Protocol-Driven Emergency Department Observation Units

Description

Nearly 120 million visits to emergency departments (EDs) occur in the United States (U.S.) each year, accounting for 50% of all hospital admissions, up from 33% in the mid-1990s. Growth in the number of visits rose between 1997 and 2007 to twice the rate of population growth while the number of EDs declined, an increasing number of new tests and treatments were being introduced, and boarding of patients emerged. As the population increases and ages, the growth in ED visits and demand for inpatient beds is expected to surge. Hospitals and health systems may choose to approach these issues with the use of ED observation units (EDOUs), considered an outpatient service by payors.

Beyond initial and stabilizing care, ED patients may require additional services to determine if inpatient admission is warranted. Active management of patients, following initial care to determine appropriate disposition, is the defining feature of observation services. Length of stay in an observation unit is typically from 6–24 hours, falling outside the “ED visit with discharge” and “ED visit with full inpatient admission” categorizations. The primary goal of observation service units is to create an incentive for an efficient and effective healthcare alternative, thereby lowering healthcare costs.

The Centers for Medicare and Medicaid Services (CMS) defines observation care as “a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.” Observation services offer appropriate monitoring, diagnostic testing, therapy, and assessment of patient symptoms and response to therapy while determining disposition.

Observation service units are assigned a variety of titles based on specific populations served and local preferences. Regardless of the title, it is important to distinguish between patients designated as observation status, patients with a disposition already determined, and patients being held or boarded in the ED pending movement, admission, or transfer.

Overall, observation services are designed to provide diagnostic and treatment capabilities managed by appropriate physician and registered nurse staffing in an efficient, safe, and comfortable environment. Selected ED patients of all ages, presenting with a variety of medical issues, may be deemed “not well enough for immediate discharge, but not sick enough to warrant inpatient admission status” leading to their treatment as outpatients, using observation services. Patients verified by physician order as eligible for admission to observation status have specified treatment goals to be met within identified time limits.

Across the US, observation services are currently provided in one of four distinct hospital settings defined by the presence or absence of two features: dedicated units and condition-specific protocols, as described by Ross, et al. Type I protocol-driven, ED-directed observation units have been the most studied and offer less diagnostic uncertainty, improved clinical outcomes, and higher patient satisfaction. Care provided in a dedicated observation unit generally driven by protocols and located in the emergency medicine environment, provides patients with continuous rounding and the ability to expedite discharge at any time of the day or night.
When observation units are used, patients and hospitals benefit from shorter lengths of stay, lowered costs, and improved use of hospital resources. Relative to inpatient care, Type 1 observation units offer cost savings of 27–42%. Key elements required to manage a Type 1 model include a dedicated unit setting with operational guidelines, condition-specific protocols, administrative oversight, and appropriate staffing with qualified professionals. Operational guidelines set the standards for appropriate patient selection, the creation of order sets and protocols to ensure consistent condition management, and criteria for home discharge. Collaborative approaches to care using evidence-based protocols have the potential to achieve similar clinical outcomes at a lower cost than inpatient admission. EDOUs provide “the right care for the right patient at the right time” and are expected to continue to advance health care delivery in the future.

**ENA Position**

It is the position of the Emergency Nurses Association that:

1. Protocol-driven EDOUs enhance the quality and safety of patient care.
2. EDOU services offer a cost-effective alternative for further treatment and evaluation, preventing unnecessary hospital inpatient admissions and negative outcomes due to premature discharge from the ED.
3. Initiation to observation is based on the individual’s medical needs and is not appropriate as an alternative holding area for patients awaiting disposition to inpatient care or transfer to another facility.
4. Emergency nurses, Advanced Practice Registered Nurses (APRNs), and providers participate in the development of written policies, diagnostic protocols, and standardized pathways that define criteria for patient selection, care, transfer, and discharge, and the oversight of observation units.
5. Dedicated EDOUs are appropriately managed by emergency physicians and APRNs, and are staffed with emergency-trained professionals.
6. Emergency nurses deliver quality nursing care to observation patients, employing standardized pathways and evidence-based protocols, and practice according to regulatory and jurisdictional guidelines.
7. Emergency nurses support the rights of patients to be informed regarding services provided, financial implications, cost-sharing, and insurance limitations of observation care.
8. Emergency nurses provide purposeful rounding and comfort measures to patients awaiting evaluation and disposition, providing progress updates and educating patients and their families.
9. Observation units provide dedicated space, equipment, and supplies, and offer hospital resources and diagnostic services to meet patient needs.
10. Emergency nurses, APRNs, physicians, and providers participate in collaborative research to refine and improve clinical and operational outcomes provided in EDOUs.
Position Statement

