Nursing Executive Center

Untapped Opportunities for **Saving Millions**

Guide to high-impact cost-reduction opportunities

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Beyond the Nursing Executive Center

In addition to the resources available through the Nursing Executive Center membership, The Advisory Board Company offers resources to support nurse executives and other members of the executive team to reduce costs.

Physician Executive Council

The Advisory Board's Physician Executive Council research membership focuses on supporting the Chief Medical Officer and team with best demonstrated practices, insights, tools, expert consultations, and networking opportunities.

Research is aimed at supporting Chief Medical Officers and their teams to keep up with industry transformation, effect change in physician practice, and implement innovative care models.

Contact Us

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The Advisory Board's Spend Performance Solutions team provides comprehensive strategy and execution support to help members enhance the margin impact of their cost-management efforts.

From targeting clinical supply cost and utilization management to optimizing service contracts to drive vendor commitment to value, Spend Performance Solutions helps hospitals identify and unlock their full supply and services cost-improvement opportunity so they can deliver greater total value from the supply chain to the point of care.

Contact Us

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Advisors to Our Work

The Nursing Executive Center is grateful to the individuals and organizations that shared their insights, analysis, and time with us. We would especially like to recognize the following individuals for being particularly generous with their time and expertise.

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Executive Summary

The “Default” Approach for Reducing Operating Costs Won’t Unlock Needed Savings

Hospital leaders are setting ambitious goals for reducing costs in the near term. Almost 80% of executives report their goal is to reduce operating costs by at least 5% over the next three years.

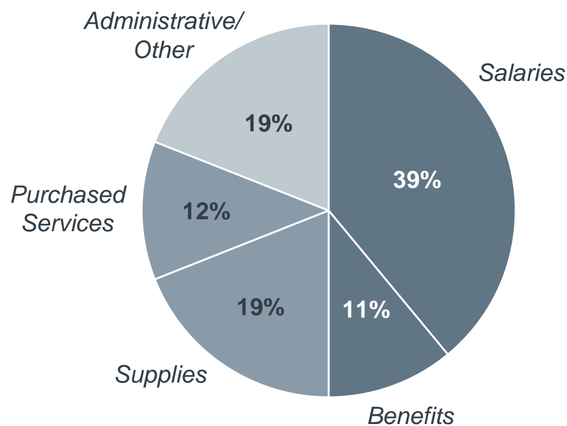
The challenge is: the majority of executives follow the “default” approach for reducing operating costs. The “default” approach is to scale cost-reduction goals according to current budget allocation. In other words, to require the largest cuts from the largest budget categories. But the problem with this approach is it overlooks more promising opportunities for reducing near-term operating costs.

Executives Need to Adopt an “Opportunity-Driven” Approach for Reducing Operating Costs

In order to generate substantial, near-term reductions in operating costs, health care executives must rethink how they set cost-reduction goals. They must start looking for “opportunity-driven” savings targets, which requires shifting the focus from where money is being spent to where there are further, untapped opportunities for reducing spending. As shown in the pie charts below, this fundamentally alters the conversation about where to unlock significant, near-term savings opportunities.

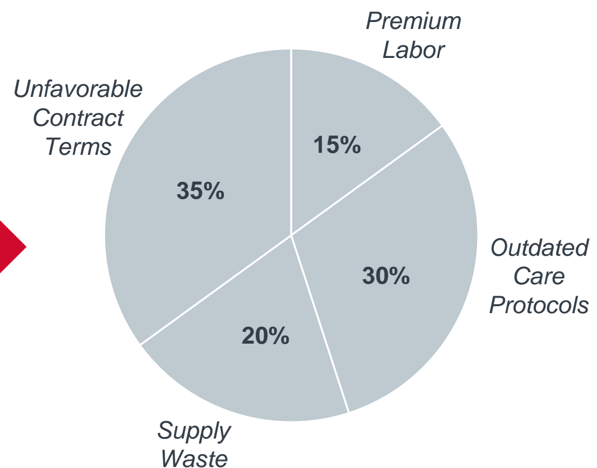
Hospital Operating Costs

Traditional Starting Point for Setting Targets



Operating Cost-Reduction Opportunities

Starting Point for “Opportunity-Driven” Targets



Read the Full Study to Learn More

Untapped Opportunities for Saving Millions equips leaders with proven strategies to reduce near-term operational costs in four key areas: premium labor, outdated care protocols, supply waste, and unfavorable contract terms.

