



KEY POINT SUMMARY

OBJECTIVES

The objectives were to create an operational observation unit for adults and to do an evaluation of its value and impact on the facility and its patients.

Creation of an Adult Observation Unit: Improving Outcomes.

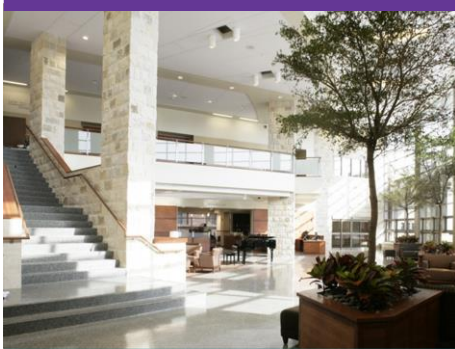
Plamann, J. M., Zedreck-Gonzalez, J., Fennimore, L., 2018 | *Journal of Nursing Care Quality*. Volume 33, Issue 1, Pages 72-78

Key Concepts/Context

Many patients who visit emergency departments do not need to be admitted but also are not ready for discharge. To improve throughput and reduce wait time, an alternative would be placing them under observation in a special observation unit. This article explains how an observation unit was created at a 489-bed hospital in St. Cloud, Minnesota. Preliminary results for length of stay (LOS) and HCAHPS scores are shared.

Methods

Initially, using several search engines, a literature review was conducted on the impact of observation units. This effort revealed that 36% of hospitals in the United States have observation units, with strict requirements for the entry and discharge of patients. A total of 46 articles were reviewed targeting the shortening of the patient's length of stay achieved specifically because of the observation unit. Additionally, the review revealed that no two units were the same rather, they were diagnosis-specific and mixed. The benefits of the observation unit ranged from decreased length of stay, increased patient satisfaction, and decreased costs, to reduction of noncompliance with governing rules and regulations. Data from a Minnesota hospital was collected at a later stage showing the patients' demographics. It included the observation unit patient volume from 2014 to 2017 and how initially it grew at a higher rate before leveling off. Information on the reduction of the patient's length of stay was also part of the data collected. This evidence-based data provided the justification for the creation of the new observation unit. Finally, a post-occupancy evaluation using top-box methodology was conducted with data collected prior to and after the opening of the observation unit.



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Findings

The creation of an observation unit resulted in better care and improved satisfaction (based on HCAHPS scores) on the part of patients and their families. An evidence-based process and an interdisciplinary team resulted in a better design of the care facility. It nearly achieved its one-year goal in the first four months by reducing the patient's length of stay from 40 hours to 26.8 hours (the one-year goal was 26). Improved throughput was achieved, with patients going to the observation unit released 10 minutes earlier than those being admitted to an inpatient unit. In addition, the direct cost of the observation unit patient was decreased compared to other patients not in the unit.

Limitations

Initially, many physicians from the emergency department (ED) did not show interest in joining the new observation unit due to a high turnover in their department. Later, because of a higher number of patients in the observation unit, this problem was overcome with better publicity of the unit's success.

Design Implications

While there is no consensus on whether an observation unit should be adjacent to an ED or not, this organization found success in a 14-bed unit located away from the ED. The location was based on available shell space along one hallway. Two types of rooms were used: single rooms with private bath for isolation precautions, and single rooms with shared hallway bath/shower. It also included decentralized nursing, a family lounge, clean and soiled utility rooms, and a reception desk. This design solution took into account that a separate unit within the hospital was superior to keeping the patients in the emergency department.

The "Iowa model" of evidence-based practice was used to develop the observation unit with the following steps:

1. Identify a practice question: Improving care through a care delivery change through an observation unit.
2. Obtain support for the project: Care concept was submitted to the board and a 14-bed unit proposal was submitted to the finance committee and board of directors for approval. An IRB was not required for the study.
3. Form a team: An interdisciplinary team was used – physicians, nurses, administrators, support functions, other ad hoc members, and the architect.
4. Review the evidence: Literature review and a conference on best observation unit development and operation.



5. Implement: Established unit design, EMR design, patient care standards, and staffing levels.
6. Evaluate: Outcome measure defined by multiple stakeholders (service line, accounting, performance improvement, IT); outcomes established as a separate area in the enterprise data warehouse and tracked monthly.

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