NYC HEALTH+ HOSPITALS | Kings County

Observation Service Standard Operating Procedures

TABLE OF CONTENTS

I. Contact
II. Mission
III. Introduction
IV. Observation Unit
V. Hours
VI. Staffing
   A. ED Resident
   B. ED Attending
   C. Nurse
   D. PCA
   E. Clerical
VII. Responsibilities
   A. ED Resident
   B. ED Attending
   C. Nurse
   D. PCA
   E. Clerical
VIII. Clinical Guidelines
   A. Overall Clinical Criteria
   B. Cardiac Patients
   Specific clinical guidelines are listed at end of SOP
IX. Operations
   A. Flow Diagram
   B. Admission Process
   C. Ongoing Care
   D. Disposition
      ➢ Discharged - Home
      ➢ Inpatient
   E. Charting/Documentation
      ➢ Notes
      ➢ Attending Attestation
      ➢ Medication Reconciliation
   F. Rounds
   G. Codes
X. Case Management/Care Management/Social Work
XI. Quality Assurance/Utilization Review
XII. Infrastructure
XIII. Clinical Guidelines
   A. General
   B. Allergic Reaction
   C. Asthma
   D. Cellulitis
   E. Chest Pain
   F. Deep Venous Thrombus
   G. Dehydration/Vomiting
   H. Hyperglycemia
   I. Hypoglycemia
   J. Transfusion
   K. Pneumonia
   L. Syncope

1. CONTACT

- **Observation Unit Telephone Number:** (718) 245-7993

- **Observation Service EM Resident Pager:** (917)219-1555
  (Located in designated desk in Station B)

- **Observation EM Director:** Selwena Brewster, MD brewstes@nychhc.org
  O: (718) 245-8554
  C: (646) 271-5640

- **Observation ED Director:** Balakrishnan, Rithvik, MD
  Rithvik.Balakrishnan@nychhc.org
  C: (708) 522-3878

- **Chief of Service EM:** Rajesh Verma, MD rajesh.verma@nychhc.org
  O: (718) 245-4790
  C: (646) 245-6397

- **EM Nursing Director:** Diana Singh, RN singhd14@nychhc.org
  O: (718) 245-4623
  C: (646) 260-6624

II. MISSION STATEMENT

The Kings County Hospital Observation Service will provide the highest quality of care for patients who require focused management of their acute medical condition. Our efficient and cost-effective service will be using diagnosis specific protocols based on the best clinical evidence to treat patients in a pleasant and comfortable environment.

We strive to be a recognized leader in the provision of Observation Services at Kings County Hospital.

III. INTRODUCTION

Observation Service (Obs) is managed by the Department of Emergency Medicine. Observation service is intended for patients whose clinical needs are expected to exceed six hours of ED care, but can realistically be fulfilled with an additional 8 - 48 hours of hospitalization. These patients will have a single acute problem with a well-defined plan for management. Within this time frame all management including testing, treatment, observation and disposition should be completed. On final evaluation, the patient will either be admitted to the appropriate service or discharged if indicated.

IV. OBSERVATION UNIT

The KCH Observation Unit (OU) is located in the C-Building ground floor adjacent with the current Short Stay Unit (SSU). The OU is a 12-bed unit each with tele-monitoring and central telemetry review station. The unit will be physically open 24 hours a day for 7 days a week. Telephone number for the unit 718-245-7993.

V. AVAILABILITY –

Observation service will be available 24 hours a day for 7 days a week. The unit will also be physically open 24 hours a day for 7 days a week.

VI. STAFFING –

During operating hours, the unit will have 24-hour coverage with consistent staffing.