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Nursing Executive Center Essay

An “Opportunity-Driven” Approach for Unlocking Near-Term Savings

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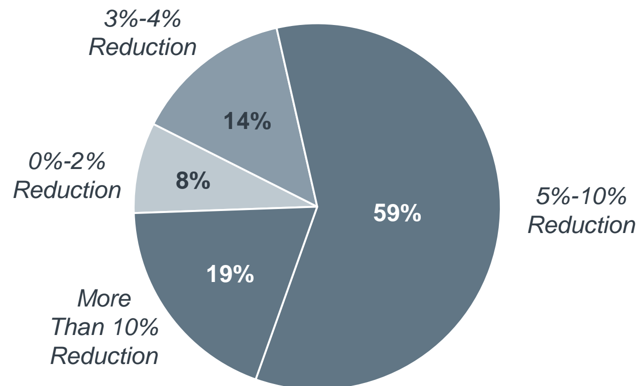
Nationwide, hospital leaders are setting ambitious goals for reducing costs in the near term. As shown here, almost 80% of executives report their goal is to reduce operating costs by at least 5% over the next three years.

No Shelter from the Cost-Cutting Storm

Three-Year Operating Cost-Reduction Goals[1]



The urgency to reduce costs is driven partially by the need to dedicate a growing portion of the operating budget to fund capital investments in new resources and methods for delivering care. While these future-focused investments hold long-term promise to elevate value, executives face a very real, near-term dilemma of freeing up dollars to fund them.

Tomorrow's Demands Only Intensify Urgency of Cost Cutting

Operating Budget

Contracting Due to Declining Reimbursement

Capital Budget

Expanding to Fund Future Investments

Growing portion of operating income required to support capital demands

1) Executive goals.

Source: "The Clinical Strategy for Financial Health—Care Redesign and Standardization," Health Leaders Media, http://healthleadersmedia.com/content.cfm?topic=NRS&content_id=305128; Nursing Executive Center interviews and analysis.

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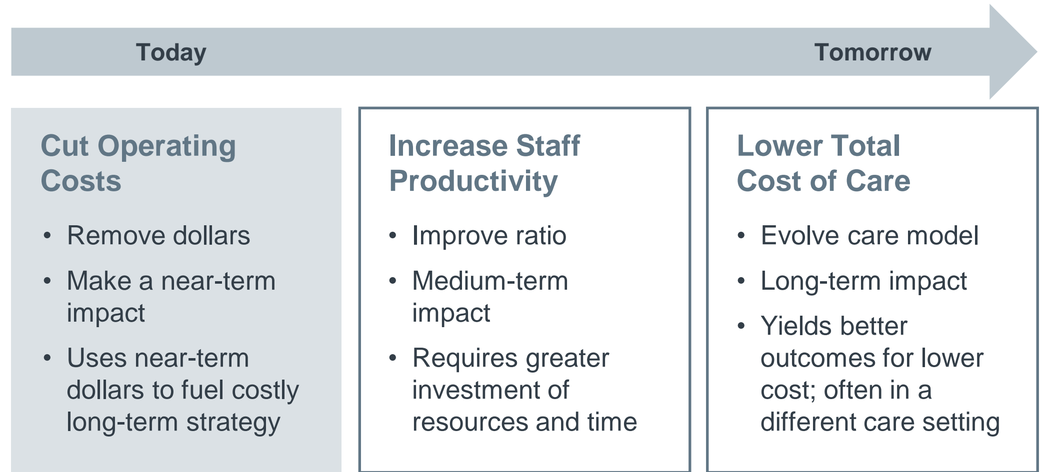
There are two principal opportunities for generating near-term savings: reducing operating cuts and increasing productivity. This publication focuses on reducing operating costs for two reasons. First, leaders looking to increase productivity can access strategies through the Nursing Executive Center. An overview of these resources is shown here.

Second, productivity gains alone are not sufficient to achieve such aggressive near-term cost-reduction goals because effective strategies often take years to scale and require a large investment up front. Moreover, these strategies often have a more significant impact on quality rather than cost.

Access these resources on advisory.com/nec.

Considering the Sequence of Savings



Nursing Executive Center Resources to Increase Productivity

Building the High-Value Care Team

Achieving Top-of-License Nursing Practice

Instilling Frontline Accountability

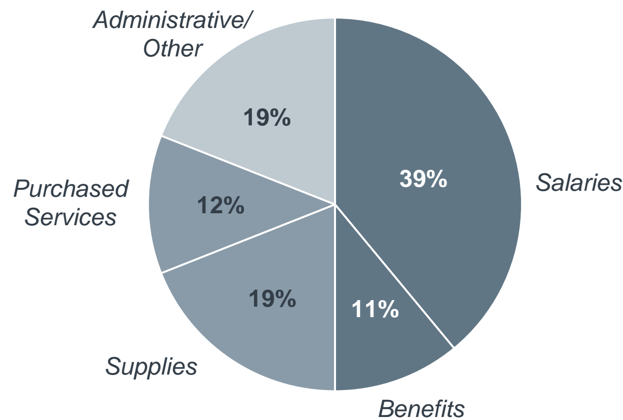
360-Degree Nurse Staffing Benchmarks

Source: Nursing Executive Center interviews and analysis.

When it comes to cutting operating costs, the majority of hospital executives follow the "default" approach shown here. This approach entails setting cost-reduction targets based on current budget allocation. As a result, the largest budget categories shoulder the largest portions of budget cuts.

