

DEPARTMENT OF
EMERGENCY MEDICINE

POLICY AND PROCEDURE MANUAL

EMERGENCY DEPARTMENT
OBSERVATION UNITS

BRIGHAM AND WOMEN'S HOSPITAL
75 FRANCIS STREET
BOSTON, MA 02115

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STATEMENT OF PURPOSE:

Emergency Department staff care for observation patients in two main settings: the ED observation unit (EDOU) and ED tower observation unit (Tower OBS), which serve patients whose condition requires additional hospitalization for treatment and/or additional evaluation to determine the need for inpatient admission.

UNIT DESCRIPTION:

The EDOU is located in the Emergency Department's main clinical unit on the ground floor of the CWN building of the Brigham and Women's Hospital and Tower OBS is located in the Tower on Pod 12D. The EDOU contains 10 rooms, all of which can be monitored; one is a negative/positive pressure room for infection control purposes. The 12D unit also has 10 beds, with one negative pressure room.

UNIT DIRECTION:

The unit is under the direct supervision of the Observation Medical Director and ED Nursing Director.

ASSIGNMENT TO OBSERVATION:

Assignment of a patient to observation is the exclusive decision of the ED attending. No other clinicians may assign a patient to observation.

Patients assigned to observation should have an anticipated length of stay of no more than two midnights and with at least an 80% likelihood of being discharged home or transferred to another facility within that timeframe. Patients with an expected observation length of stay of less than 6 hours should not be managed as observation visits, patients with an expected length of stay of less than 12 hours should be avoided in Tower OBS and patients with an expected length of stay of over 24 hours should be avoided in the EDOU.

Alpha is the only area of the Emergency Department that stays open 24/7. The Bravo and Charlie pods close for at least a portion of the night shift. Patients that remain in the pods close to closing time may need to continue their care in an observation unit. Any decisions to increase the ED observation census will be made in collaboration between the EM administrative attending on call and nursing leadership.

NOTE: Observation is a defined outpatient status, and patients need not be within the physical confines of the the EDOU or Tower OBS to be considered in observation status. Unless otherwise stated, the principles and requirements for observation apply to all patients assigned to observation status, regardless of their location within the ED.

DOCUMENTATION:

Documentation for assignment to observation will include a focused history and physical exam, a working diagnosis or differential diagnosis, and a diagnostic/treatment plan that justifies the need for observation. In addition, there should be explicit criteria for admission or discharge, so that the patient does not exceed the length of stay timeframe defined in the initial note. This initial note must be signed by the attending physician.

Multidisciplinary progress notes are written on daily rounds, as the patient's condition warrants or as outlined by a specific protocol, and should generally occur about every 8 hours and always upon discharge. Regardless of the disposition from observation, a discharge summary will be completed, including the discharge diagnosis, a summary of the observation course, a brief discharge exam, and a synopsis of the discharge instructions. The discharge summary is completed by the physician assistant or resident and the responsible attending must be notified of every discharge from observation. An attending note should be completed on the date of discharge, but not necessarily at the exact time of discharge. Attendings must sign the observation discharge note for every resident discharge; if they are not physically present for a PA observation discharge, signing the note is optional. Finally, nurses are required to document a final summary to include current level of consciousness, pain level, discharge vital signs, wound care and pertinent information related to resolved or ongoing nursing problems

INTRODUCTION TO PROTOCOLS:

Condition-specific protocols will guide the care of observation patients. However, these are meant to serve as guidelines, and the attending physician remains the final arbitrator of clinical decisions.

Observation patients are best served by a clear plan of care with distinct and objective end points. Prospectively, the likelihood of discharge to home is not to exceed a two midnight stay with an 80% likelihood of discharge.

The list of protocols and the content of the protocols is the product of the medical staff of the Department of Emergency Medicine; which protocols are operative at any given time remains the decision of this group. Protocols can be found in file cabinets in each part of the ED; missing protocols can be replaced upon request by any business specialist. All protocols are subject to revision at any time should the opportunity to improve care be determined. All protocols will be reviewed at least annually.

