

## STANDARDS FOR OBSERVATION IN VA MEDICAL FACILITIES

**1. REASON FOR ISSUE:** This Veterans Health Administration (VHA) Directive provides the policy for the observation of patients requiring continued evaluation and treatment who may not need admission to a VA medical facility. **AUTHORITY:** 38 U.S.C. 7301(b).

**2. SUMMARY OF CHANGES:** This VHA Directive provides:

a. A change in the duration of the Observation period from 23 hours and 59 minutes to 47 hours and 59 minutes in order to comply with CMS standards.

b. Combines the components of two previous Directives (VHA Directive 2010-011, Standards for Emergency Departments, Urgent Care Clinics, and Facility Observation Bed, and VHA Directive 2009-064, Recording Observation Patients) into one Document.

c. A more comprehensive list of appropriate conditions for Observation patients (see Appendix A).

d. The assessment, monitoring, and documentation requirements for Observation patients (see Appendix B).

**3. RELATED ISSUES:** None.

**4. RESPONSIBLE OFFICE:** Specialty Care Services (10P4E) is responsible for the contents of this Directive. Questions may be referred to the National Director for Emergency Medicine (10P4E) at 202-461-7120. For issues related to recording Observation contact the Office of the Assistant Deputy Under Secretary for Health for Informatics and Analytics (10P2), Health Information Management Office (10P2C) at 217-586-6082.

**5. RESCISSIONS:** VHA Directive 2010-011, dated March 4, 2010 and VHA Directive 2009-064, dated November 30, 2009, are rescinded.

**6. RECERTIFICATION:** This VHA Directive is scheduled to be recertified on or before the last working day of February, 2019.

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**STANDARDS FOR OBSERVATION IN VA MEDICAL FACILITIES**

**1. PURPOSE:** This Veterans Health Administration (VHA) Directive provides the policy guidelines for the observation of patients requiring continued evaluation and treatment who may not need admission to the VA medical facility. In addition, this Directive provides policy for the definition and recording of Observation patients. **AUTHORITY:** 38 U.S.C. 7301(b).

**2. BACKGROUND:**

a. Traditionally, patients who require services in the Emergency Departments or Urgent Care Clinics or an outpatient clinic are admitted to the acute care VA medical facility. Mounting concerns about VA medical facility overcrowding and the lack of available beds for patients needing inpatient services have led to the more frequent utilization of Observation status and Observation beds as an alternative to hospital admission or discharge.

b. The Department of Veterans Affairs (VA) recognizes the importance of placing patients in the most appropriate clinical setting. In many instances this requires observing a patient for an extended period of time as an outpatient before admitting them as an inpatient. The goal of Observation is to provide an opportunity for a response to initial therapy or to clarify a patient's diagnosis.

c. Observation units or beds provide additional medical benefits by allowing for continued evaluation and better definition of the patient's problem with the goal of preventing admission and an additional, simultaneous, reduction in both costs and inappropriate dispositions. The ultimate goal is to improve the quality of care provided to these patients. Additional advantages include:

(1) Allowing additional time for patients requiring extensive workups prior to determining clinical disposition or discharge from the ED or UCC to an Observation bed or acute care inpatient setting.

(2) Making efficient use of inpatient beds, reducing both unnecessary hospitalizations and expediting hospital flow, by maintaining control of the observation patients.

(3) Reducing patient revisits by ensuring adequate time to make appropriate diagnosis and facilitating difficult discharges.

**3. POLICY:** It is VHA policy that all VA medical facilities with EDs, UCCs, and/or acute care inpatient beds must have a written policy to provide care for Observation patients in place no later than May 1, 2014. All patients must be assigned a treating specialty code of Observation, as applicable, and all services and costs associated with the Observation treating specialty must be captured and assigned to inpatient services.

**4. RESPONSIBILITIES:**

a. **National Director for Emergency Medicine.** The National Director for Emergency Medicine is responsible for:

(1) Providing national guidance to ensure a standardized approach for the Observation of patients.