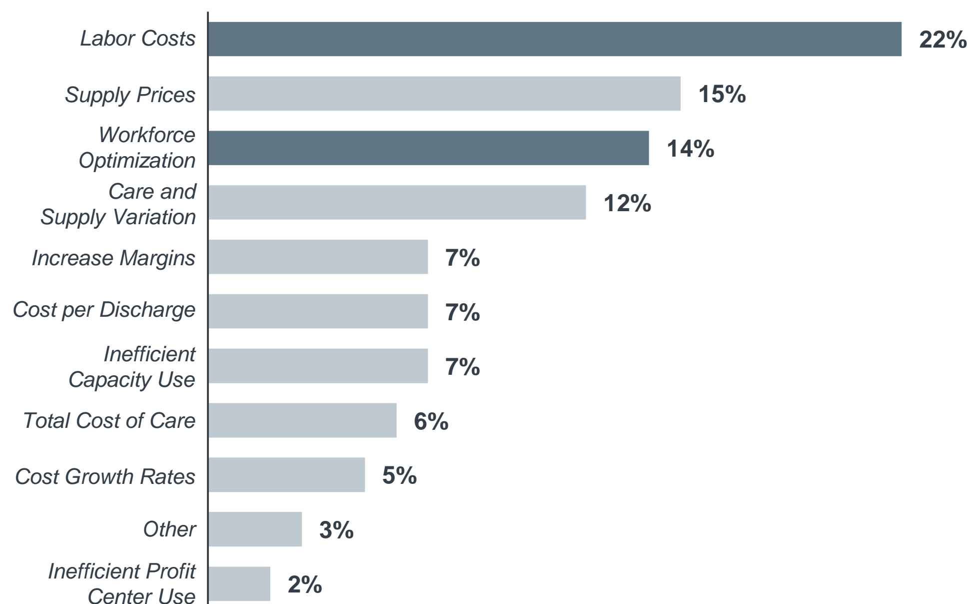
The Default Approach

Setting Cost Cutting Goals Based on Budget Allocation



Not surprisingly, this default approach to reducing operating costs places labor front and center. Because it is the largest segment of hospital budgets, labor is nearly always viewed as the biggest potential source of savings. Over the years, labor (most specifically nursing) has always delivered. As shown here, CFOs today most commonly cite labor expenses as the principle area in which their organization pursues cost-cutting goals.

Labor Usually Tops the CFO's List



Source: *Cost Strategies and Challenges of Health Care CFOs*, Corporate Strategy Washington, DC; The Advisory Board Company, 2014; Nursing Executive Center interviews and analysis.

To generate substantial, near-term reductions in operating costs, health care executives must rethink how they set cost-reduction goals, transitioning away from “budget-driven” savings targets and toward “opportunity-driven” targets.

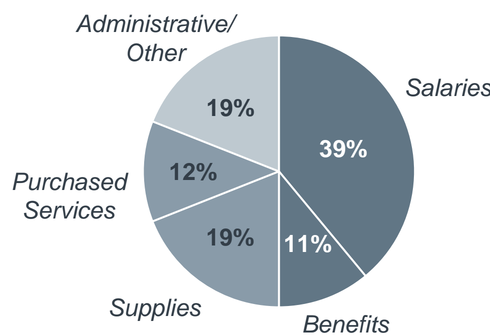
In other words, leaders should stop equating the biggest categories of their operating budgets with the biggest opportunities for cost savings. Instead, leaders should evaluate potential savings opportunities using the following criteria: 1) unlocks significant, hard-dollar savings within 9 to 18 months, 2) contains relatively novel ideas, and 3) is applicable to all organizations regardless of payer environment.

Using these criteria, we evaluated strategies that resulted in demonstrated savings across the industry, and identified the four largest cost savings opportunities, shown in the pie on the right. Our research indicates that roughly 15% of near-term savings opportunities lie in reducing premium labor, 20% in eliminating supply waste, 30% in modernizing outdated care protocols, and 35% in correcting unfavorable contract terms.

Look for Opportunity-Driven Savings Targets

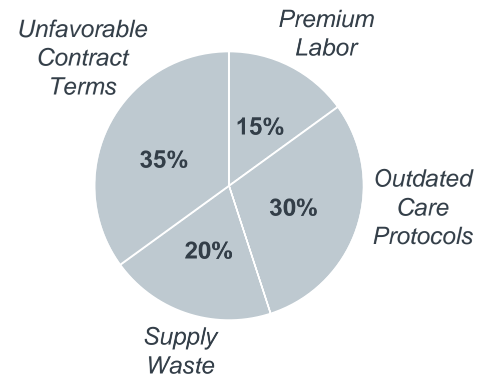
Hospital Operating Costs

Traditional Starting Point for Setting Targets



Operating Cost-Reduction Opportunities

Revised View for Big-Dollar, Near-Term Strategies



Source: Nursing Executive Center interviews and analysis.

