

March 4, 2010

STANDARDS FOR EMERGENCY DEPARTMENTS, URGENT CARE CLINICS, AND FACILITY OBSERVATION BEDS

1. PURPOSE: This Veterans Health Administration (VHA) Directive provides policy guidelines for Emergency Departments (ED), Urgent Care Clinics (UCC), and facility observation of patients requiring continued evaluation and treatment who may not need admission to the hospital.

2. BACKGROUND

a. Traditionally, patients who require services beyond the first hours in EDs have been admitted to the acute care hospital. Mounting concerns about hospital overcrowding and the lack of available beds for patients needing inpatient services have led to the more frequent utilization of observation status 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 without 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 areas provide additional medical benefit by allowing for continued evaluation and better definition of the patients 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 to the patient, the ED, UCC, and the facility include:

(1) Allowing additional time for patients requiring extensive workups or ED and UCC care prior to determining disposition or discharge.

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

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

d. Definitions

(1) **Observation Patient.** An observation patient is a patient with a medical, surgical, or psychiatric condition showing a degree of instability or disability that needs to be monitored, evaluated, and assessed for either admission to inpatient status or assignment to care in another setting. All patients admitted to observation must be assigned a treating physician, as well as a

THIS VHA DIRECTIVE EXPIRES MARCH 31, 2015

VHA DIRECTIVE 2010-011

March 4, 2010

specialty code outlined in current VHA policy on Recording Observation Patients (see Attachment A for guidance and for types of patients appropriate for observation).

(2) **Observation Unit.** An observation unit is a designated area that can be either a virtual unit located anywhere in the facility, or a unit located in close proximity to the ED where patients with medical, surgical, or psychiatric conditions can be kept for up to 23 hours and 59 minutes for extended monitoring, evaluation, and treatment.

(3) **Observation Status Bed.** An observation status bed is a bed in the facility on one of the inpatient units where patients with medical, surgical, or psychiatric conditions can be kept for up to 23 hours and 59 minutes for extended monitoring, evaluation, and treatment. The ideal location for these beds must be in close proximity to the nurse's station to facilitate observation. These patients must be assigned to a service with a clearly defined responsible attending physician identified. These beds are not designed to be holding beds and the length of stay (LOS) cannot exceed 23 hours and 59 minutes. Routine post recovery from procedures is not considered observation and these beds must not be utilized for these cases. It is appropriate to consider utilizing these beds for patients who develop short-term complications or require extended observation past the routine recovery time from ambulatory surgery or procedures (examples of such complications may include bleeding, pain, headache, vomiting, unable to void, arrhythmia, extended observation and delayed recovery from anesthesia).

(4) **Lodger.** A lodger is not an observation patient. By definition, a lodger does not receive health care services.

3. POLICY: It is VHA policy that all facilities with EDs and UCCs open 24 hours a day have a written policy to provide care for observation patients for up to 23 hours and 59 minutes.

4. ACTION

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 within VHA EDs and UCCs.

(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 (VISN) Director.** The VISN Director is responsible for ensuring that all facilities with EDs and UCCs within the VISN have policies that define and establish the provision of care to observation patients.

c. **Facility Director.** The Facility Director is responsible for ensuring:

(1) That local policy is in effect for the management of observation patients (see Attachment B). 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 current VHA policy on Utilization Management).*

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

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

(d) The maximum allowable length of stay in the unit is not to exceed 23 hours and 59 minutes. Patients need to be admitted, transferred or discharged following this period of observation.

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

(f) Assessment, monitoring and documentation expectations.

(2) The observation unit is appropriately equipped and supplied to provide care for the types of patients expected to be placed in observation.

(3) The appropriate number of staff are available to operate an effective observation program.

(4) That facility leadership (Chief of Staff, Nurse Executive, and Department Directors or Managers):

(a) Provide sufficient support services to the observation unit in the ED and UCC or on the inpatient unit to ensure that necessary and appropriate care is consistently delivered to the observation patient in a timely fashion.

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

1. A focused goal must exist for the period of observation, such as evaluation of high-risk chief complaints, short-term therapy for emergent conditions, and 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).

2. Limited need for intensive medical, surgical, or psychiatric services.

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

VHA DIRECTIVE 2010-011

March 4, 2010

4. A clinical condition that is appropriate for observation (see Attachment A for examples of clinical conditions appropriate for observation status).