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Background

The 2015 American College of Emergency Physicians Board of Directors reaffirmed their policy statement that modern hospitals and EDs continue to face an array of challenges including overcrowding, inefficient use of resources, escalating health care costs, and concerns over avoidable admissions. One solution to these challenges is the use of observation service units. EDOUs have been shown to be safe and effective, are considered best practice when managed appropriately, and offer an important service line for hospitals to help avoid financial penalties associated with patient readmissions. EDOUs provide access to quality care to selected patients at a lower cost. These distinct and reimbursable services may include further diagnostic evaluation, continued therapy, and management of acute psychosocial issues. EDOU systems provide a benefit to health systems in diagnosing a variety of acute conditions including asthma, chest pain, heart failure, dysrhythmias, syncope, neurological conditions, abdominal pain, and more.

The prevalence of US hospitals delivering observation services has steadily increased to 36%, typically in or adjacent to the ED, and sometimes located on inpatient floors. Half of these hospitals use condition-specific protocols and half do not. Internationally, emergency observation services have been reported in Australia, Canada, South America, Britain, India, China, Singapore, and throughout Europe. Research in this outpatient setting will provide a better understanding of its benefits and improved use of resources as compared with patients admitted to the inpatient setting.

Leadership and appropriate staffing are essential for EDOUs to operate successfully. Quality observation care is provided by experienced emergency nursing professionals monitored by emergency physicians augmented by advance practice providers (APPs) with the ability to manage complex patients. A national survey by Mace, Graff, Mikhail, & Ross (2003) revealed observation units were staffed with an average of one nurse per 4.2 patients, and 21.4% of observation units employed APPs to assist in patient care.

Pediatric observation units are emerging as an alternative site of care for children with selected diagnoses. Patients younger than 15 years account for close to 25 million ED visits per year, and those 15–24 years make more than 22 million visits. Previous data have shown that pediatric patients are often hospitalized for brief durations, with nearly one third admitted for one night or less. For these reasons, pediatric observation units are an ideal setting for monitoring serial physical examinations, awaiting consultations, and administering short courses of treatment. The most frequent pediatric diagnoses associated with observation services include abdominal pain, allergic reactions, asthma, bronchiolitis, croup, dehydration, gastroenteritis, minor trauma such as head trauma, and toxic ingestions.

Limited data show there are pediatric observation units in almost 39% of free-standing children’s hospitals, 39% of hospitals with separate pediatric wards, and approximately 4% of hospitals without pediatric wards. Macy, Kim, Sasson, Lozon, & Davis (2010) attempted to summarize the literature on standard outcome measures for pediatric observation units and found that the metrics, including length of stay, admission rates, return visit rates, and costs, were variable and not clearly defined.

Elderly patients are an increasingly large demographic seeking care in the ED, representing 43% of all admissions. These patients are often quite complex, require longer ED visits compared with their younger counterparts, undergo far more testing, and pose unique treatment needs, given their comorbidities and social circumstances. Often admitted when diagnosis is unclear, geriatric patients are more vulnerable to complications resulting from inpatient hospitalization, including nosocomial infections, skin breakdown, and functional decline. Observation units are a clear option to effectively monitor and further evaluate the geriatric patient with an unclear presentation.
Under the Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act of 2015, hospitals are required to notify Medicare beneficiaries of their outpatient observation status, including services provided and the cost-sharing implications. Observation services are classified as outpatient and may not be covered by insurance, including the three-day stay required by Medicare to be eligible for long-term care and skilled nursing facilities. CMS finalized changes to the two-midnight rule in 2015. Observation length of stay may not count toward the inpatient stay and is not covered by the two-midnight rule. For stays in which the patient will require hospital care spanning less than two midnights, inpatient admission may be allowed on a case-by-case basis with supporting documentation from the admitting physician or may be subject to review.

Observation units have emerged as a diagnostic treatment option at the intersection of outpatient and inpatient care during a time of dramatic change in both emergency and hospital medicine. Observation services offer safe, efficient, and quality care to ED patients with common complaints, decreasing unnecessary inpatient admissions and improving fiscal performance for hospitals. As more hospitals choose the benefits of observation services, education and research will further optimize the use of ED observation and clinical decision medicine for patient of all ages.

**Resources**


References


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