A. Resident:

1. EM Resident

a) The OU will be staffed with a dedicated senior EM or EM/IM resident during all shifts

b) All EM Resident shifts in the OU will be 8 hours

c) EM Resident Coverage is available via *www.amion.com*

B. Attending:

1. Emergency Medicine Attending

a) EM attending will be the attending of record for observation 7 days 24 hours a day

C. Nurse:

1. Observation Unit (OU) will be staffed during operating hours with a maximum of 2 nurses per shift. Once greater than eight (8) patients in the unit, a second nurse will be added

D. PCA:

1. The OU will have a single dedicated PCA per shift

E. Clerical:

1. The OU will be staffed with a single clerical associate per shift

VII. RESPONSIBILTIES – *(Please refer to appendix for Standard Work)*

A. ED Resident:

1. Initiates appropriate OU protocol order set or management plan.
2. Performs serial examinations or orders relevant diagnostic tests, consultants, etc.
3. Considers and initiates needs for social work, case/care management, pharmacy within three (3) hours of initial evaluation.
4. Diet Order Entry- For patients without contraindications, a diet order will be placed in line with any underlying co-morbidities (e.g. Low Sodium diet for CHF, Diabetic diet for patients with DM, etc.). Diet status should also be discussed with consultants for patients pending procedures (e.g. NPO for EGD)
5. Completes documentation each shift with brief synopsis and reason for observation and continued observation needs
6. Completes home disposition process by preparing disposition note including summary of care, discussing discharge instructions and return precautions with patient, arranging follow-up and writing prescriptions.
7. Completes admission disposition in EMR and discusses case with relevant party (medical senior, surgery, etc.).
8. Update patients on plan of care.
9. Notifies Obs RN and clerk of all changes in patient status (discharged, admitted, transfer)
10. Keep Obs Attending and Nurse informed of significant patient management issues – including those suggested by consultants.
11. Although highly unlikely, responsibilities of the OU resident will fluctuate with the OU census. This does not apply when the OU is staffed by a non-EM resident.
    - **a)** If there are 2 or less patients in observation status, OU the resident is expected to see new patients in the main Emergency Department. They must:
        - (1) Maintain responsibility for patients in the observation unit
        - (2) Ensure ease of availability to nurse in observation unit.
        - (3) Ensure ease of availability to ED staff for new admissions to the OU.

(4) Avoid care of complex ED patients that require extensive time or significant resources.

(5) If a patient unexpectedly becomes more complicated or time intensive the observation unit resident should sign that patient out to another ED resident.

(6) If the OU increases its census, and the OU residents feels they can no longer care for active ED patients then they should sign out those patients to the ED staff in the appropriate area.

b) If there are between 3 and 6 patients, the resident may use his/her discretion to see patients in the main emergency room. The guidelines above apply.

c) If there are 6 or more patients in the OU, the residents must specifically care for OU patients.

B. Obs Attending:

1. Discusses with ED attending directly the patient's suitability for the OU
2. Ensures suitability for observation, identifies specific reason for observation, approves the decision to admit patient to observation
3. Perform tasks 2-10 listed under resident responsibilities
4. At the 24th hour of treatment in the Obs Unit, if the physician has not or can not predict a safe discharge, communication with the medicine service need to transpire

C. Nurse:

1. Receives transfer of care information. Ensures property is done and medication administration completed.
2. Updates patient location in EMR
3. Obtain vital signs at least every 4 hours, unless it's ordered otherwise, check labs, perform nursing assessment and documentation and provide patient care as per protocol or orders.
4. Update observation provider on changes in patient's condition and significant results.
5. Update patients on plan of care.
6. Participates in interdisciplinary observation rounds with obs providers, administrators, social work, case/care management

7. Prompts for disposition when protocol endpoint is reached, when patient needs to be admitted or discharged, or when LOS reaches 36hrs
8. Performs patient teaching, remove invasive lines, and performs final assessment.