(c) Verify that policies and procedures meet The Joint Commission standards. These must include policies and procedures that address the type of patient that is appropriate for the unit, the maximum time period of use, the mechanism for providing appropriate surveillance, requirements for documentation and staffing. 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 UCC's with respective responsibilities and authority for the medical and nursing care services clearly delineated. The authority over an ED observation unit must rest with the emergency physician, or designee, on duty until either the patient is admitted or the patient's treating physician comes to the observation unit and assumes full control of the patient. **NOTE:** *Policy must dictate that all physicians admitting patients to observation status follow the policies and procedures of the observation unit, including the medical record documentation requirements and time limits.*

(d) 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. 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. 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. Disposition needs to be documented in a summary note with a clear discharge plan.

(5) Utilization Review and Quality Assurance Programs are established to monitor utilization of the observation bed program. Data collection needs to include patient volume, LOS, number of patients subsequently admitted, and type of patient in the observation program and the percentage of total ED or UCC patient visits that are placed in observation.

(a) Patients that are admitted to the hospital after a period of observation must have their chart reviewed to be sure observation was appropriate.

(b) If the number of subsequent admissions is high (greater than 30 percent), the department needs to re-examine the unit's criteria for observation, as well as proper utilization by the medical staff.

5. REFERENCE: ACEP Practice Management Committee, American College of Emergency Physicians, Management of Observation Units. Annals of Emergency Medicine 188:17; 1348-1352. July 1994.

6. FOLLOW-UP RESPONSIBILITY: The Office of Patient Care Services (11) is responsible for the contents of this Directive. Questions may be referred to the National Director for Emergency Medicine (111) at (202) 461-7120.

7. RESCISSIONS: None. This VHA Directive expires March 31, 2015

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ATTACHMENT A

SAMPLE POLICY FOR FACILITY 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 (CXR);
- (6) Abdominal trauma, normal initial evaluation;
- (7) Drug overdose, clinically stable;
- (8) Syncope, negative initial evaluation; and
- (9) Deep venous thrombosis.

b. **Short-Term Therapy.** Short-term therapy includes 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; and
- (8) Specialty exams not available at night (i.e., Venous Doppler).

VHA DIRECTIVE 2010-011

March 4, 2010

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

(1) Alcohol intoxication;

(2) Depression (situational, related to intoxication, expected to improve with short stay); and

(3) Social disposition problems.

2. Conditions Not Appropriate for Observation Patients

a. The Emergency Department (ED) or Urgent Care Clinic (UCC) and Facility Observation policy is not designed to be used for: patients needing elective or prescheduled health care services; patients who need therapeutic procedures, such as blood transfusion or chemotherapy; or Same Day Procedure or Same Day Surgery patients. However, if in the course of an evaluation, if it is discovered that the only therapeutic intervention necessary to obviate admission is blood transfusion, then this would be appropriate for observation status.

b. Observation must not be used solely for the convenience of the patient, the patient's family, the facility or the attending physician.

c. An inpatient admission cannot be converted to outpatient observation status.

ATTACHMENT B

**SAMPLE POLICY FOR EMERGENCY DEPARTMENT AND FACILITY
OBSERVATION**

1. PURPOSE. To establish guidelines for the Emergency Department (ED) and facility observation of patients requiring continued evaluation and treatment that may not need admission to the hospital. This period of observation may not exceed 23 hours 59 minutes before the decision to admit or discharge the patient is made. Patients determined to require observation need to be kept in the ED if beds are available and staffing is appropriate or admitted to one of the inpatient units.

2. POLICY. This policy defines the process used to place a patient in observation status in the _____(Name of Facility)_____ and is in keeping with Veterans Health Administration (VHA) policy on recording observation or short-stay patients and VHA policy on standards for ED or Urgent Care Clinics (UCC) and facility observation beds or units in VHA facilities. Patients that spend more than 6 hours in the ED and not deemed candidates for admission may be placed in observation. This includes patients who are medically unstable; those whose social situation makes it unsafe for them to be discharged home; or patients that need further testing, treatment, or evaluation that can be accomplished within 23 hours and 59 minutes. Examples of patients that may benefit from this policy are those presenting with: gastroenteritis, abdominal pain of uncertain etiology, alcohol intoxication, uncomplicated community acquired pneumonia, chest pain that is of mild to moderate risk for cardiac disease; with negative initial cardiac markers and not escalating in frequency or severity; and various other entities that could be expected to improve sufficiently in 23 hours and 59 minutes.

