Department of Nursing
POLICY AND PROCEDURE

POLICY NUMBER: 233
VERSION: 1

SUBJECT: OBSERVATION ROOM

PURPOSE: To establish a guideline for utilization of the observation room for the evaluation, monitoring, and/or treatment of patients with acute conditions.

POLICY: Critical or unstable patients will be placed in the observation room for close monitoring, stabilization and treatment.

Patients requiring extended observation and/or treatment (e.g. nebulizers, IV hydration, cooling measures), may also be placed in this monitoring environment.

The observation room may be used to provide comfort for certain types of patients. (The criteria for Observation Room care does not apply to these patients. This is strictly for the comfort of the patient and/or convenience of the staff.)

DEFINITIONS:

Unstable patient: A patient whose condition is such that he/she may be in a life threatening situation.

Hand off communication: The communication between staff members regarding the patient's condition at the time that care is being transferred from one person to the next.

PROCEDURE:

1. As a minimum, the urgent care observation room will have the following equipment:
    a) Cardiac monitors
    b) Universal crash cart [pediatrics and adults combined] with defibrillator
    c) Airway management equipment;
        - suction devices and set ups
        - oxygen administration equipment
        - ambu bags, age specific
    d) Birth out of asepsis (BOA) pack
    e) Mobile emergency response box (MERB)

2. The pediatric observation rooms have a pediatric crash cart and a defibrillator.
3. A licensed nurse will provide care to the observation room patient.
4. When there is a critical or unstable patient in the observation room, a registered nurse will be assigned to that individual. If the patient is unstable and a second RN is needed, triage may close until the patient is stabilized or transferred.
5. For critical or unstable patients, the assigned nurse will remain with the patient and perform and document the following:
    a) Assess/reassess the patient's condition
    b) Monitor EKG pattern if placed on the monitor
    c) Maintain patient comfort and reassure by keeping him/her informed of procedures and treatment
    d) Document patient's response to treatment, assessment and ongoing monitoring findings, in the medical record
6. Vital signs will be done every 15 minutes unless counter ordered by the provider.
7. Nursing will administer all ordered treatments
8. Nursing staff will notify the provider of any changes in patient's condition
9. Nursing staff will facilitate communication with the patient's family members, regarding patient condition and plan of treatment.
10. Nursing staff will disposition the patient as ordered by the provider. Hand off communication must occur for the purposes of patient safety and continuity of care

REFERENCE:

Hand-Off Communication, HDHS Ambulatory Care Manual, 702.4 10/7/08
Triage Nurse Assessment, Urgent Care, 1503, 11/30/07

Approved By: Susan Knapp (CHIEF NURSING OFFICER I)	
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