D. PCA:

1. Obtain vital signs at least every 4 hours
2. Perform tasks such as phlebotomy, patient care, POC testing, and those directed by nurse or provider
3. Ensures property completed
4. Will stock the OU as needed

E. Clerical:

1. Assist with OU communication, scheduling of follow up appointments, pages and transportation requests
2. Reconcile census with bed Czar and nursing
3. Manages telephone, printer/fax, label maker function
4. Stock clerical supplies

VIII. CLINICAL GUIDELINES –

A. Overall Clinical Criteria:

1. Patients placed in the KCH Obs Service should have a reasonably high (>85%) expectation of discharge within 48 hours of hospital observation. However, 4 hours of additional observation, for a total of 52 hours, is allowable for patients with pending results which may highly result in discharge home.
2. 48-hour clock begins at the time of the disposition to Observation, not from triage.
3. Observation service is available to all patients who meet the general inclusion without any exclusion criteria who have a clear management plan to be executed in observation.
4. Patients with significant psychiatric, opioid, use, behavioral or social issues, including advanced dementia requiring 1:1 as a primary or concomitant illness, are unsuitable for the OU**.** They can be kept in the ED under OU status.

5. Referring ED physician should verify that the above, in addition to other exclusions, are not present prior to considering observation. Although diagnostic evaluation will occur, there will be a concentration on therapeutic modalities.
6. Ongoing evaluation and quality assurance may lead to the addition or subtraction of appropriate diagnoses.

B. *Specific Clinical Guidelines:

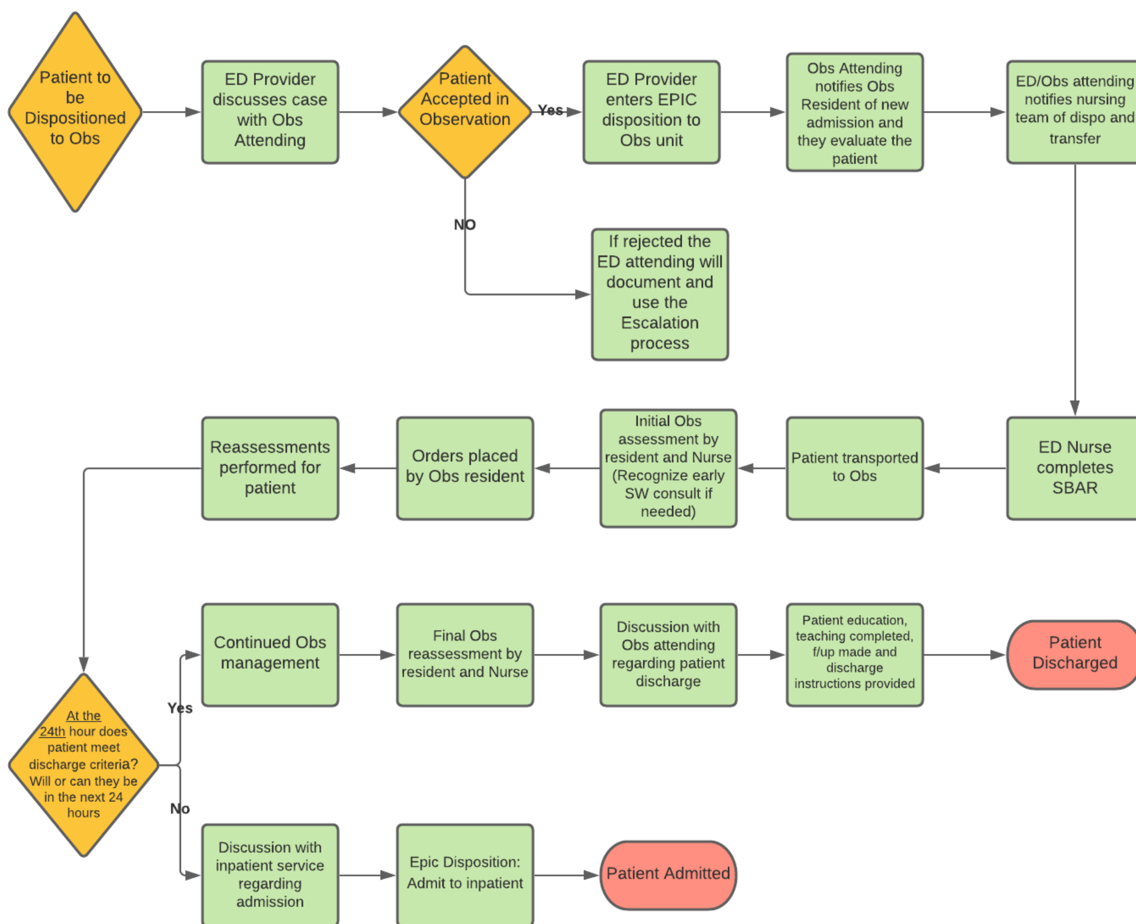
1. Clinical guidelines exist for selected clinical conditions and should be followed when applicable (see accompanying clinical guidelines for disease specific inclusion criteria, exclusion criteria and management recommendations).
2. Clinical judgment may allow care outside these guidelines.
3. Cardiac Patients:
   - **a)** Routine cardiology consult will be placed for chest pain patients by the Obs provider performing the initial assessment. Include clinical history and observation status in consult.
   - **b)** Dedicated cardiology attending is available to obs 9AM-5PM.
     - (1) Cardiology attending will round by 10AM on all observation patients with cardiac related diagnoses.
     - (2) A page to the cardiology attending should occur by 10AM for all Obs chest pain patients waiting to be evaluated or stressed.
   - **c)** Provocative Candidates
     - (1) Pending evaluation will be placed NPO at midnight for possible provocative testing in the AM. If scheduled for afternoon testing, patient may have a light breakfast.
     - (2) For chest pain patients scheduled for nuclear medicine stress test, talk to cardiology to determine their recommendations.
     - (3) In early afternoon (~ 1PM), the OU resident will page the cardiology attending for new chest pain patients who presented after their morning rounds who have completed their standard work up (two troponins and EKGs) and are in need of evaluation/provocative testing.

