An Urgent Need to Understand and Address the Safety and Well-Being of Hospital "Sitters"

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Background *Hospital sitters provide continuous observation of patients at risk of harming themselves or others. Little is known about sitters' occupational safety and well-being, including experiences with patient/visitor-perpetrated violence (type II).*
Methods *Data from surveys, focus groups, individual interviews at six U.S. hospitals were used to characterize the prevalence of and circumstance surrounding type II violence against sitters, as well as broader issues related to sitter use.*
Results *Sitter respondents had a high 12-month prevalence of physical assault, physical threat, and verbal abuse compared to other workers in the hospital setting. Sitters and other staff indicated the need for clarification of sitters' roles regarding patient care and sitter well-being (e.g., calling for assistance, taking lunch/restroom breaks), training of sitters in personal safety and de-escalation, methods to communicate patient/visitor behaviors, and unit-level support.*
Conclusions *The burden of type II violence against hospital sitters is concerning. Policies surrounding sitters' roles and violence prevention training are urgently needed.*
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KEY WORDS: type II violence; sitters; mixed-methods; workplace violence; constant observation

INTRODUCTION

Hospitals are faced with the challenge of providing quality care for patients who have the potential to harm themselves or others. Monitoring and managing these patients may include the use of compartmentalized rooms or lock-down ability, use of security personnel and systems, "flagging" medical records of high-risk patients, and the use of physical and/or chemical restraints. There are concerns, however, surrounding the use of these approaches. For example, "flagging" patient records may be stigmatizing to patients by the healthcare worker, or may pose a threat to patient privacy. In addition, flags may not be accessible to all workers who interact with the high-risk patient such as nurses' aides, housekeepers, and dietary workers. The use of seclusion, physical restraint, and chemical restraint is considered unnecessary and potentially harmful by several national patient advocacy stakeholder groups [Worley et al., 2000].

In the acute care hospital setting, there is a growing emphasis on the provision of care for geriatric patients and patients with mental health diagnoses [Nagamine et al., 2006; Honberg et al., 2011]. Related concerns of self-harm (e.g., suicide) and unintentional injury (e.g., fall) predicate the use of custodial or therapeutic interventions; acute care

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hospitals may rely on constant observation of these and other at-risk patients. Although constant observation may be carried out by a variety of provider types (e.g., nurses, security personnel, nurses' aides, other paid employees, volunteers, family members), it is generally the unskilled or untrained hospital worker who fill this role. In the United States, these workers are often referred to as "sitters."

Sitters' roles may strictly involve direct observation of the patient, or they may include care tasks such as checking vitals or bathing the patient, suggesting the job title of "sitter" is a misnomer. They are also referred to as "constant observers," "observation assistants," "patient attendants," "patient care attendants," "patient safety attendants," "specials," "activity companions," and "therapeutic companions" [Wheeler and Houston, 2005; Dick et al., 2009; Nadler-Moodie et al., 2009; Harding 2010; Weeks 2011; Wiggins et al., 2012].

Currently, there are no national guidelines or regulations for employers specific to use of sitters or sitters' health and safety on the job. There is considerable variability in sitters' job descriptions, their purpose (i.e., custodial versus therapeutic) and the definition of patients needing observation (i.e., "appropriate" sitter use) [Wiggins et al., 2012; Carr, 2013]. The sitters' role generally has been described as the provision of continuous, one-on-one observation of "patients who are confused, may be harmful to themselves or others, and whose behavior is unpredictable or difficult to manage" [Talley et al., 1990] "for the purpose of providing a safer environment for the patient" [Harding, 2010]. Specifically, sitters care for a patient population who include those who are anxious/agitated, drug-impaired, withdrawing from alcohol, mentally ill (to include those who have been involuntarily committed to a mental institution), suicidal, in behavioral restraints, in seclusion, a suspected victim of child abuse/neglect, at high risk of falling, delirious/demented, neurologically impaired, and vision/hearing impaired [Nadler-Moodie et al., 2009].