3. DEFINITIONS

a. **Observation Patient.** An observation patient is a patient with a medical, surgical, or psychiatric condition showing a degree of instability or disability that needs to be monitored, evaluated, and assessed for either admission to inpatient status or assignment to care in another setting. All patients admitted to observation must be assigned a treating specialty code as outlined in current VHA policy on Recording Observation Patients.

b. **Observation Unit.** An observation unit is a designated bed in the ED, (a virtual observation bed) or unit located in close proximity to the ED where patients with medical, surgical, or psychiatric conditions can be kept for up to 23 hours and 59 minutes for extended monitoring, evaluation, and treatment. These patients must be the responsibility of, and managed by, the ED or UCC staff. These beds are not designed to be holding beds for the ED patients awaiting inpatient beds and the length-of-stay (LOS) cannot exceed 23 hours and 59 minutes. Routine post recovery from procedures is not observation and these beds must not be utilized for these cases.

VHA DIRECTIVE 2010-011

March 4, 2010

c. Observation Status Bed

(1) An observation status bed is a bed in the facility on one of the inpatient units where patients with medical, surgical, or psychiatric conditions can be kept for up to 23 hours and 59 minutes for extended monitoring, evaluation, and treatment. The ideal location for these beds must be in close proximity to the nurse's station to facilitate observation. These patients must be assigned to a service with a clearly-defined responsible attending physician identified. These beds are not designed to be holding beds and the LOS cannot exceed 23 hours and 59 minutes. Routine post recovery from procedures is not considered observation and these beds must not be utilized for these cases.

(2) Patients admitted to ED observation status by the ED attending physician must be kept in the ED. The ED has a three-bed limit for observation and holding patients. Once this limit is reached the remaining observation patients must be placed on the appropriate floors in conjunction with the service required, if the appropriate beds are available. All observation patients admitted to the floor must be assigned to a service with a clearly-defined attending physician. Every effort must be made to maintain all observation patients in the ED if possible.

(3) The observation patient must be placed in a bed in the ED that is designated as an observation bed or admitted to one of the acute care floors. The Charge Nurse on Duty in cooperation with the physicians evaluating and treating the patient must decide the location of the observation bed. There are three monitored beds currently in the ED identified as appropriate for ED observation beds. Observation status begins when the order is written.

d. Conditions Appropriate for Observation. Conditions appropriate for observation include:

(1) **A diagnostic evaluation of:**

- (a) Abdominal pain;
- (b) Chest pain (low or moderate probability of myocardial infarction);
- (c) Flank pain (rule out renal colic);
- (d) Gastrointestinal (GI) bleed with stable initial evaluation;
- (e) Chest trauma, normal initial evaluation and chest X-ray (CXR);
- (f) Abdominal trauma, normal initial evaluation;
- (g) Drug overdose, clinically stable;
- (h) Syncope, negative initial evaluation; or
- (i) Deep venous thrombosis.

- (2) **Short-Term Therapy.** Short-term therapy includes therapy for:
 - (a) Asthma, or Chronic Obstructive Pulmonary Disease (COPD);
 - (b) Acute exacerbations of chronic CHF;
 - (c) Dehydration;
 - (d) Hyperglycemia, mild to moderate;
 - (e) Hypertensive urgencies;
 - (f) Selected infections (urinary tract infection (UTI), clinically stable pneumonias);
 - (g) Seizure disorder required anticonvulsant loading; and
 - (h) Specialty exams not available at night (Venous Doppler).
- (3) **Psychosocial Needs.** Psychosocial elements for observation include:
 - (a) Alcohol intoxication;
 - (b) Depression (situational related to alcohol intoxication); and
 - (c) Social disposition problems.

e. **Conditions Not Appropriate for Observation Patients**

(1) The medical center ED observation policy is not designed to be used for patients needing elective or prescheduled health care services, or for patients who need therapeutic procedures, such as, blood transfusion, chemotherapy, same day procedure, or same day surgery patients. However, if in the course of an evaluation it is discovered that the only therapeutic intervention that is necessary to obviate admission is blood transfusion, then this can be considered appropriate for observation status.

(2) Observation is not to be used as a convenience to the patient, the patient's family, the facility or the attending physician.