(4) Concerns and/or issues in regard to who receives provocative testing should result in an attending-to-attending discussion. Standard escalation procedures apply.

(5) Patients who receive provocative testing should not be discharged until the official testing report is documented in Epic.

IX. OPERATIONS –

A. FLOW DIAGRAM



B. Admission Process

1. Once the decision to place a patient in observation is made, the ED Attending will contact the designated Obs Attending to discuss case.

2. Escalation Procedures regarding Disagreements:

a) Cases of disagreement regarding patient appropriateness for OU:

(1) A verbal discussion must have occurred between the ED attending of record and the designated Obs attending.

(2) The patient should be seen and evaluated by both attending's and plan of care discussed.

(3) If the disagreement remains, the ED/Obs attending should use the Escalation Process in real time and contact directly Dr. Balakrishnan, Dr. Brewster, and/or Dr. Verma via phone for the final decision.

3. Upon acceptance by the Obs attending, the ED provider will enter observation unit disposition in Epic.

4. The Obs Attending will then endorse case to the Obs resident and they will evaluate the patient.

5. The ED provider will inform patient's nurse of the patient's disposition to Observation, while the Obs provider notifies OU nurse of pending transfer.

6. ED Nurse will give *(electronic, verbal)* SBAR to Obs Nurse.

7. Patient transferred to OU via PCA +/- ED nurse.

8. *Prior to or on arrival to the unit, an Obs provider and nurse will perform an intake assessment and documentation.

9. Obs provider will place orders based on applicable protocol, documented and/or discussed management plan.

C. Ongoing Care

1. Upon disposition to observation, the Obs resident will write orders as outlined in the applicable clinical protocol or detailed in the patient's disposition.

2. The Obs provider may initiate orders, consults and testing for observation patients as necessary, however they are expected to follow the applicable guidelines unless clinical situation dictates otherwise.
3. If a patient becomes unstable at any time, interventions as necessary will be performed A "Code 66", Rapid Response Team (RRT), will be called and if necessary, the patient will be admitted to the appropriate service and transferred to an appropriate clinical area. If possible, please notify MD and RN prior to transfer.
4. The ED and the Medicine Rapid Response Team will present for all codes called to the C-building ground floor.
   - **a)** The Obs provider team (Obs attending and Obs resident) must report to all codes on C-building ground floor
   - **b)** The Quad 3/4 ED attending must report to all codes on C-building ground floor
5. If there are any questions regarding a patient's course or non-emergent concern, the Obs resident will contact the Obs attending for assistance and or guidance.