To unlock the near-term saving opportunities in each of these four categories, the Center identified 11 proven strategies that equip nurse leaders to significantly reduce or influence operating costs in the near term.

The strategies targeting premium labor and outdated care protocols fall almost exclusively within nurse leaders' traditional purview, while the strategies targeting supply waste and unfavorable contract terms do not predominantly fall within nursing's traditional scope. Strategies in the latter categories equip nurse leaders to help diagnose and call attention to potential savings in their organizations and relieve undue pressure on nursing budgets.

Eleven Strategies for Saving Millions

1

Premium Labor

1. Bolster Accountability for Sitter Use
2. Spotlight Incremental Overtime
3. Hire Advanced Practitioners as "Nocturnists"

2

Outdated Care Protocols

4. Reinforce Nurse-Led Sepsis Protocols
5. Expand Value Analysis to Standing Orders

3

Supply Waste

6. Employ Supply "Garbage-ology"
7. Trade Disposable for Reusable Supplies

4

Unfavorable Contract Terms

8. Optimize Purchased Services Contracts
9. Direct Contract for High-Cost Clinical Preference Items (CPI)
10. Block Physician Preference Item (PPI) Savings Leakage
11. Close Benefits Contract Loopholes

Source: Nursing Executive Center interviews and analysis.

The relative size of each cost savings strategy is shown here. To maximize your chances for success, select and implement no more than three or four strategies best suited for your organization's circumstances. A typical midsize health system can generate $10 million or more by implementing only three of these strategies.

Many of the strategies with greatest cost savings potential fall outside of nursing's traditional scope. However, these ripe-for-savings categories equip nurse executives to proactively engage in financial strategy conversations, and highlight not only what will alleviate pressures on nursing budgets but also what will most benefit their organizations.

The remainder of this publication provides in-depth guidance on how nurse executives should identify ripe savings opportunities and selectively implement these 11 strategies.

Quantifying the Opportunity

Strategy	300-Bed Hospital	Five-Hospital System	Regional System	
1. Bolster Accountability for Sitter Use	$250,000	$1.0M	$1.5M	**Premium Labor**
2. Spotlight Incremental Overtime	$500,000	$2.0M	$3.5M	**Premium Labor**
3. Hire Advanced Practitioners as "Nocturnists"	$375,000	$1.5M	$2.5M	**Premium Labor**
4. Reinforce Nurse-Led Sepsis Protocols	$2.0M	$5.0M	$7.5M	**Outdated Care Protocols**
5. Expand Value Analysis to Standing Orders	$1.0M	$4.0M	$6.0M	**Outdated Care Protocols**
6. Employ Supply "Garbage-ology"	$1.5M	$6.0M	$9.0M	**Supply Waste**
7. Trade Disposables for Reusable Supplies	$350,000	$1.0M	$1.5M	**Supply Waste**
8. Optimize Purchased Services Contracts	$3.0M	$7.5M	$10.0M	**Unfavorable Contract Terms**
9. Direct Contract for High-Cost Clinical Preference Items	$1.0M	$3.0M	$6.0M	**Unfavorable Contract Terms**
10. Block Physician Preference Item Savings Leakage	$2.0M	$5.0M	$7.5M	**Unfavorable Contract Terms**
11. Close Benefits Contract Loopholes	$250,000	$1.2M	$2.0M	**Unfavorable Contract Terms**

Source: Nursing Executive Center interviews and analysis.

Cost Savings Opportunity 1

Premium Labor

Strategy #1: Bolster Accountability for Sitter Use

Strategy #2: Spotlight Incremental Overtime

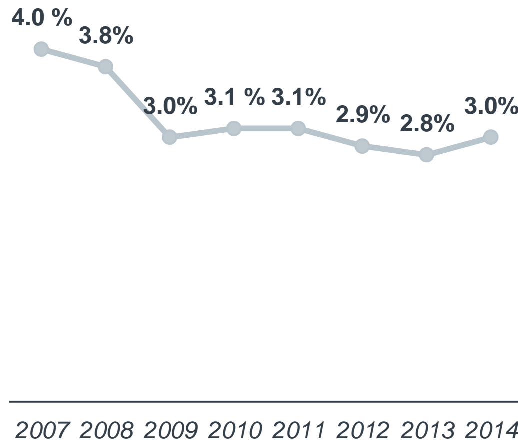
Strategy #3: Hire Advanced Practitioners as “Nocturnists”

The first category of near-term and significant cost savings opportunities is premium labor. At first glance, this might seem counterintuitive. Premium labor has been one of the first places nurse leaders looked to reduce spending—and this effort has paid off. As shown, most organizations have dramatically reduced spending on premium labor in recent years. But, recent data indicates organizations may be seeing an uptick in premium labor costs.

Impressive Track Record on Overtime and Agency

Median Dollars Spent on Overtime as Percentage of Total Payroll[1]

n=250[2]



Median Dollars Spent on Agency as Percentage of Total Payroll[1]

n=250[2]

Many nurse leaders are facing rising premium labor pressure and will need to remain vigilant to ensure premium labor spending doesn't creep back up. The good news is nurse leaders can largely prevent premium labor spending from increasing by maintaining their current premium labor practices.