The literature about sitter use in the hospital setting is largely focused on concerns related to costs associated with constant patient observation [Turjanica et al., 1998; Worley et al., 2000; Park and Alistair, 2001; Nadler-Moodie et al., 2009; Harding, 2010; Rausch and Bjorklund., 2010; Rochefort et al., 2011, 2012; Weeks, 2011; Adams and Kaplow, 2012; Spiva et al., 2012; Wiggins et al., 2012]. The use of sitters has also been examined as it relates to patient outcomes such as falls, pressure ulcers, need for restraints, and patient satisfaction [Boswell et al., 2001; Park and Alistair, 2001; Tzeng and Yin 2007; Tzeng et al., 2008; Harding 2010; Wiggins et al., 2012]. Likewise, the sitters' role in easing the job demands of the registered nurse has also been studied [Rochefort et al., 2011]. Current evidence of sitters' effects on these diverse measures is conflicting, and the paucity of detail on the type of training sitters receive is noteworthy [Carr 2013]. Particularly striking is the absence of research focused on the occupational safety, health, and well-being of sitters. One concern of sitters, as well as all health care workers in the hospital setting [NIOSH 2002; Pompeii et al., 2013; Pompeii et al., 2015], is their risk of experiencing violence perpetrated by patients or visitors (type II violence).

During the course of a larger study focused on the surveillance of type II violent events in the hospital setting, sitters emerged as an occupational group that warranted further examination. The purpose of this report is to describe hospital sitters' roles and responsibilities, as well as training and experiences with type II violence. Additionally, we examined aspects of sitters' work organization, including unit level support and job satisfaction.

METHODS

Study Setting and Population

This study took place in two large US healthcare systems (one in North Carolina, one in Texas) that each consist of one large medical center and two smaller community hospitals. These hospitals vary by size, location, and types of communities they serve. Combined, they employ approximately 11,000 workers who likely interact with patients or visitors as part of their job. According to the policies at the study hospitals, sitters are responsible for providing a safe environment for a patient (or patients) requiring continuous observation, performing required patient care within their scope, and reporting observations to the appropriate direct patient care provider.

The policies surrounding sitter assignment, skill set, and expectations vary across the health systems. In one of the study health systems, sitters were primarily certified nurses' aides who come from the hospitals' internal float pools or external contract services. In the other health system, sitters typically do not have training as a certified nurses' aide. Rather, they attend an orientation session on patient safety maintenance. In both health systems, other staff may function as a sitter as needed, including unit secretaries, dietary workers, housekeeping staff, or "light duty" staff. Sitter requests may be assigned, re-evaluated, and discontinued by an authorized individual (e.g., a physician, nurse, other designee). Utilization is required for patients who are suicidal, involuntarily committed to a mental health institution, in behavioral restraint/seclusion, or is a victim of suspected child abuse/neglect.

Prior to requesting a sitter, the assigned registered nurse (RN) is responsible for assessing the patient's physical condition and mental status, attempting other interventions (e.g., diversional activities, environmental management, behavioral management, modified staffing), and considering the use of restraint. Prior to a sitter's shift, the assigned RN is responsible for giving report to the sitter, establishing the

sitter's job responsibilities, and establishing the sitter's lunch/restroom break schedule. Sitters are responsible for completing patient "handoff" forms as a way of communicating with the unit nursing staff various elements of their shift: number of times the sitter prevented the patient from pulling on tubes or from falling, activities provided to the patient (e.g., linen change, bathing, oral care, vital signs), etc. Sitters' shifts are typically eight or 12 hr in length.

Data Collection

Surveys

A brief, 5 min, anonymous, voluntary survey was emailed to hospital staff at the study hospitals in September 2011 (*Blitz* survey), along with information about the study and the investigators' contact information. Paper-copy and Spanish versions of surveys were made available, as well. Participants were asked about their experiences with type II violence (including sub-types of physical assault, physical threat, and verbal abuse) in their career and in the previous 12 months. Among those who experienced type II violence in the previous 12 months, we asked them for details surrounding the one event (if they had more than one) they deemed the most serious: perpetrator type (i.e., patient, visitor), perceived contributing factors, location, weapon(s) involved, and whether/how the event was reported. Participants were also asked to describe (using free text) "any concerns or comments about your personal safety at work regarding how you are treated by others."

