PIONEER MEDICAL CENTER
P.O. Box 1228, Big Timber, MT
406-932-4603 Fax: 406-932-5468

POLICY and PROCEDURE		
Title	Observation	
Manuals	CAH-PCECT	
Approved By	Date: 03/05/2015 By: Erik Wood Title CEO	

Policy Statement

Pioneer Medical Center is committed to providing high quality affordable medical care. Observation is one part of that care.

Purpose

Observation may be used in certain situations where the medical provider evaluates a patient and determines that they are not able to safely return home and require a short period of monitoring by medical and nursing staff. Observation should not be used for any patient that is unstable or will need monitoring for more than 48 hours.

Definition

Observation care involves ongoing short-term treatment, assessment, and reassessment before a decision can be made to admit the patient for further inpatient hospital treatment or discharge the patent from the hospital. When a provider places a patient in observation care, a provider order is required and the patient status is outpatient. Observation time begins at the clock time documented in the patient's medical record, which coincides with the time the patient is place in an observation bed. All patient care documentation will be recorded in the Clinical Information System (CIS).

Procedure

In order to ensure that patient's being admitted for observation receive high quality care the following protocols will be followed:

Admission

1. All patients admitted for observation will first need to be evaluated by a medical provider. The medical evaluation may take place in the clinic or emergency room.
2. Observation admit orders will be obtained from the medical provider prior to the patient being transferred from the clinic or emergency room. Admission orders shall include all pertinent medical information such as allergies, diagnosis and medications.
3. The ER encounter will be updated to Observation status in R Access Management by the unit secretary or nurse. .
4. An admission note and discharge note shall be dictated or documented on the patient's medical record by the medical provider.
5. Nursing assessment and documentation will include:
   a. Observation patient history
   b. Admission vitals and assessment
   c. Hourly charting.
   d. Authorization for Treatment
   e. Advance Directives- POLST
6. Observation should be used only for relatively stable patients.

Discharge

7. Upon discharge of an observation patient the following documentation will include:
   a. Completed Depart in Powerchart
   b. Discharge orders noted and explained to patient and/or family on Patient Depart Summary handout.
   c. Discharge Summary notes appropriate for diagnosis
   d. Discharge information for any patient pack medication given to patient
   e. If patient status needs to be changed to acute care the following will need to be done:
      1. In R Access management (registration), the observation encounter will be discharged. A new encounter will be created for the inpatient stay.

	2. Make out client change sheet. 3. Send new diet change sheet to dietary department notifying of patients change in status 4. Complete CAH patient care plan 5. Complete the Patient History for the Inpatient encounter 6. Start a new charge sheet indicating the level of care change.

Regulatory Reference Sources	
OBRA Regulatory Reference Numbers	
Survey Tag Numbers (optional)	