One area where premium pay can often increase without being immediately noticed is in pay codes and pay practices. For leaders especially concerned about spending on premium labor, the Center recommends reviewing your existing pay practices using the Pay Practice Audit.

Keeping Old Habits in Check

Practice in Brief: Pay Practice Audit

Uncover previously overlooked opportunities for rationalizing dollars paid per hour by conducting a pay practice audit. This audit helps reduce labor costs by:

- Minimizing legacy pay offerings
- Rationalizing call coverage policy
- Closing pay policy loopholes

Access the Pay Practice Audit on advisory.com/nec.

1) Figures are based on the HR Advancement Center's Turnover, Vacancy, and Premium Labor Benchmarks.
2) Number of organizations reporting data varies by year.

Source: HR Advancement Center, 2007-2013 Turnover and Vacancy Benchmarks; Nursing Executive Center interviews and analysis.

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Unfortunately, while tried and true labor strategies can prevent future increases in premium labor spending, they will not unlock significant near-term cost savings. Once the foundational practices shown here have been implemented, nurse leaders must turn to a new generation of strategies to reduce premium labor costs.

The Center recommends three next-generation strategies to reduce premium labor. The first strategy is to reduce overreliance on and overpayment of 1:1 sitters. The second strategy is to address avoidable use and abuse of incremental overtime. The third strategy is to better leverage Advanced Practitioners by placing them in roles typically filled by higher-cost providers.

The following pages provide additional details on implementing each strategy.

The Next Generation of Premium Labor Reduction

Tried-and-True Labor Strategies

- [x] Reduce use of agency staff
- [x] Minimize use of scheduled overtime
- [x] Build out float pool

Next-Generation Labor Strategies

- [ ] Bolster accountability for sitter use
- [ ] Spotlight incremental overtime
- [ ] Hire Advanced Practitioners as “nocturnists”

Source: Nursing Executive Center interviews and analysis.

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Strategy #1: Bolster Accountability for Sitter Use

Strategy in Brief

To prevent overreliance and overpayment of 1:1 sitters, nurse leaders define clear expectations for sitter use and monitor compliance, while also standardizing sitter pay for all staff regardless of training or tenure.

Estimated Savings Opportunity per Year

$250K	$1M	$1.5M
300-Bed Hospital	*Five-Hospital System*	*Regional System*

Implementation Components

Component #1: Migrate to One (Low) Hourly Rate for All Sitters
Pay all 1:1 sitter staff one hourly rate, regardless of training or tenure.

Component #2: Spell Out Standards for 1:1 Sitter Use
Define 1:1 sitter responsibilities according to patient type and acuity. Sitter protocols must include guidelines for reevaluating need for sitter, and clear boundaries around when sitter use is appropriate.

Component #3: Embed Oversight for 1:1 Sitter Use into Workflow
Establish a process to monitor compliance with sitter use protocols; options include requiring sitters to document patient safety needs, or creating a role to monitor sitter use and cost.

Strategy Assessment

This strategy requires few resources to implement and will yield a moderate return within months of implementation. To maximize impact on sitter costs, the Center recommends organizations implement all three components of this strategy.

Applicability Audit

To assess whether or not this cost savings strategy is right for your organization, answer the following questions. Two or more “yes” responses suggest an untapped cost savings opportunity.

		Yes	No
1	Are all sitters provided with identical instructions and responsibilities?	☐	☐
2	Do different sitter staff receive different pay (i.e., based on level of education)?	☐	☐
3	Are sitter assignments evaluated infrequently, or not at all?	☐	☐

The first next-generation strategy nurse leaders should pursue to reduce premium labor is reining in the use of 1:1 sitters.

While 1:1 sitters are critical to patient safety, they are often overused or misused. And this can be costly. According to current estimates, the average 300-bed hospital spends $1.5-$2.0 million per year on sitters alone.

1:1 Sitters Presenting Unwanted Costs to Nurse Leaders

"Staff just want to use sitters as band-aids everywhere—if we don't make it a little difficult they're going to keep adding them on."

Chief Nursing Officer
600-Bed Hospital, Midwest

"Sitters are the bane of my existence."

Chief Nursing Officer
160-Bed Hospital, Pacific Region

Source: Nursing Executive Center interviews and analysis.

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Despite their best efforts, many nurse leaders struggle to find the right balance of sitter utilization. Current baseline practices include writing policies that outline appropriate sitter use, requiring manager approval for sitter use, and arranging patients two to a room or close to a nurses station to minimize staff required for patient supervision. While these efforts are necessary, they have not proved sufficient to reduce overuse and misuse and bring down sitter costs to manageable levels.

There are three primary root causes behind why sitters remain both overused and misused. First, organizations lack clear guidelines that illustrate when the use of sitters is or is not appropriate. Second, frontline nurses are prone to overreliance on sitters to assist with basic care. Finally, managers are not held accountable for misuse of sitters on their units.