(2) The policy and direction for Observation of patients requiring continued evaluation or treatment, but not necessarily requiring admission to the hospital.

b. **Veterans Integrated Service Network Director.** The Veterans Integrated Service Network (VISN) Director is responsible for ensuring that all facilities with EDs, UCCs and/or acute care inpatient beds within the VISN have policies that define and establish the provision of care to Observation patients.

c. **Medical Facility Director.** The medical facility Director is responsible for ensuring:

(1) That local facility policy is in effect for the management of Observation patients.

(2) Observation policies and procedures must address the following issues:

(a) Patient criteria for admission to the unit, discharge from the unit, and inpatient admission from the unit. ***NOTE: Utilization Management criteria must be considered in the decision to admit or discharge to the most appropriate level of care (see VHA Directive 2010-021 Utilization Management Policy).***

(b) A clear delineation of the service and provider responsible for the patient.

(c) Defined provider and nursing responsibilities throughout the course of treatment and a description of appropriate handoff of care to subsequent providers.

(d) Admission, transfer or discharge before Observation in the unit reaches 48 hours.

(e) A description of the process to be used to monitor and report appropriate utilization.

(f) Assessment, monitoring, and documentation requirements (see Appendix B).

(g) All providers admitting patients to Observation status must follow the policies and procedures of the Observation unit, including the medical record documentation requirements and time limits.

(3) The Observation unit is appropriately equipped and supplied to provide care for the types of patients expected to be placed in Observation. This includes availability of gender-specific supplies and designated female bathrooms with locks to meet the personal care and privacy needs of female patients.

(4) The appropriate number of nursing staff is available as determined by VHA Directive 2010-034, Staffing Methodology for VHA Nursing Personnel, to operate an effective Observation Program.

d. **Facility Leadership (Chief of Staff, Nurse Executive, and Department Directors or Managers)**. The facility leadership is responsible for ensuring:

(1) Sufficient support services are available to the Observation unit in the ED, UCC, or on the inpatient unit to ensure that necessary and appropriate care is consistently delivered to the Observation patient in a timely fashion.

(2) Appropriate policies are enforced outlining the four major principles that are necessary for success of the Observation program. These principles are:

(a) A focused goal must exist for the period of Observation, such as evaluation of high-risk chief complaints, short-term therapy for emergent conditions, or addressing psychosocial needs required for a safe discharge (for example, for those patients presenting with atypical chest pain, the focus is to rule out any acute cardiac injury followed by provocative testing or risk assessment and management).

(b) Limited need for intensive medical, surgical, or mental health services.

(c) Limited severity of illness (for example: patients with acute allergic reactions, dehydration from Gastrointestinal Illness (GI), or acute exacerbation of chronic congestive heart failure).

(d) A clinical condition that is appropriate for Observation (see Appendix A for examples of clinical conditions appropriate for Observation status).

(3) All patients admitted to Observation are assigned a primary treating provider and an observation treating specialty code. The primary treating provider is not a provider in the ED or UCC unless the patient is in ED or UCC Observation bed status.

(4) The length of stay (LOS) for patients placed in observation cannot exceed 47 hours and 59 minutes.

(a) Routine post recovery from ambulatory procedures is not considered Observation and these beds must not be utilized for this purpose. However, patients who require greater than 6 hours, but no more than 47 hours and 59 minutes, recovery from an elective ambulatory procedure for postoperative procedural management or required monitoring of co-morbid conditions may recover and receive care and treatment in a non-count observation units/wards on a case-by-case basis. The reason for admitting a patient to Observation following an ambulatory surgery procedure must be clearly documented in the electronic health record.

(b) At no time will any patient be kept or maintained in the ED or UCC longer than 23 hours and 59 minutes. Patients assigned to Observation beds located in the ED or UCC by specialty services, or as ED Observation, must be limited to a 23 hour and 59 minute stay in the ED itself. Patients who cannot be discharged in this time frame must be transferred or placed in Observation in a non-count bed or unit at a location outside of the ED or UCC. If placed in

Observation in an inpatient non-count bed the patient must be placed in Observation under a clinical service that cares for admitted patients. Observation beds are not to be used as holding beds for the ED or UCC.

(c) VA Community Living Center (CLC) beds may not be used for Observation.