Among the 5,385 *Blitz* survey respondents, a small number (n = 41 total: n = 19 from the TX health care system and n = 22 from the NC health care system) were identified as sitters. Although this group was small, we observed a significantly high proportion, relative to other occupational groups, of type II violence in the previous 12-months among those who responded. This led us to gather additional data through focus groups and key informant interviews among sitters, nurses, sitter managers, and nurse managers.

Focus groups and key informant interviews

Focus groups and key informant interviews conducted as part of the larger study were designed to capture information about type II violence relevant to several broad domains pertaining to workplace violence: magnitude of the problem, nature of events, existing policies and procedures, training, mitigation, reporting, communication, and recommendations. A semi-structured guide was used to begin our discussion and probe for details. Participants were encouraged to highlight additional issues as well. Between April 2012 and December 2013, 21 focus groups and seven key informant interviews were conducted with a total of 110 participants. Although the initial data collection guides were not focused on the safety and roles of sitters, discussions surrounding the use of sitters were nearly ubiquitous across all sessions. To examine this work group more closely, several focus groups and interviews (n = 10) were conducted specifically with sitters and/or their managers. However, data from all focus groups and interviews were analyzed to understand—from the perspective of sitters and others (e.g., nurses, security personnel, managers)—sitters' roles, training, interaction with co-workers and patients, job satisfaction, experience with violent events (including reporting), and recommendations for improvement.

Participants were recruited through email invitation and verbally by study staff. Managers assisted in extending invitations to sitters. All focus group participants were compensated $25. All sessions were audio-recorded following written informed consent of participants. Within each session, participants were assigned a number to allow transcription of the audio files without using participants' names.

Analysis

Survey data were collected in survey software (http://www.qualtrics.com) stored in Microsoft ACCESS [Microsoft Corporation, 2010] and imported into SAS v9.3 software [SAS Institute Inc., 2011] for cleaning and analysis. The frequency and percent distribution of the study population was described by age, gender, race, and occupational history. Participants' career and 12-month prevalence of type II violence, as well as the proportion of these events with characteristics of interest (e.g., perpetrator type, worker alone, object/weapon used against the perpetrator), were calculated.

Content analysis [Patton, 2002] of the transcribed focus group and key informant interview text data was performed using qualitative data analysis software [QSR International Pty Ltd., 2012]. Initial coding followed the domains outlined in the focus group or key informant interview guide. Additional relevant constructs that arose in the analysis were labeled and cataloged as well.

All procedures were approved by the Institutional Review Boards at Duke University Medical Center and at The University of Texas Health Science Center at Houston.

RESULTS

Surveys

Among the survey respondents who worked as a sitter (n = 41), 24% were less than 30 years old, most were female (88%), and 80% were non-white. One-fifth of sitter participants spent less than a year working in their profession. Eighty percent of sitters indicated they had

experienced some form of type II violence in their career. While at work in the hospital setting in the prior 12 months, 76% of sitter respondents experienced at least one event of type II violence. More specifically, among sitter respondents, 61% experienced physical assault, 63% experienced physical threat, and 73% experienced verbal abuse. Among the 31 sitters who experienced type II violence in the previous 12 months the number of events by sub-type was 69 physical assaults, 77 physical threats, and 119 events of verbal abuse. These are not mutually exclusive events.

When asked to describe their most serious event in the previous 12 months, sitters indicated the perpetrator was often a patient (94%), and the sitter was alone with the perpetrator in two-thirds of the events (65%). Among events in which patients were the perpetrator, characteristics perceived by sitters to contribute to the events commonly included patients being disoriented (66%), having behavioral issues (45%), sundowning (34%), or being drunk/on drugs (31%). Nearly three-fourths of sitters' events involved an object used against the sitter, commonly a body part(s) (e.g., fist, nails) (n = 19) or bodily fluids (n = 7).