The following strategy, Bolster Accountability for Sitter Use, equips nurse leaders to address each root cause in turn.

Unable to Rein in Sitter Use Despite Best Efforts

Baseline Practices for Reducing Sitter Use

- ✔ Policies for sitter use put in place
- ✔ Patients colocated two to a room
- ✔ Patient's family members and friends assist and monitor patient
- ✔ Patient placed near nurses' station
- ✔ Helpful tasks assigned to occupy patients (e.g., folding towels, counting supplies)
- ✔ Manager approval required for sitter use

Root Causes of Sitter Overutilization

Guidelines do not definitively indicate when use is appropriate

Frontline nurses over-rely on sitters as caregivers

Managers are not held accountable for unnecessary sitter use

Source: Nursing Executive Center interviews and analysis.

Component #1: Migrate to One (Low) Hourly Rate for All Sitters

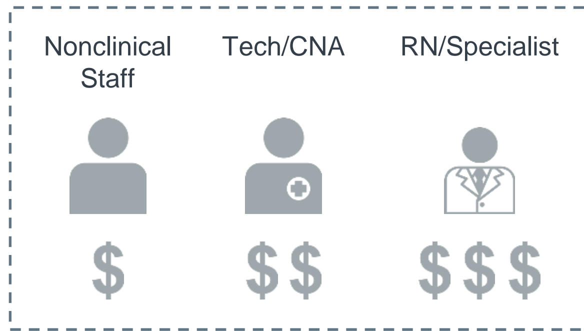
The first component of this practice is to migrate to one (low) hourly rate for all sitters.

Oftentimes, highly skilled staff such as nurses or technicians are paid overtime rates to work as sitters—which results in high rates for work that does not require skilled staff. Leaders can reduce premium pay by standardizing the rate for all sitters, regardless of experience or training.

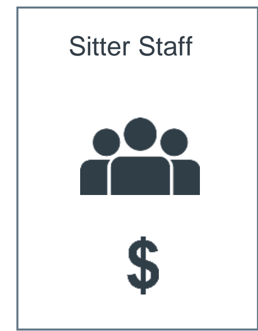
If you are concerned you won't have a sufficient sitter supply if you move to a single, hourly sitter rate, the Center recommends expanding your pool of potential sitters by adopting one of the sitter options shown here.

Minimizing Premium Price for Sitters

Hourly Rate for Sitter Staff Based on Skill Level



Single Hourly Rate for All Sitter Staff



Cost-Effective Sitter Options

- Family members or friends of patient
- Nursing students
- Volunteers
- Ancillary staff
- Security guards
- Transport staff
- Environmental services staff

Source: Nursing Executive Center interviews and analysis.

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Component #2: Spell Out Standards for 1:1 Sitter Use

The second component of this practice is to clarify standards for 1:1 sitter use. An example of clear sitter standards comes from Baptist Health Lexington. As shown here, Baptist Health Lexington explicitly defines sitter responsibilities, differentiates sitter responsibilities according to patient type, and clarifies sitter expectations.

A complete version of Baptist Health Lexington's List of Sitter Duties can be accessed through an online version of this publication on advisory.com/nec.

Baptist Health Lexington Clearly Assigns Duties

Sitter Responsibilities by Patient Type

Suicide Risk	No Suicide Risk
Remain with the patient at all times to provide 1:1 direct observation. Must stay in room even when family is visiting.	Can leave room to assist on floor when family present **if approved by assigned RN.**
Remain within arm's reach of the patient at all times including during personal care, bathroom, etc.	Can allow patient to be in bathroom with door ajar and distance further from sitter than arm's length **if approved by assigned RN.**
Do not leave the patient for any reason until another staff member comes in to assume responsibility.	
Patient activity is restricted to assigned unit unless leaving for a diagnostic exam (when 1:1 supervision is required during transport).	No 1:1 sitter required during diagnostic exams.
Patient must be continually monitored when going to the bathroom or showering.	Can allow patient to be in bathroom with door ajar with sitter at door **if approved by assigned RN.**

Explicitly defines sitter responsibilities based on patient type

Differentiates need based on patient type

Clear expectations and boundaries eliminate gray areas

Case in Brief: Baptist Health Lexington

- 383-bed Magnet hospital in Lexington, Kentucky
- Defined explicit policies and procedures for sitter use to minimize misuse of 1:1 sitters; outlined sitter responsibilities for specific patient types
- Created protocols mandating frequent reevaluation of sitter use; instituted sitter log to track safety incidents and help assess continued need for 1:1 sitter
- Leaders observed decreased sitter use house-wide; lowered annual sitter expenses by $166,000 in two years without adverse impact on patient fall rate

Source: Baptist Health Lexington, Lexington, KY; Nursing Executive Center interviews and analysis.

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If your organization already has a sitter policy in place, the Center recommends using the audit shown here to assess whether your policy is clear and cost-effective as possible.