(5) Policies and procedures meet The Joint Commission standards (see references 5e.). These standards state that policies and procedures must address the type of patient that is appropriate for the unit, the maximum time period of use, the mechanism for providing appropriate surveillance, and requirements for documentation and staffing. **NOTE:** *It is important that the policies and procedures of the unit reflect effective collaboration of the Medical Director and Nurse Manager(s) of the ED and UCCs with respective responsibilities and authority for the medical and nursing care services clearly delineated.* The authority over an ED or UCC Observation unit rests with the emergency provider or designee, on duty until either the patient is admitted or the patient's treating provider comes to the Observation unit and assumes full control of the patient.

(6) Compliance with necessary documentation, including a provider's order for Observation status, a detailed admission note indicating the reasons for Observation, a working diagnosis, a treatment plan, and a clear definition of the endpoint for patient disposition. In the case of ED or UCC Observation, the ED or UCC note can serve as the admission note.

(a) The responsible providers and nurses must examine the patient at regular intervals as directed by protocol, and notes must be written documenting the patient's course while in Observation.

(b) Transfer of care at the end of a provider or nursing shift must occur and include a discussion about the clinical course and treatment plan.

(c) Disposition must be documented in a summary note with a clear discharge plan.

(7) The following Patient Treatment File (PTF) treating specialties and revised Monthly Program Cost Report (MPCR) account numbers are utilized for recording Observation patient activity. Only the treating specialties outlined in this Directive are used for setting up Observation units. The service for the Observation unit bed must be a "non-count" service, and must include the Gains and Losses (G&L) location.

Treating Specialty	PTF Number	MPCR Number
Medical Observation	24	1150.00
Surgical Observation	65	1250.00
Psychiatric Observation	94	1350.00
Neurology Observation	18	1151.00
Spinal Cord Injury Observation	23	1156.00
Rehabilitation Medicine Observation	41	1153.00
Emergency Department (ED) Observation	1J	1150.00

**NOTE:** *ED or UCC Observation Treating Specialty became effective October 1, 2009 (part of the Veterans Health Information and Technology Architecture (VistA) ADT patch DG\*5.3\*813.*

(8) PTF Treating Specialty 1J is used for ED or UCC providers admitting patients to the ED or UCC for Observation. For other Observation admissions, the appropriate PTF treating specialty number must be used based on the type of clinical Observation versus where the patient is physically being observed (i.e., a medical provider may admit a patient to Medical Observation in the ED or UCC using treating specialty 24).

(9) Observation status is used appropriately (i.e., a patient is not to be discharged from inpatient and re-admitted to an Observation treating specialty for the same episode of illness).

(10) Patients placed on Observation status are assigned to one of the preceding listed treating specialties (see paragraph 4.d.(7), enabling the facility to track the patients on the G&L. An Observation patient requiring subsequent admission would be released from Observation status by discharging the patient from the Observation bed and then admitting the patient to an acute care-treating specialty. **NOTE:** *Observation care is considered outpatient care. However, the term and process "Admitted to Observation" is used to create virtual non-count wards or beds that address the VistA limitation which prevents the entry of Computerized Patient Record System (CPRS) orders for nursing care, pharmaceuticals, food, etc., when in an outpatient status).*

(11) Patients admitted to non-count units or wards to facilitate treatment during the preoperative, perioperative, and postoperative phases of ambulatory surgery may be discharged and then admitted to Observation if they sustain a complication that requires an extended stay as outlined in paragraph 4.d.(4)(a).

(a) These patients must be discharged and re-admitted to an Observation bed and must be assigned an Observation treating specialty for no more than 47 hours and 59 minutes. If further hospitalization is required following the Observation period, the patient must be discharged from Observation and re-admitted to inpatient status. **NOTE:** *Utilizing this data report methodology enables data users to separate the activity of these patients for their purposes.*

(b) For performance measurement purposes, these patients would not be included as acute care inpatients. Procedures performed while a patient is assigned to Observation status must be considered ambulatory for performance measure purposes.

(12) Documentation is accurate and complete. Appendix B outlines the minimal requirements for patient record documentation of Observation patients.