Focus Groups, Key Informant Interviews, and Open-ended Survey Questions

Focus groups and interviews provided an understanding of domains of interest: sitters' experiences with patient and visitor perpetrated violence (e.g., magnitude of the problem, nature of events, related policies, and procedures), training, mitigation, communication, event reporting, and recommendations. Several constructs not initially probed were identified as well: sitters' role and responsibilities, patient satisfaction, unit-level co-worker support/rapport.

The role of the sitter. Sitters' roles were described as lacking clarity from the perspective of both sitters and unit staff, and this concern extended beyond violence mitigation and prevention. Sitters noted:

> *"There is no discussion about what kind of behavior is expected from a sitter. They tell you, 'Go sit with this patient. . .' Is it ok to talk to them? Should I be ignoring them? Am I like the security?"*

> *"I think there's sometimes some confusion, between say, nursing and the medical staff over what sitters are even allowed to do. There are things that we simply are not allowed to do."*

> *"The number one word that a lot of sitters been told '[keeping the patient safe is] why you're there.' But most of them don't understand why they're there, what actions to take and not take if you are in a situation. I mean, if the patient's becoming combative to the point that they're hitting, then kicking, then spitting, what actions do you take?"*

Sometimes other hospital workers were required to sit with a patient in the event a sitter was not available: A nurse manager recounted:

> *"I have a new unit secretary who has been pulled to sit. One of the first things she said to me is 'I have not been trained on how to handle this patient if they decide to get up. If they start falling, what do I do?' So I had to make some phone calls to figure out what. . .*"

Among the sitters who were nurses' aides, there was satisfaction in being able to use their clinical skillset as part of caring for a sitter case.

> Sitter: *"Being able to tell a nurse the level of training I have, I actually get to kind of take over a lot of patient care for the day, which is really nice."*

> Sitter manager: "*You know, the more exciting things you give them to do, besides you know go empty the bedpan. . . They are going to be more engaged."*

Sitters' importance in providing bedside care on a unit was relayed by managers in the context of the hospital systems' emphasis on patient and visitor satisfaction:

> Sitter manager: "*The day to day stuff [nurses] have to do, it takes away from them actually being able to be at the bedside of the patient. And being able to have a nursing care assistant. . . can be huge. You know, we are getting graded on our patient satisfaction scores. I mean, I think [sitters are] the group we need to tap into, I really do, to help us succeed our targets*."

However, sitters stressed the importance of allowing a patient to do as much for them self as they can:

> Sitter: "*If we take away all their abilities, then they are not going to do anything. Because if I could just lay here and I know somebody's going to wash my butt, feed me, do all this, and do all that, I'm just going to lay here and flip my TV channels. That's getting waited on hand and foot. We are not maids, we're aides*."

***Experiences with violence*.** Sitters described dangerous and inappropriate situations involving verbal abuse, physical

threats, physical assault, and sexual assault—some with little warning and some without adequate backup from unit staff.

> Sitter: "*I have been hit by a patient before and it was not pretty. The young lady was nice to me the whole eight hours and at the last 30 minutes she just walked up to me and said, 'I don't like you. I'll kick your ass.' I looked back. Was she looking at somebody else but me? Because we were cool. She said she wanted popcorn, and I went and got her popcorn out of the vending machine, bought her sodas, and washed her hair, and when I turned around she was standing in my face and she is like, 'I'll knock you out,' and she actually swung, and she hit me*."

> Sitter: "*When I came in, the sitter that I was taking over for had not even left, [the male patient] touched me on my butt and was smiling. I told him, "Don't do that."... I had to hold him to try to prevent him from falling out of bed. He tried it again, so I had to call the nurse... I told her, 'I can't take care of this guy. They need to get a guy for him, because he is touching me inappropriately.*"

> Sitter: "*This [patient] hated me so much because of how I was trying to prevent him from falling... So this guy was so mad, he smashed my food and that was about maybe nine hours after I had been there. I was so tired. So he smiled and his hand is full of poop because he has been messing around with stuff and you know. Then I told him...'Look at what you have done to my food..' Then the nurse came in and that is when they relieved me for break, after nine hours*."