This audit provides examples of effective policies that offer clear and actionable standards for sitter use—and those that are common, but insufficient for clamping down on overuse and misuse. For example, an effective sitter policy must set clear boundaries around sitter responsibilities—in addition to including what sitter responsibilities are, leaders must also outline what aspects of patient care sitters should not be responsible for.

Designing an Effective Sitter Policy

	Effective Sitter Policy Elements	Example: Impactful Policy	Example: Insufficient Policy
1	Explicit guidelines that define when a 1:1 sitter is and is not warranted	1:1 sitter order meets documented clinical criteria and explains why other predefined patient safety management interventions are insufficient for this patient	Decision to order 1:1 sitter is at the discretion of the physician or nurse manager
2	Instructions for assigning sitters take into account patient characteristics	Sitters for suicidal patients must have basic mental health training	*No guideline in place for what experience or training sitters must have to monitor patient*
3	Clearly defined sitter responsibilities for most common patient types	Suicidal patients: Sitter remains within arm's reach at all times, including personal and bathroom time	Provide 1:1 supervision of suicidal patients
4	Clear boundaries around responsibilities for all sitters	Sitter cannot receive or administer medications	Sitters may provide basic patient care as needed
5	Formalized protocol for frequency of reevaluating a patient's need for sitter supervision	Clinician must reevaluate need for 1:1 sitter every four hours	Clinician must reevaluate need for 1:1 sitter each shift
6	Clear accountability and enforcement strategy to discourage misuse of sitters	If documentation requirements and protocols not explicitly followed, sitter costs come from unit budget	Nurse manager approval is required for 1:1 sitter use

Source: Nursing Executive Center interviews and analysis.

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Component #3: Embed Oversight for 1:1 Sitter Use into Workflow

The third component of this practice is to embed oversight for 1:1 sitter use into workflow. At Baptist Health Lexington, review of sitter use is embedded into manager workflow. Unit managers are asked to evaluate the need for continued sitter presence following every sitter shift. Their decisions are informed by detailed logs kept by 1:1 sitters. Sitters are asked to document their actions and patients' needs on an hourly basis in a shift log. Sitters' shift accounts include details such as the time family members are present (which indicates sitter supervision may be redundant for this patient).

After introducing improved policies and protocols that enable managers to hold units accountable for use of sitters, leaders at Baptist Health Lexington estimate they saved $166,000 and reduced sitter hours by 57%. In addition, leaders observed a reduction in fall rates across this same period.

A complete version of Baptist Health Lexington's Sitter Log can be accessed through an online version of this publication on advisory.com/nec.

Frequently Reassess Continued Need for 1:1 Sitter

Baptist Health Lexington's Sitter Log

Sitter documents patient needs and actions taken during shift on standardized template

Documents frequency that family member is present

Manager uses log to reevaluate need for 1:1 sitter after each shift

Visitor _____ allowed _______must check at station

Activity Level _______________

Observation during shift

Record hourly

Attempting to get out of bed/chair fill in every hour with zero # attempts

Time	7	8	9	10	11	12	1	2	3	4	5	6
Attempts												

Family in Room

Record duration	

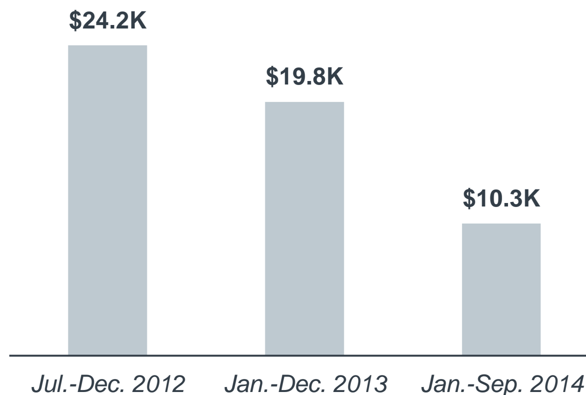
Several times a shift familiarize the patient to the environment

-Have the patient "teach back" call light use.
-Keep the call light within reach at all times.
-Keep patient's personal possessions within reach.
-Keep the hospital bed in low position with brakes locked.
-Provide non-slip, well-fitting footwear for the patient.
-Utilize night light or supplemental lighting.
-Keep floor surfaces clean and dry. Clean up all spills promptly.
-Keep patient care areas uncluttered.

Tech duties:
-Recieve report from current sitter -then from nurse.
-Do bedside care (bath-linen-assist), Never leave the room to get equipment.
The tech on the floor is rstill esponsible for VS, accucheck ice water and charting. If the floor has an extra flow cart to leave in the room you can chart on pt.
-When up to bathroom leave door open 10-12 inches so that you can maintain visual contact.
-Speak to the charge nurse to arrange meal break. Use call light and req tech relief for any other breaks.
-If you become sleepy or 12 hours sitting is difficult, request Change nurse switch assignment with floor tech
-If **RN approves**-while family present tech can assist with others pts.