(13) The Utilization Management Program is responsible for monitoring utilization of the Observation bed program. Monitoring includes an evaluation of Observation stays using evidence-based appropriateness criteria documented in the National Utilization Management Integration (NUMI) application. Additional data collection needs to include patient volume, LOS, number of patients subsequently admitted, type of patient in the Observation program and the percentage of total ED or UCC patient visits that are placed in observation.

(a) Patients who are admitted to an acute care inpatient setting after a period of Observation must have their medical records reviewed by Utilization Review to ensure Observation was appropriate.

(b) If the number of subsequent admissions is high (greater than 25 percent), the department must re-examine the unit's criteria for Observation, as well as proper utilization by the medical staff.

## 5. REFERENCES:

- a. VHA Directive 2010- 021, Utilization Management Program, [http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub\\_ID=2239](http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2239).
- b. VHA Directive 2010-034, Staffing Methodology for VHA Nursing Personnel, [http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub\\_ID=2274](http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2274).
- c. American College of Emergency Physicians (ACEP) Clinical & Practice Management Committee, American College of Emergency Physicians, Emergency Department Observation Services Policy statement. Revised and approved ACEP Board of Directors January 2008.
- d. American College of Emergency Physicians (ACEP) Policy Resource and Education Paper, State of the Art: Observation Units in the Emergency Department, May 2011.
- e. Joint Commission Standards. *NOTE: Current Joint Commission standards may be available through the facility Quality Management offices. The public may contact the Joint Commission at <http://www.jointcommission.org/> to learn more about accreditation of health care facilities.*

## 6. DEFINITIONS:

- a. **Observation Patient.** An Observation patient is one with a medical, surgical or mental health condition showing a significant degree of instability or disability that needs to be monitored, provided with short term treatment and re-assessed while a decision is being made as to whether the patient requires further treatment in an acute care inpatient setting or can be discharged or assigned to care in another setting.
- b. **Observation Unit.** An Observation unit is a designated area that can be either a virtual unit or bed located anywhere in the facility, or a unit located in close proximity to the ED or UCC where patients with medical, surgical or mental health conditions can be kept for up to 47 hours and 59 minutes for extended monitoring, evaluation, and treatment. These units are designated as non-count wards and contain beds that can be used as Observation beds.
- c. **Observation Status Bed.** An Observation status bed is a bed in the facility on one of the inpatient units designated as a non-count observation ward or in the ED or UCC where patients with medical, surgical, or mental health conditions can be kept for extended monitoring, evaluation, and treatment.
- d. **Gains and Losses (G&L) Sheet.** The G&L Sheet provides information concerning patient movement for a given date. It shows all gains (admissions, transfers in from other facilities, returns from authorized and unauthorized absence) and losses (discharges, transfers out and deaths). Inter-ward transfers are counted as both a gain and a loss. The G&L Sheet also displays lodger check-ins and check-outs. Admission types (direct, ambulatory care, etc.) and

discharge types (regular, service connected, non-service connected, etc.) are specified. Applicable patient names and ward locations are listed under the appropriate sections.

e. **Non-Count Ward.** An inpatient non-count ward is one that allows bed assignments as an inpatient to facilitate order entry in CPRS (for nursing care, meds, etc.), but does not count as an ‘admission’ in the medical center statistics. Observation beds are always linked to non-count wards as the services provided are considered outpatient services and not related to an inpatient admission.

f. **Utilization Management.** Utilization management is a proactive approach by trained licensed healthcare professionals including nurses, physicians, social workers and case managers using tools for managing quality and resource utilization. It strives to ensure patients receive the right care, in the right setting, at the right time, for the right reason. This is accomplished by application and interpretation of standardized evidenced based criteria to increase efficiency, promote quality, improve access and assure effective use of resources. Just in time information is provided to guide evidenced-based decisions about appropriate levels of care and services, provides information to assist with decision making related to patient care management and discharge coordination processes, and identifies delays in services.