Communication and violent event reporting. Having an understanding of patients' and visitors' behavior was viewed as an important aspect of coming onto a shift. However, the "handoff" form was not well-utilized, and there was inconsistency in the initial amount and type of information communicated verbally.

> Sitter (speaking about communicating with another sitter): "*We do our best . . .besides the basics of what we need to do for the patient, the other information that's more personal... watch out for this certain family member. There are some times when it is not communicated, and there are some situations I feel like nurses know a little bit more personal what's going on with that patient that as sitters we don't get. And we kind of face that head on when we're sitting in that room...*"

> Unit nurse: "*Sitters, um, sitters are harder. Usually we try to catch them before they go in the room so we can kind of give them a little bit of what's going on because otherwise we kind of have to stand at the doorway and talk about it, in which case we... can't really talk as much about the social aspects*."

> Nurse manager: "*We don't give the sitters information that they need to know to sit with the patient... The nurses don't do a good job consistently at letting the sitter know the real reason why they're there*."

Communication with nurses during a shift was viewed as frustrating and ineffective by sitters. A sitter described her assignment to a patient at high risk for falls. When the patient tried to get out of bed, the sitter tried to redirect him verbally, and then tried to use physical reinforcement, only to agitate the patient. Then the sitter called the nurse:

> "*The nurse came and said...'He'll listen to you if you [verbally] redirect him.' I said, 'well ma'am, I just tried to re-direct him and he wouldn't listen to me.' [She said] 'Well, what are you [sitters] here for?' [I said] 'I cannot physically hold this guy down in the bed.' She said 'Well, just let him fall then.' ...This ain't no kind of conversation to be having. We need to kind of figure out what we going to do about this situation here. [The patient] don't want me holding him down, and I don't want to get myself in no trouble. [The nurse] is not cooperating with me, so in a situation like that, I want to know, what do I do?*"

Another sitter recounted:

> "*One time I told the nurse that the patient had hit me and she said, 'Well tell me if he hits you again.' I'm like...'I've got glasses on here. I can't afford new glasses*.'"

Sitters commonly described incident reporting as something that followed the "chain of command." Reporting of events through more official channels was lacking.

> Sitter: "*I have never reported any of my events. Like one time I was bitten, but she did not break my skin. I just had little marks, so I didn't really feel the need... Even with the guy I worked with last week... he did not really physically touch me. Though he charged at me and people had to stop him... there was not really anything to report.*"

Sitter managers: "*I don't know if they use [the safety reporting system] as much as the other units, but you know, they have access to it and they know that it's there. . . A lot of the [float pool] staff send emails or they will tell me verbally. . .*"

Sitter: "*Now, if they were to physically come after me, that'd be another issue. And then yes, that would be something worth me reporting. But just sitting there and cussing me out because they're just whatever, I'm not going to report that*."

Training. At the study hospitals, there is an orientation process for nurses' aides, including those in the float pool, who serve as sitters. It reviews written sitter "do and don't" rules as well as protocols specific to certain types of patients (e.g., suicidal). None of the formal training received by sitters, however, is specific to violence recognition, mitigation, or prevention. At one hospital, a manager included a session on dealing with a difficult patient or nurse as part of workers' annual "skills blitz." At another hospital, a unit-level manager spoke of providing informal training to sitters on their unit in de-escalation techniques and safety skills.

When asked how they would prepare a new sitter coming onto their unit, sitters noted "be prepared for anything," "expect the unexpected," "come in here with your armor on," "come in with an open mind," "it's only 12 hr," "tomorrow is a new day" and "whatever doesn't go perfectly, then it's just an opportunity to learn something." They often spoke about learning on the job, and noted "over the course of time you'll learn how to deal with certain situations."

Clinicians and unit leaders were more forthcoming about the urgency of the need for sitters to be trained in violence recognition, mitigation, and prevention:

Manager: "*The sitters are the least trained individuals in this hospital. And they are the ones who are really, really on the front lines. There are times when I will go in, and I will see a [psychiatric] patient who is really scary, and I'm like 'If this guy decides to go for [the sitter's] throat, [the sitter's] not going to get out of the room. They're not going to be able to call for help. They're going to be dead*."

