American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

POLICY STATEMENT

Approved June 2021

Emergency Department Observation Services

Revised June 2021

Reaffirmed October 2015

Revised January 2008, with current title October 1998, January 1993

Originally approved titled "Emergency Department Observation Units" September 1987

As an adjunct to this policy statement, ACEP has prepared a policy resource and education paper (PREP) titled "State of the Art: Observation Units in the Emergency Department"

Emergency department (ED) patients frequently require services beyond their initial ED care to determine the need for inpatient admission. These distinct and reimbursable services may include but are not limited to: further diagnostic evaluation, continued therapy or management of acute psycho-social issues.

To promote quality of care and patient safety for ED observation patients, the American College of Emergency Physicians (ACEP) supports the following principles:

- Observation of appropriate ED patients in a dedicated ED observation area, instead of a general inpatient bed or an acute care ED bed, is a "best practice" that requires a commitment of staff and hospital resources.
- Successful observation units include the availability of services that contribute to patient care and disposition. This includes:
  - Case management and social work
  - Physical therapy/Occupational therapy
  - Availability of consultants with a discrete expectation of turnaround time for evaluation
  - Consultations should be completed, as appropriate, via in-person or telehealth.
  - 24-hour access to radiology and interpretation of radiologic findings
  - Interdisciplinary collaboration with hospital services for protocols and clinical pathway development to participate in value-based purchasing programs, eg, CMS Hospital Readmissions Reduction Program
  - Availability of evidence-based clinical algorithms reflecting established and newly emerging clinical indications. Newer protocols may include those reflecting behavioral health observation, and placement needs (such as skilled nursing facility (SNF), acute rehab, hospice, and addiction services placement.)
- An emergency physician and emergency nurse should direct ED observation areas with clearly defined administrative responsibilities for the unit. A dedicated observation unit physician assistant or nurse practitioner should be directly supervised by an emergency physician.
- Direct patient care services or supervision may occur in-person or through telehealth.

- Written policies and procedures for the ED observation area should be approved by appropriate ED and hospital medical staff representatives.
- ED observation area policies and procedures should address the following:
  - Patient criteria for admission into the unit, discharge from the unit, and admission to an inpatient bed;
  - Criteria for placement of patients in the ED observation unit should not be based solely on InterQual or other third-party inpatient criteria;
  - A clear statement of which physician bears clinical responsibility for each patient in the area;
  - A clear delineation of emergency physician, nurse practitioner, physician assistant, and nursing staff roles and responsibilities throughout the day – including how care will be transferred between providers;
  - Circumstances that require notification of the physician who is responsible for the patient;
  - Maximum allowable length of stay in the unit and means to address outliers; and
  - A description of how utilization and relevant quality measures will be monitored and reported.
- ED observation areas should have adequate space, staffing, equipment, and supplies appropriate for the conditions being managed.
- Mechanisms should be in place to expedite the discharge, admission to an inpatient bed, or transfer to an offsite facility (such as skilled nursing, rehabilitation, or hospice facility) as appropriate.