**GUIDANCE AND CONDITIONS APPROPRIATE FOR OBSERVATION**

**1. CONDITIONS APPROPRIATE FOR OBSERVATION:** Conditions appropriate for Observation include, but are not limited to:

a. **Diagnostic Evaluation.** Diagnostic evaluation of:

- (1) Abdominal pain.
- (2) Chest pain (low probability of myocardial infarction).
- (3) Flank pain (rule out renal colic).
- (4) Gastrointestinal (GI) bleed with stable initial evaluation.
- (5) Chest trauma, normal initial evaluation and Chest X-Ray).
- (6) Abdominal trauma, normal initial evaluation.
- (7) Drug overdose, clinically stable.
- (8) Syncope, negative initial evaluation.
- (9) Deep venous thrombosis.

b. **Short-Term Therapy.** Short-term therapy includes, but is not limited to therapy for:

- (1) Asthma, Chronic Obstructive Pulmonary Disease (COPD).
- (2) Acute exacerbations of chronic congestive heart failure (CHF).
- (3) Dehydration.
- (4) Hyperglycemia, mild to moderate.
- (5) Hypertensive urgencies.
- (6) Selected infections (i.e., urinary tract infection (UTI), clinically stable pneumonias, etc.).
- (7) Seizure disorder required anticonvulsant loading.
- (8) Specialty exams not available at night (i.e., Venous Doppler).
- (9) Post-invasive procedure management requiring intensity of services that do not warrant acute ward/unit admission.

c. **Psychosocial Needs.** Psychological needs, such as:

- (1) Alcohol intoxication.

- (2) Depression (situational, related to intoxication, expected to improve with short stay).
- (3) Social disposition problems.

**2. CONDITIONS NOT APPROPRIATE FOR OBSERVATION PATIENTS:** The Emergency Department (ED), Urgent Care Clinics (UCC), or Facility Observation Unit is not designed to be used for:

- a. Patients needing elective or prescheduled health care services.
- b. Patients who need therapeutic procedures, such as blood transfusion or chemotherapy.
- c. The convenience of the patient, the patient's family, the health care facility, or the attending physician.
- d. An inpatient admission cannot be converted to outpatient Observation status.
- e. Community Living Centers (CLC) beds may not be used for Observation.

***NOTE:** If in the course of an evaluation, it is discovered that the only therapeutic intervention necessary to obviate admission is blood transfusion, then this would be appropriate for Observation status.*

**OBSERVATION PATIENT RECORD**

<b>DOCUMENTATION REQUIREMENTS DOCUMENT OR ITEM</b>	<b>COMPLETION TIME</b>	<b>COMPONENTS OF DOCUMENT REQUIRED</b>
1. Admission Order	On Admission	A timed and dated order for admission of the patient to an Observation Bed.
2. Initial Assessment and History and Physical (H&P)	Within 24 hours of admission to Observation or before discharge if the Length of Stay (LOS) is less than 24 hours.	<p>a. An Initial Assessment and screening of physical, psychological (mental), and social status to determine the reason why the patient is being admitted to an Observation Bed, type of care or treatment to be provided, and need for further assessment.</p> <p>b. An extensive Emergency Department (ED) note or Progress Note, or Community Living Center (CLC) progress note documented by the admitting physician, encompassing the normal criteria for an H&amp;P is sufficient as an initial assessment, and H&amp;P for the Observation patient.</p>
3. Progress Notes	Within the Observation period or as clinically indicated.	<p>a. Progress Notes must reflect the status of the patient’s condition, course of treatment, patient’s response to treatment, and any other significant findings apparent at the time the progress note is documented.</p> <p>b. Reassessments must include a plan for (1) discharge or transfer; (2) admission or readmission to inpatient status; or (3) continued Observation with evaluation and rationale.</p>
4. Discharge Order	On Discharge	A timed and dated order for discharge from the Observation status.
5. Discharge Diagnoses	On Discharge	A complete listing of all final diagnoses including complications and co-morbidities.
6. Discharge Note	On Discharge	A summarization of the reason for the Observation admission, the outcome, follow-up plans and patient disposition, and discharge instructions (such as diet, activity, medications, special instructions). <b>NOTE:</b> <i>This summary may be documented in the Progress Notes, or dictated according to local policy.</i>