Physician: "*Ours are sent there [to the ED] to take care of those [psychiatric] patients, without that official training*."

Managers also highlighted barriers to such training for sitters (and nurses' aides in general). Specifically, they described a lack of institutional and unit-level support for continuing education for nurses' aides, in contrast to that provided for nurses and physicians:

Sitter manager: "*There are no courses funded by [the hospital] for nursing care assistants*."

Sitter manager: "*It is a huge challenge to get the units to let the nursing care assistants away from the unit to go to an hour class or an hour meeting. Now they cover for the nurses, but it's like the unit is going to fall apart if the nursing care assistant goes*."

Sitter manager: "*I think that alone speaks volumes that you can allow that. . . we budget time [for training] for nurses but we don't for nurses' aides. What kind of message does that send?*"

Job satisfaction and team integration. When asked if they would rather be a nurses' aide in the float pool or on a unit, sitters were clear about enjoying the "challenge" and "diversity" of the work provided through being a float pool staff member, which included being a sitter. They also recognized the challenges in their work, and they recounted situations in which others recognized it as well:

Sitter: "*Not that it is okay, but we know when we go on a unit we are going to get the not-so-good assignments, and we just know how to deal with that, and we move on*."

Sitter: "*We had five sitter patients, and we had taken up two [each] at the same time, and the nurse said 'I don't know how you're doing it, but you guys are holding it together. Good job!*'"

Sitter: "*I've had some nurses that will say, 'Hey, it's going to be a rough one, but we'll get through it.' I love when I get those kinds of nurses. . . You know, they come in and help you*.

When prompted for comments and concerns about their own personal safety at work regarding how they are treated by others, sitters' responses related to their perceived lack of integration into the unit team and its effect on their safety and job satisfaction:

Sitter: "*At times I feel that I'm looked over and not heard, especially when something of importance is being addressed to the RN or MD*."

Sitter: "*Coworkers (nurses and nursing assistants) pretty consistently assume that because one works for the float pool, one is incompetent and [they] make comments to that effect. These comments are sometimes hurtful, but more often just discouraging. . .*"

Sitter: "*My concern is the nursing staff leaving you alone to deal with the situation. They assume that since we are sitting in the room with the patient that they do not need to check on us to make sure that we are okay.*"

Sitters' managers were more forthcoming about the difficulties of sitters' work on a unit, including sitters' lack of appropriate work breaks (e.g., for a meal or to go to the restroom).

Sitter manager: "*[Sitters] kind of feel like the low man on the totem pole*."

Sitter manager: "*[Nurses] don't treat [sitters] like they are there to help them. You know, it can be very, just not kind*."

Sitter manager: "*They do the grunt work, and then they don't get treated with any kind of level of respect. They may not feel like they are part of the team or get kudos when it's needed*."

Sitter manager: "*On a 12-hour shift, [sitters] don't get a lunch break because the units will not give them a lunch break. . .they can't even go use the bathroom. They can't leave the patient. They can't use the patient's bathroom. So they are dealing with a lot of challenges that I don't think [nurses] realize is unfair to the person who is doing the work*."

At one hospital, a "lunch relief team" had been established to provide dedicated time for a sitter to leave the unit to eat. Notably, breaks during sitters' 12 hr shifts were referred to by sitters as "health breaks" and "mental breaks:" One sitter indicated, "After you've been hit, punched, kicked for so long. . .You can only take so much."

Recommendations. Sitters expressed several recommendations for improvement: improve communication between sitters and unit staff, limit personal belongings that visitors may bring into a patient's room, lunch and restroom breaks at realistic times (e.g., not at the very end of a 12 hr shift), and de-escalation and physical release training. One participant placed these needed efforts in the broader context: "It is the responsibility of the hospital to ensure that we are being protected and that we have the skills and tools we need to protect our patients."