(3) An inpatient admission cannot be converted to outpatient observation status

VHA DIRECTIVE 2010-011

March 4, 2010

4. PROCEDURES

a. Determination of the suitability for placement in observation status must be made by the treating physicians caring for the patient. This may include specialists called to the ED by the attending physician or Medical Officer of the Day (MOD) to evaluate the patient. Once the decision to place the patient in observation is made, the Charge Nurse, in consultation with the ED physician on duty, must collectively determine the appropriate bed placement for the patient. This may be a bed in the ED or a bed on one of the inpatient units. In the event that the patient needs to be observed on an inpatient floor, the Charge Nurse and the ED must notify the Bed-Coordinator or Nursing Supervisor.

b. The ED physician or a physician from a consulting service (the physician responsible for the care of the patient during the patient's observation stay) must place orders in the computer. Specific order sets for use with observation patients are available in the Computerized Patient Record System (CPRS).

c. The patient is placed in observation status by the appropriate service; for example, a patient with cellulitis may be assigned to the Medical Service. The responsible physician must go to the orders section in CPRS, click on ED Admit to Observation under the write orders section and follow directions for observation orders. The admitting physician must indicate that the patient is being assigned to Medical observation (MOB), Surgical observation (SOB), Neurological observation (NOB), Telemetry observation (TOB), Rehabilitation observation (ROB), Psychiatric observation (POB) or Emergency Department Observation (EDOB). The remainder of the orders must be completed using a template provided.

d. The continued management of the patient placed in observation in the ED is the responsibility of the assigned physician. Acute life threatening problems must be managed by the ED physician. All other questions in regard to routine care or observation orders are to be referred to the covering physician on the assigned service.

e. All patients placed in observation are to be discharged from observation and sent home or admitted to the hospital within 23 hours and 59 minutes. All patients kept in the ED over 23 hours and 59 minutes must be admitted to the service that placed them in observation or to the appropriate service for their presenting complaint as determined by the ED physician. All patients must be discharged from observation. This includes patients sent home, as well as, patients subsequently admitted to the hospital.

5. DOCUMENTATION REQUIREMENTS

a. Patients assigned to observation are required to have an admit to observation order and an initial assessment, history, and physical performed by the admitting physician. An extensive ED note or progress note documented by the admitting physician is adequate.

b. Progress notes reflecting the patient's status, the course of treatment, response to treatment, and any other significant events or findings need to be recorded at least every 12 hours. In the case of observation to the ED attending service, a note is required each time a new ED attending service assumes control of the case.

c. Patients placed in and subsequently discharged from observation to home are to have a discharge note written or dictated. This note needs to summarize the observation stay and include the evaluation, outcome, discharge diagnosis, follow-up plans, disposition, and condition upon discharge.

d. Nursing documentation for patient's in observation status must have the nurse's documentation recorded in the electronic medical record.

e. Nutrition and Food Service must deliver meals to observation bed patients on orders.

6. MISCELLANEOUS

a. Certain conditions are unacceptable for admission to an observation bed. Patients with unstable vital signs, those that are severely ill, and any patient whose death is imminent are not candidates for placement in an observation bed.

b. All physicians admitting patients to an observation bed must follow the policies and procedures of the unit, including medical record documentation and time limit requirements.

7. PERFORMANCE IMPROVEMENT

a. Patients admitted after a 23-hour and 59 minute period of observation must have the record reviewed to determine if utilization of observation status was appropriate. Inappropriate admissions to an observation bed must be discussed with the providers involved to prevent recurrence in the future.

b. Patient records must be filed and reviewed monthly to assess all aspects of the utilization of the observation beds. This includes the diagnosis, the assigned service, the time of day, shift, day of the week, and final disposition (i.e. admission versus discharge). The average length of time spent in observation for all patients is to be tracked and followed.

c. All patient stays that exceed the 23-hour and 59 minute time limit must be reviewed to determine the issues that prolonged the stay.

8. RESPONSIBILITY: The ED Lead Physician is responsible for managing and overseeing the operation of the ED observation beds in concert with the Nurse Manager of the ED.

9. REFERENCES: ACEP Practice Management Committee, American College of Emergency Physicians, Management of Observation Units. Annals of Emergency Medicine 188:17; 1348-1352. July 1994.

VHA DIRECTIVE 2010-011

March 4, 2010

10. RESCISSIONS: Facility Specific.

11. REVIEW DATE: Facility Specific.

12. FOLLOW-UP RESPONSIBILITY: Faculty specific, i.e., the:

- a. ED Lead Physician and Nurse Manager,
- b. Chief of Staff and Clinical Nurse Executive.