D. Discharge Process

1. All discharges must be approved by the Obs attending prior to completion.
2. Utilize the **Disposition Note** *(Observation Dispo note currently does not print*) for dispositions (admit or discharge) out of observation
3. If the clinical situation strongly suggests that disposition may occur within 12 hours past the 24 hour mark due to pending results observation period may be extended to a total of 36 hours.

4. <u>Disposition Home</u> – When the patient meets the predefined criteria, the patient will be discharged home from the observation unit.
   - **a)** All typical discharge processes must occur, i.e. teaching, appropriate follow up, written instructions, and return precautions.
   - **b)** Prior to discharge, the Obs resident must document patient's clinical course, final diagnosis, and examination. The Obs nurse will document final discharge assessment and vital signs.
   - **c)** Upon discharge, all patients will be provided with a discharge papers, continued care recommendations and plan for follow up.

5. Disposition to Inpatient – If patient deteriorates during the observation stay or at the 48-hour mark requires further clinical care, the patient will be admitted to the hospital for further management.
6. Admissions to the hospital from the observation unit will occur in the same process as admissions from the ED.
   a) The admitting service (Physician-in-Charge for Medicine) will be contacted by the observation provider and given an endorsement of patient. The Obs provider will then complete a disposition note for the particular service.
   b) Upon endorsement, the admitting service will be responsible to write all orders and direct additional management of the patient.
   c) The now admitted patient will then await transfer to inpatient floor.
   d) The Obs provider will intervene in cases of emergency for admitted patients dwelling in the observation unit.
   e) If patient is in extremis or admitted to ICU and no ICU bed available, the patient will be transferred back to the ED.
   f) Unless clinical circumstances dictate otherwise, observation unit patients who are admitted will be given priority over admitted ED patients for inpatient beds. Obs Clerk will notify bed czar of all upgraded observation patients.

E. Charting/Documentation

1. Upon presentation to the unit, the Obs resident and nurse must perform an initial evaluation and document this evaluation.
2. Provider Notes
   a) Each patient should receive at least one note per 8 or 12-hour shift.
   b) A progress note should be documented within 4 hours after initial obs evaluation. Additional notes should be completed at 6-8 hours' intervals or more frequently if needed. If a patient has a planned discharge within 2 hours of a required note, then the discharge note will suffice
   c) Provider Progress Note (ED Progress Note)
      (1) Chief complaint, brief HPI, examination and reason for placement on observation
      (2) Physical exam, pertinent results for all diagnostic tests
      (3) Assessment and plan including any planned/pending labs,

diagnostic studies, or consults

(4) Whenever possible include in notes or sign out to incoming team

(a) Any change in patient status, including any new results from labs, diagnostic studies, or consults and follow-up of any pending labs, diagnostic studies, or consults

d) Discharge Note

(1) Upon meeting criteria for discharge, a disposition will be completed, which will include the patient's clinical course in observation, the final examination, final diagnosis, and instructions for continued care.

3. Attending Attestation

a) The covering OU attending must cosign notes completed on OU patients during their coverage period.

b) If the Obs attending physically sees and examines patients at any time during their hospital course, then option 1 or 2 [see red box in above figure] attestation should be used, confirming this. The attending may choose instead to write his/her own note.

c) The general supervision, option 4 [see green circle in above figure] attestation should be used in those cases when only a verbal discussion occurs.

d) Possible attestation phrases for Obs attending not designated in the disposition of the patient:

(1) Patient placed in observation for ________________. Clinical guideline reviewed and put into effect. Patient reassessed and care adjusted appropriately based on clinical indication.

4. Medication Reconciliation

a) Medication reconciliation will be available in Observation once applicable EMR changes have been made.

b) Changes in medications (additions, removals) should be documented in the patient's discharge instructions so outpatient providers can be aware.

c) Any chronic medication that patient takes, i.e. hypertensive medications, should be ordered.