DISCUSSION

To our knowledge, this study is the first to examine hospital sitters' work-related safety and well-being, with emphasis on their experiences related to patient and visitor perpetrated violence. In the study hospitals, a relatively high proportion of sitters who responded to the survey experienced physical assault, physical threats, and verbal abuse by patients and visitors. In the previous 12 months, 76% of these sitter respondents experienced type II violence compared to 64% of security/police, 54% of nurses, 46% of physicians/physician assistants/nurse practitioners, 45% of social workers/case managers, and 42% of nursing unit managers [Pompeii et al., 2015]. A similar pattern held across subtypes of type II violence. Compared to survey participants as a whole, sitters' events were more likely to occur in a patient room/exam room (90% versus 72%), involve a patient perpetrator (94% versus 76%), and involve an object used as a weapon against the worker (72% versus 30%). Sitters were also more likely to be alone with the perpetrator when the event occurred (65% versus 40%).

Despite ambiguity in the details of sitters' job responsibilities, there was consistency across study participants that sitters' overarching role was to protect the patient—even without adequate tools, training, and resources to do so. Protection of the patient sometimes came at the expense of sitters' own safety and well-being, as well as that of their personal belongings.

Sitters and sitters' managers described the need for support and respect from staff on the patient care units. Sitters' efforts to seek assistance from unit-level staff—for crisis situations, as well as for required lunch and restroom breaks—were not always effective. They described being left alone to deal with challenging situations, disregarded after voicing concerns (related to both personal and patient safety), and disrespected as an occupational group by patients, visitors, and hospital staff. They perceived that the physical and mental intensity of their work was not commonly recognized by nursing staff. The concerns of this predominantly female workgroup, typically centrally managed, bear striking similarities to those described of hospital cleaners nearly two decades ago [Messing, 1998]. Placed at the bottom of the hierarchy—"the low man on the totem pole" as one study participant characterized—cleaners and their work were described as "invisible" and their tasks perceived by others as "undemanding." Yet, their function—like that of hospital sitters—is essential. Specifically in this study, sitters' took pride in the patient care they provided, and the importance of their job was suggested to have important implications on patient and visitor satisfaction (i.e., "customer service").

Related to concerns about lack of hospital unit support, there is limited institutional-level focus on providing sitters with appropriate training to recognize violence, de-escalate situations, and maintain personal safety. This situation is both unfortunate and ironic, given that sitters are on the front lines and routinely are assigned to care for patients often known to be aggressive or potentially aggressive. Education addressing violence was available at the study hospitals.

However, without continuing education funding or protected time to engage in such opportunities, these classes were generally inaccessible to sitters. In some cases, the burden of developing and delivering training—including training specific to workplace violence—was carried out, voluntarily, by sitter managers.

The literature on sitter training is sparse. An evaluation of a one-hour training program for sitters, nursing staff, and managers focused on sitters' roles, symptom recognition, and risk assessment showed not only clinical and financial improvements related to sitter use; it allowed sitters to become a more integral part of the treatment planning team [Ragaisis and Wedler, 1997]. Further, in a study of volunteer sitters in the UK, a lack of adequate training was linked to higher sitter turnover [Franks et al., 1997]. In a recent review of the role of sitters in the care of patients with delirium, Carr (2013) suggests "adequate training for sitters is crucial for clinical, ethical, and financial reasons. Inadequate training for the management of aggressive or agitated patients could put sitters, the patient, and staff at danger and has legal consequences" (p. 34).

It is notable that compared to all survey participants, sitters were younger (68% were $\leq$40 years old, compared to 43% of all survey participants) and had relatively few years of experience in their role (20% of sitters worked less than a year in their profession, compared to 7% of all survey participants) [Pompeii et al., 2015]. Based on discussion with managers at one study hospital, turnover among hospital sitters was 11% in 2012. In a study from the UK [MacKay and Paterson Cassells, 2005], constant observers' experience—gained through years on the job and formal training—was viewed as a key component of conducting risk-assessments and making subsequent decisions. Inexperience was seen as a reason to exclude certain nurses or assistants from undertaking a constant observation role, citing the Nursing, and Midwifery Council's (2002) Code of Professional Conduct: "a professional requirement in any nursing endeavor is to possess the knowledge and skills that are compatible with the demands of the task" (p. 465).