SCOPE OF CARE:

Both observation units are capable of providing the following evaluation, monitoring, diagnostic, and treatment services:

1. Monitoring of vital signs (no more frequently than every 4 hours)
2. Monitoring of inputs and outputs, patient weights
3. Neurologic and vascular checks (no more frequently than every 4 hours)

4. Fingerstick blood glucose checks (not more frequently than every 2 hours)
5. Pulse oximetry
6. Cardiac telemetry
7. Comprehensive laboratory and radiology services
8. Acces to cardiac stress testing and non-invasive imaging
9. Oxygen supplementation
10. Oral and IV medications
11. Intravenous fluids
12. Respiratory therapy
13. Wound care
14. Nourishment
15. Routine nursing care
16. Specialty consultations
17. Physical therapy evaluation
18. Social Service intervention
19. Care coordination

EQUIPMENT:

The Emergency Department observation units use the same equipment and supplies as the acute areas of the Emergency Department.

ATTENDING PHYSICIAN RESPONSIBILITIES:

All observation patients remain under the care and supervision of the attending physician staff of the Emergency Department at all times. ED attendings will transfer responsibility of their observation patients to the oncoming attendings at shift changes. The attending assignment on the patient tile in ED Tracking will be updated to always reflect the current responsible attending.

Patients assigned to observation require 1) an initial observation note completed by the physician assistant or resident and signed by the attending physician indicating intent to assign the patient to observation status and the plan of care and 2) an ED encounter note to be written contemporaneously (i.e., before the attending leaves the ED).

ED attendings will make regular rounds in both units and are responsible for ensuring adequacy of documentation, discharge planning and follow-up. The decision to discharge a patient from observation (whether to home, transfer, or to an inpatient service) is exclusively the responsibility of the ED attending. The ED attending will play a usual role in facilitating admissions to the inpatient setting. In addition to communicating the service and accepting inpatient attending to admitting, the ED attending will indicate whether the patient will continue as observation status or change to inpatient status. This determination will be informed by the Care Facilitator.

PA AND RESIDENT STAFF:

The EDOU is staffed by a Physician Assistant (PA) from 11am to 11pm every weekday and from 10am to 10pm every weekend. On weekdays, at 10:45pm (9:45pm on weekends), the EDOU PA signs out to the overnight Alpha PGY 3 resident. On weekdays at 6:45am, this outgoing PGY 3 resident signs out a maximum of 10 EDOU patients to the oncoming Bravo resident. The Bravo resident and attending round on the observation unit from 7am until 8am. A progress note should be completed and signed by the attending for each patient during these rounds (alternatively, the attending can sign a discharge note if the patient is leaving). At 11am, the resident passes off to the PA. On weekends, the overnight Alpha attending signs out to the oncoming Bravo attending at 8am. The Bravo attending rounds in the EDOU between 8am and 10am, documents a note for each patient and then passes off to the EDOU PA at 10am.

Tower OBS is staffed 24/7 by a PA. The PAs work shifts from 7am to 7pm and 7pm to 7am. At 7am every morning, the Charlie attending rounds with the overnight PA, daytime PA and Care Facilitator and document on each patient in the same way as the EDOU. Between 8am and 9am, the Flow Manager and Charlie Nurse in Charge will not place any patients expected to need a resuscitation in the Charlie pod in case rounds in Tower OBS run long. In addition, the PA in Tower OBS will perform an initial screen on all EKGs performed on that unit. The ESA will deliver the EKG within 10 minutes and the PA will review, sign their name and write "no STEMI" if STEMI criteria are absent. If there is any concern for STEMI or other clinically significant abnormalities, the PA will immediately speak with the responsible attending, who will remotely review the EKG and determine the appropriate action.

NURSING STAFF:

The nursing staff will consist of registered nurses from the Emergency Department or "float" pool. There will be 2 RNs working in the EDOU and 3 RNs working in Tower OBS. Flow Managers will round on observation patients at regular intervals with the attending, observation PA and nursing staff.

ANCILLARY STAFF:

The support staff will consist of 1 ESA for both observation units 24/7. In the EDOU, there is 1 Business Specialist scheduled for 16 hours 8am-12am and in Tower OBS 1 Business Specialist works between 8am and 8pm. Business Specialists and ESAs will be assigned to the observation units at the discretion of the Nursing Director.

VISITORS:

The observation unit visitor policy is the same as the overall ED visitor policy.

DISCHARGE FROM UNIT:

Patient disposition will be determined by the ED attending. If a patient requires inpatient admission, the ED attending will arrange for the admission as usual. If a clear and imminent disposition is planned, a stay may extend beyond 24 hours in the EDOU and 36 hours in Tower OBS.

