment and emotional intensity the impact on sitters is not known. There is abundant literature focused on effectiveness, cost, injury and associated fall risks when sitters are used (Dewing, 2013; Harding, 2010; Laws & Crawford, 2013; Primmer et al., 2015; Rape, Mann, Schooley, & Ramey, 2015; Rausch & Bjorklund, 2010; Rochefort et al., 2012; Tzeng et al., 2008) but scant literature could be found describing the perceptions or experiences of sitters when they are exposed to hours upon hours of simply sitting with patients who are in physical or emotional distress.

BACKGROUND

The use of sitters has long been a practice in mental health settings with efforts aimed primarily at preventing highly disturbed patients from injuring themselves. More recently it has become a standard practice in medical–surgical settings as a method to manage the safety concerns of increasingly complex patients. Much of this change in focus has been driven by the move toward consumer satisfaction in addition to a broader spotlight on patient safety.

As the movement toward a restraint free environment has taken hold, hospitals have been held accountable for meeting the standards set forth by both professional and accrediting agencies like The Joint Commission (TJC) and the American Nurses Association (ANA). In 2002 TJC established its National Patient Safety Goals (NPSGs) program and together with the Patient Safety Advisory Group has worked to identify emerging patient safety issues. Hospitals have come under great scrutiny in order to meet these goals and must now comply with the new standards while at the same time provide care that is both dignified and safe (Laws & Crawford, 2013; Salamon & Lennon, 2003; Tzeng et al., 2008). The use of sitters emerged in response to these initiatives. Healthcare's focus on safety and patient centered care is now the expectation.

Not only are hospitals charged with minimizing and eliminating the use of restraints, but more recently safety efforts have focused on strategies to reduce harm resulting from falls (Dewing, 2013; Laws & Crawford, 2013; Tzeng & Yin, 2007). There are hospitals using sitters as a prevention strategy to stay with patients who are deemed at high

E-mail address: rschroeder@winhosp.org.

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Fig. 1. Thematic model.

risk for falls yet there is controversy regarding the lack of assessment prior to instituting this intervention or the effectiveness of the practice itself (Harding, 2010; Laws & Crawford, 2013; Rausch & Bjorklund, 2010; Tzeng et al., 2008).

Sitters are often used for patients with mental health conditions such as dementia, delirium, substance use or suicide ideation (Carr, 2013; Dewing, 2013; Harding, 2010; Manna, 2010; Rape et al., 2015; Vrale & Steen, 2005). In medical–surgical settings, Rochefort et al. (2012)) suggest that the cost associated with sitter use is higher for patients with comorbid mental health conditions. As the mental health needs of the general medical hospital population increases, so have the number of sitters (Rape et al., 2015).

Despite the cost of a patient sitter program and the enormous burden on staffing resources, sitters continue to play a significant role in nursing care. (Boswell, Ramsey, Smith, & Wagers, 2001; Rape et al., 2015; Tzeng et al., 2008). Disagreement exists over the effectiveness and resource intensity for this practice, since the expense is frequently diverted from nursing budgets (Harding, 2010; Rausch & Bjorklund, 2010; Rochefort et al., 2012; Salamon & Lennon, 2003).

The practice of sitting with a patient at risk in a psychiatric setting is commonly shared between licensed and unlicensed staff (Cardell & Rogers Pitula, 1999). In the medical–surgical setting, the job of sitting is primarily a responsibility assigned by nurses and carried out by unlicensed staff. Interestingly, it has long been reported that medical–surgical nurses feel that they lack the expertise, time and resources to care for patients with mental health problems (Rutledge, Wickman, Drake, Winokur, & Loucks, 2012; Sharrock, & Happell, 2002) and yet sitters who may have the least skills are placed side by side with patients who often require the most care.

Little is known about how sitting is experienced by the patient, although some literature exists in the mental health field that discusses the effectiveness, observational assessment as well as the therapeutic and non-therapeutic communication aspects of one-on-one sitting (Bjorkdahl, Nyberg, Runeson, & Omerov, 2011; Cardell & Rogers Pitula, 1999; Manna, 2010). Like the medical–surgical setting there is inconsistent role preparation and in both settings there is indication that sitters may be inadequately trained (Schoenfisch et al., 2015; Bjorkdahl et al., 2011; Bowers & Park, 2001; Carr, 2013; Cardell & Rogers Pitula, 1999). Steward and Bowers note, "It is of concern that some of the most acutely ill patients are looked after constantly by the least qualified staff" (2012, p. 8).

Hospital sitters who provide one-on-one observation and companionship are in close contact with the patient at all times. This puts them at higher risk for harm. Healthcare staff who carry out tasks involving close personal contact are more likely to experience patient or visitor violence (Hahn et al., 2012). Schoenfisch, Pompeii, Lipscomb, and Dement (2014) report an alarming burden of violence among sitter staff and suggest a need for clarification of sitters' roles along with a need for enhanced policies for sitter well being such as the ability to call for help and education about patient and visitor de-escalation.

Scarce research could be found that addresses the sitters' experiences of caring for this complex patient population (Schoenfisch et al., 2015). Despite the intensity of patient contact, minimal training, and the acute nature of sitting with distressed and often confused patients there appears to be a lack of attention to this common yet controversial practice. Given the paucity of literature and the overwhelming numbers of hospitalized patients who have sitters, attention must be paid to the healthcare workers' perspective. Eliciting the views and experiences of sitters who constantly observe patients from an intimate space is important to understand.

RESEARCH QUESTION

What are the lived experiences of hospital workers who sit with patients that require close watching?

METHODOLOGY

Purpose and Design

The purpose of this study was to conduct a qualitative inquiry into the perceptions of hospital personnel who sit with patients that require close watching. The goal of this study was to better understand the nature of this experience. This question was answered using a qualitative design consisting of interviews, field notes, and participant observations. A phenomenological approach was the method chosen for this study.

Hermeneutic phenomenology is a research method concerned with both the description and interpretation of lived experience and is based on Heidegger's philosophy (1962). The purpose is to reflect and grasp the essential meaning of something (van Manen, 1990). As such, it was ideal for investigating the personal encounters between sitters and their patients. As a study of lived experience, phenomenology targets our human need to understand the nature and meaning of everyday life. This method relies on the systematic process of uncovering, describing, and assigning meaning structures to lived experiences and involves dialog, review, and repeatedly moving from the parts to the whole (van Manen). Heidegger asserted that it is impossible to disengage from preconceptions or pre-understanding; therefore, bracketing the descriptions is not a part of this hermeneutic process. Drawing on previous knowledge and clinical practice helped the researcher to understand the phenomenon of interest. Participants were viewed as co-researchers. Heideggaerian phenomenology takes an insider's view of the world, in that the participant's experience may be integrated with that of the researcher in an attempt to co-construct reality (Hamill & Sinclair, 2010). For example, the researcher's exposure to the phenomena of "sitting" is based on his or her expertise working in the field of psychiatric nursing and as someone who is familiar with the role of sitter in a general hospital setting. This added deeper understanding to the descriptions and meanings of the participant's narratives. Therefore, the aim was to construct evocative descriptions and structural analysis of the sitter's behavior, intentions, and actions.

Max van Manen's Phenomenological Method

van Manen's (1990) approach to understanding lived experience was chosen because the researcher was concerned with reaching a new and rich understanding of persons whose role is to sit with patients. The areas of inquiry involved the description of the individual's life–world and the interpretation and meaning of these experiences. The researcher used van Manen's six step process to guide this investigation which included the following: attending to a phenomenon of

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