There are no guidelines or regulations specific to the use of sitters or sitters' safety and health. However, there are broader national guidelines aimed at the prevention of violence in the hospital setting. Occupational Safety and Health Administration (OSHA) guidelines [US Department of Labor Occupational Safety and Health Administration, 2015] to prevent workplace violence in hospitals include training and education in "the risk factors for violence in the health care environment" and "control measures available to prevent violence incidents." Specifically, they note "training should include skills in aggressive behavior identification and management, especially for staff working in the mental health and emergency departments." Additionally, the Joint Commission (2012) revised Standard PC.01.01.01 related to patient flow through the emergency department: "If a patient is boarded while awaiting care for emotional illness and/or the effects of alcoholism or substance abuse, the hospital provides orientation and training to any clinical and nonclinical staff caring for such patients in effective and safe care, treatment, and services (for example, medication protocols, de-escalation techniques)" [abbreviated and emphasis added] [The Joint Commission, 2012]. It will be important to understand what changes have been made in hospitals in terms of such recommended and required training for sitters who are sent to this setting to provide for patients' safety.

Despite calmly talking about their experiences of dangerous and overtly egregious situations in the focus group discussions, sitters reported in the survey that they felt frightened or worried about their own personal safety in nearly two-thirds of events described—a proportion higher than that observed among all hospital study participants (38%) [Pompeii et al., 2015]. The effect of the reported violent events on the job satisfaction and mental health of hospital sitters is concerning. In prior analyses of workers' health and safety data at study hospitals in NC, an association was observed between experiencing a type II violent event and workers' subsequent prescriptions for anti-depressant and anti-anxiety medication [Dement et al., 2014]. Although the nature of these secondary data precludes our ability to examine these concerns among sitters as an occupational group, the overall findings suggest the need to examine the effects of sitters' job exposures on their mental well-being.

From an epidemiological perspective, the occupational safety and health of hospital sitters can be particularly challenging to study. They may have a job title of "nurses' aide," making their work-related events not easily discerned from other nurses' aides in existing sources of occupational safety and health data. Further, under-reporting of sitters' experiences with violence in the "official" channels hampers data collection efforts. Finally, sitters' assignments are often highly mobile; many are managed centrally in a hospital's float pool or contracted, and they are routinely sent to different units. We were able to capture important details about sitters' experiences with type II violence through our survey. Although the sample size was small and precluded our ability to do more in-depth analyses, the data suggest sitters are at high risk of type II violence compared to other direct patient care groups in the hospital setting. Further, the survey data informed our larger assessment through qualitative measures that provided contextual details with respect to the risk of workplace violence that sitters face. The qualitative information gathered from several work groups, across six hospitals, provided a perspective of sitters' work and risk for type II violence that would not otherwise be captured through a cross-sectional survey.

There has been tremendous growth in the understanding of violence in the health care sector over the past two decades. Yet, the lack of information about sitters'

occupational safety and health is striking. Continued efforts are needed to build on the understanding of their work, safety, and well-being, as well as to inform the development and implementation of effective interventions. In so doing, hospitals should not ignore or delay the provision of basic tools that sitters need to recognize and respond to known work challenges in the hospital setting.

CONCLUSION

Hospital sitters are an integral part of hospitals' provision of safe patient care at the bedside. Although there have been efforts to reduce the use of sitters from an economic perspective, the average patient profile is increasingly marked by elderly patients and patients with mental health issues. Hospitals have come to rely on the important role of sitters to ensure the safety of these and other at-risk patients. This research suggests the urgent need for a better understanding of the sitter's role from an occupational safety and health perspective. Institutionally-supported policies that focus on sitters' safety, well-being, and human rights are crucial. Such policies will provide guidance to sitters, as well as to the managers who supervise them and managers of patient care units where sitters work. In line with national guidelines, the policies should: clearly define the role of the sitter; recognize sitters as an integral part of a patient care unit; and address the provision of accessible and appropriate education for sitters to learn about identifying, managing, and preventing events of violent behavior, as well as remaining safe during such events.

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SURVEY LINK

BlitzSurvey https://sphuth.az1.qualtrics.com/SE/?SID=SV_4HnFxN9KxTs5RTD

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