Elevated Scrutiny Paying Off at Baptist

Average Monthly Sitter Expenses[1] at Baptist Health Lexington



$166K

Annualized[1] reduction in sitter expenses at Baptist Health Lexington

57%

Reduction in sitter spending at Baptist Health Lexington after two years

1) 2012 data annualized based on six months of available data; 2014 data annualized based on nine months of available data.

Source: Baptist Health Lexington, Lexington, KY; Nursing Executive Center interviews and analysis.

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Another method to embed oversight for 1:1 sitter use into workflow is to introduce a "sitter patrol." This was the approached used by Abbott Northwestern Hospital. At Abbott Northwestern, the "sitter patrol" rounds every two to four hours on units with sitters. The patrol monitors if units are complying with sitter policies, and double-checks there is clinical justification for continued sitter use. This role is filled by a manager who provides a daily sitter summary to the nursing leadership team to track sitter utilization.

Introducing the Sitter Patrol to Regularly Monitor Sitter Use

Components of "Sitter Patrol" Role at Abbott Northwestern

Approves requests for 1:1 sitter

Rounds on patients with sitters in place

Monitors staff compliance with protocols for ordering sitters and continuing use

Sends daily summary of sitter use to nurse leaders to track sitter utilization

Be Careful Not to Backslide

"We have someone rounding Monday through Friday, and by the time we get back after the weekend the sitters have started to multiply."

Terry Graner, VP Patient Care
Abbott Northwestern Hospital

Case in Brief: Abbott Northwestern Hospital

- 605-bed hospital in Minneapolis, Minnesota; part of Allina Health
- Faced with overutilization of 1:1 sitters; as a result, exceeded annual budgeted FTEs
- Leaders created a sitter float pool and strict protocols for sitter use on units to minimize sitter misuse and overcompensation
- Leaders designated a manager to round on patients with 1:1 sitters and to monitor staff compliance with protocols; if the manager documents the unit is abiding by sitter protocols, the sitter costs are covered by a centralized cost center; if the manager documents the unit has not followed protocols, the sitter cost is taken from the unit's budget
- Since introducing new sitter protocols, leaders observed decreased use of 1:1 sitters per shift and eliminated multiple sitter positions

Source: Abbott Northwestern Hospital, Minneapolis, MN; Nursing Executive Center interviews and analysis.

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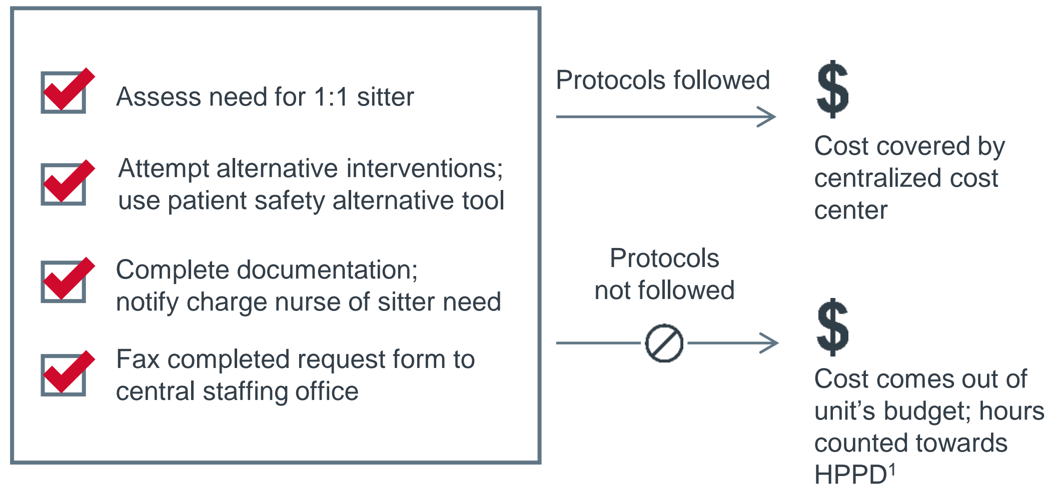
If you are considering introducing a “sitter patrol” it is critical that the patrol has true authority—and there are consequences if the patrol judges that a unit isn’t abiding by policies. One effective way to do so is to link funding of sitters to compliance with policies. At Abbott Northwestern Hospital, if the sitter patrol assesses that a unit is following sitter policy, then the sitters are funded through a central sitter department. However, if the patrol determines sitter use was extraneous, or if proper protocols for documentation were not followed, sitter expenses are allocated to the unit’s budget, and sitter hours are counted towards the unit’s HPPD[1].

Since refining sitter policies and revisiting sitter funding, Abbott Northwestern Hospital has eliminated multiple sitter positions.

Budget Accountability Ensures Protocol Compliance at Abbott Northwestern

Checklist of Sitter Protocols



1) Hours per patient day.

Source: Abbott Northwestern Hospital, Minneapolis, MN; Nursing Executive Center interviews and analysis.

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