QUALITY IMPROVEMENT:

Quality improvement will be discussed on a monthly basis at staff meetings led by the Observation Unit Medical Director and attended by physician, PA and nursing staff representatives. Additionally, cases and concerns can be forwarded to the Dr. Christopher Baugh, Dr. Josh Kosowsky, or Dr. Jay Schuur for further review.

OUTCOME MONITORS:

Processes in the unit will be subject to ongoing review with respect to outcome. Data used will consist of both specific and generic screens, including but not limited to:

Specific Screens:

1. Total number of patients assigned to observation
2. Percentage of observation patients admitted to an inpatient service
3. Patient demographics: age, sex, time of day admitted
4. Frequency of admissions by protocol
5. Disposition of patients by protocol
6. Completeness of medical records
7. Mortality and morbidity
8. Return visits to ED within 72 hours of OBS discharge
9. Patient satisfaction
10. LOS > 2 midnights
11. LOS < 6 hours

BUDGET:

The observation unit's operating budget will be included in the budget of the Department of Emergency Medicine.

APPENDIX

AVAILABILITY OF ADVANCED CARDIAC TESTING (PROVOCATIVE TESTING AND CORONARY CTA):

There are 3 slots for exercise treadmill tests from OBS every day, including weekends and most holidays (except Thanksgiving Day, Christmas Day and New Year's Day). Stress tests with imaging are only available on weekdays (non holidays) and generally only one spot is guaranteed from OBS (usually can accommodate 2 without much difficulty). MIBIs may also be available on non-holiday Saturdays and Sundays. CT angiograms can be performed at any time, but currently, the coronary angiography element of the scan will not be formally interpreted until morning if the scan is performed late in the evening or overnight.

PROCEDURE FOR ASSIGNMENT TO OBSERVATION:

1. ED clinical team decides observation is appropriate disposition
2. Attending completes observation bed request (found on patient tile right click menu; the "OBS ABR"), which automatically notifies the Flow Manager
3. Flow Manager assesses patient, discusses with nursing and reviews observation unit bed availability and resources
4. If Flow Manager believes the best observation destination is different from the attending recommendation in the OBS ABR, the Flow Manager will discuss with attending to jointly determine the best bed location
5. Flow Manager completes bed assignment, which will display on patient tile in tracking, along with observation unit PA passoff information
6. ED resident or PA completes initial observation note (signed by attending and placed with patient's paper record) and completes complaint-specific obs template in EDOE, which contains the order to "assign patient to observation"
7. Business specialist changes patient's status in BICS to observation, using the time of the "assign to observation" order as the start time for the observation stay and copies paperwork; OBS binder is created and the patient's tile in ED tracking now has a green border with "edobs" text.
8. Verbal passoff from ED resident or PA to obs unit PA **prior** to dispo order
9. After dispo order when bed is open and clean, patient is transported to observation unit

Exceptions:

Between 12am and 8am, since there is no Flow Manager, the attending completes the bed assignment in the OBS ABR to best match patient needs with resources. The attending should discuss any cases with a potential heavy nursing burden with the Alpha nurse in charge prior to assigning an observation bed.

Between 11pm and 11am (10pm and 10am on weekends), there is no EDOU PA; as a result no PA passoff is needed to enter a dispo/transport order for patients moving to the EDOU. The resident or PA following that patient will continue to do so, and pass off the patient to the next provider when their shift ends or when the EDOU PA arrives, whichever is first.

ALTERNATIVE USE OF THE OBSERVATION UNIT:

The EDOU rooms may, on occasion – and at the discretion of the Flow Manager – be used to care for non-observation ED patients (either primarily, or starting out from another pod) depending on patient acuity and availability of space/resources.

GLOBAL EXCLUSIONS:

Background:

Both observation units is designed for patients who require short term interventions or additional time for diagnosis. It is not intended for patients that require an inpatient-level of care or an intensity of service inappropriate to the staffing of the unit. The ED attending, with input from the Nurse in Charge and/or Flow Manager if needed, will determine whether patient needs can be appropriately met with the available resources in each observation unit. Patient safety and unit efficiency dictate the following global exclusions from both units:

- Patient in physical restraints
- Patient with GCS of < 13 (if new)
- Patient with acute intoxication
- Patients requiring a PCA
- Patients expected to receive chemotherapy
- Patients expected to go to surgery and return to the observation unit

In addition, patients with a primary behavioral health problem will not be managed in Tower OBS.