F. Rounds Principles

1. Interdisciplinary rounds with providers, nurses, administration, social work, case/care management as needed, should occur once daily.

2. In addition to this, consultation with social work, case/care management, and administration to facilitate patient disposition may occur as needed
3. Compelling questions to be discussed during all rounds
   a) "How long has this patient been here?" Critical times to note in a patients length of stay from disposition is 18 hours, 24 hours, and 36 hours?
   b) "Why is this patient still here?"
4. The beginning of a shift is the time to get "sign out", examine the patient, give orders, make plans and assign your name to each patient on the whiteboard. As patients present to the unit this will be repeated.

G. Codes

a) All clinical codes (66, 88, 99, code Heart, Stroke, trauma, etc.) are applicable to be called in the OU
   (1) Code 66 (Rapid Response Team) - Response Team needed at bedside due to potential clinical deterioration (excluding cardiac or respiratory arrest).
   (2) Code 88 – Respiratory emergency requiring intubation/assistance from anesthesiology.
   (3) Code 99 – Cardiac or Respiratory arrest
   (4) Code Heart – Any patient with (1) STEMI, (2) unstable cardiac rhythm, (3) any other cardiac malady that cannot wait for a routine cardiac consult.

(5)Stroke – Suspected cerebrovascular accident due to acute neurologic deficit occurring within 6 hours of presentation.

(6) Trauma – Potential surgical emergency due to acute trauma

If a patient becomes unstable at any time, interventions as necessary will be performed, code may be called and if necessary, the patient will be admitted to the appropriate service and/or transferred to an appropriate clinical area.

b) The ED and Medicine Code Teams will present for all codes called to the C-building ground floor.

X. CARE MANAGEMENT/ SOCIAL WORK

Some patients placed in observation will benefit from Care Management, Case Management or Social Work Services. As done on active ED patients, a consult for Care Management and SW service should be placed if indicated. *Case management should be contacted for any patient to be admitted from observation.*

A. Care Management

1. Services include but are not limited to setting up visiting nurse services, disease and medication education (especially newly diagnosed DM), follow up appointment assistance, PE/DVT management. etc.
2. Diagnoses for care management intervention:
    - a) Asthma
    - b) Angina/Chest Pain
    - c) Diabetes (Poorly Controlled)
    - d) Heart Failure
    - e) Hypertension
    - f) Pneumonia
    - g) Chronic Obstructive Pulmonary Disease
    - h) Dehydration
    - i) Urinary Tract Infection
    - j) Deep Vein Thrombosis (DVT)
    - k) Cellulitis
    - l) Syncope
    - m) ED Revisits within 7 days
    - n) High Utilizers (i.e. 3+ ED visits within 12 months; 2+ admissions within 6 months)
    - o) Potential re-admissions within 30 days (IP 7, IP 30, etc.)
3. Please place a consult for Care Management
4. **Care Management Coverage and Contact Information**
    - a) Telephone Number 718-245-2653 (cannot leave message)

b) Monday – Friday

(1) 7AM – 3PM: Donna Felix (347-242-1610) ext. 8548 and Carol Bailey (917-681-4209) ext. 3031

(2) 11AM – 7PM: Marie Nicolas (347-386-5882)

(3) 3PM – 11pM: Gary Taylor (646-996-4590) and Sabine Champagne (646-996-4890)

c) Saturday – Sunday

(1) 7AM – 3PM: varies

B. Social Work

1. Available 24/7
2. Office Telephone Number 718-245-4374
   1. Conetta Brantch- M-F 9am-5pm Sat 4pm-12am (646-281-1381)
   2. Helsie Barthelus- Sat 12am-4pm (646-260-7997)
   3. Velda Graves-Pearce Fri 4pm-12am, Sat 8am-4pm, Sun Flexible (917-205-3227)
   4. Winsome Mattis M-F 12am-8am
   5. Horace Ward -Tues and Wed 4pm-12 and Sun 8am -4pm
   6. Zipporah Yoel- M-F 8am -4Pm (646-418-1982)

C. Case Management – Day

1. Shawnette Cottingham (347-234-0857) ext. 7448
2. Lennora Dennis-York (646 315 1375)

Evening

1. Linda Wells (646-281-8691)

XI. QUALITY ASSURANCE/ UTILIZATION REVIEW

A. Observation unit utilization and quality of care will undergo continuous monitoring to ensure optimal performance.

B. Meetings will be held monthly with the following metrics reviewed periodically or when available.

1. Volume metrics
   - i Overall Census
   - ii Census by service
   - iii Number of cases by clinical protocol
   - iv Number of cases pending interventional procedure
2. Revenue Leakage Metrics
   - i Percentage left before treatment completed
   - ii Percentage left AMA
   - iii Number of patients exceeding 48 hours LOS
   - iv Number of patients with fewer than 8 hours LOS
3. Process Flow Metrics
   - i Percentage of patients converted to inpatient status
   - ii Number of patients without a disposition within 24 hours
   - iii Median LOS
4. Safety Metrics
   - i Number of falls
5. Utilization Management
   - i Percentage of cases reviewed by UM

C. Utilization Monitors

D. Quality Monitors

1. Concerns voiced by patients, staff, consultants or administration
2. Inpatient/ICU Admission Rate
3. Length of Stay
4. Protocol Compliance and failure characteristics
5. Complications – sentinel events, resuscitations, deaths

6. Charting
7. Appropriateness of admissions
8. Attending feedback form

XII. INFRASTRUCTURE –

A. Observation Unit is confluent with the Transition Unit (formerly Short Stay Unit). There is a single entrance to the TU/OU clinical area with OU beds on the right of the entrance. The OU beds are located in cubicles 11-20 and 23-24.

B. Two work stations exist in the observation unit which will be shared by providers, nursing and clerical staff. Station A is located near bed 18-19, while station B is located near bed 11-12.

C. Central telemetry monitory is installed by Station A.

D. Landline telephones exist at each station. The OU extension is x7993, x5733 and x1126

E. Portable telephones are available for patient use. They may be loaned to patients for use, collected and cleaned after use with appropriate cleaning material.

F. Translation services available with cyracom mobile phones.

G. Bathroom: Patient bathrooms are located in the TU near bed 3 and in the OU by bed 11. Shower capabilities are also available in the bathroom in near bed 11. Staff bathroom are located in the adjacent area of the TU.

H. Supply/Linen area will be shared between the OU and TU, but is located in CG115 (near bed 20).

I. Ice/water machine and food refrigerator will be shared between the OU and TU but is physically located in the TU.

J. The soiled utility area will be shared between the OU and TU but is physically located in the TU.

K. A pneumatic tube system is available in the OU or TU. The system is a bidirectional path between TU/OU and Blood Gas/Blood Bank area only. Lab samples can be sent from Blood Gas to pathology.

L. The OU has dedicated EKG machine, glucometers, and phlebotomy carts available for use. M. Fire Safety:

1. Fire alarm pull boxes are located at two locations in the observation unit:

a) Directly inside the main observation/transition unit entrance
b) Next to the restroom nearest to the doctor's workstation (station B) by room CG110.

2. A fire extinguisher is located next to Bed 17.

3. The medical gas alarm system is located in Unit A next to the telemetry monitor if needed.

XIII. LIST of OBSERVATION UNIT CLINICAL GUIDELINES

A. General
B. Allergic Reaction
C. Atrial Fibrillation (pending)
D. Asthma
E. Cellulitis
F. Chest Pain
G. Congestive Heart Failure (Pending)
H. Chronic Obstructive Pulmonary Disease (COPD)
I. Deep Venous Thrombus/Pulmonary Embolus (stable)
J. Dehydration/Vomiting
K. Hyperglycemia
L. Hypoglycemia
M. Pneumonia

N. Pending Procedure

O. Transfusion

P. Syncope

XIV. APPENDICES

A. Standard Work Provider

B. Standard Work Nursing

C. Standard Work Nursing