Observation Units as part of the Emergency Department

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Introduction

Emergency Department Observation Units were first recognised in the UK in 1960 by the Nuffield review of casualty services. They have existed alongside Emergency Departments since then and are identified by various names, including clinical decision units, observation wards and assessment units/wards.

The main objective of these units is to manage a cohort of patients that originally present to the ED with specific identifiable characteristics. These patients have either

- Limited medical needs (e.g. alcohol intoxication or minor head injury)
- A need for short term observation (e.g. overdose with no specific medical intervention required, or
- A short-term treatment need (e.g. comparatively simple medical intervention such as rate control in atrial fibrillation).

Evidence from historical systematic reviews of observations units suggest that they have a benefit in terms of concentrating medical expertise and resources in a single defined area and enable early senior review of the patient. In addition, they improve patient satisfaction, are safe and decrease overall length of stay in appropriate patient groups. They may also deliver overall cost savings related to reduction in length of stay.

Observation units can consist of beds, chairs or combination of both.

Standards

1. Observation units run by Emergency Physicians are short stay facilities. A 48-hour cut off for length of stay is a reasonable standard, however most patients will stay in the observation unit for a shorter length of time (24 hours maximum).
2. Patient cohorts selected for Observation Units are locally agreed. However, they should be patients with limited medical needs, with a need for short term observation, or with a short-term treatment need, only.
3. Observation units must not be used as a performance management tool to manage nationally imposed performance standards. They are for suitable patient cohorts only and must not accommodate the ‘next patient in the bed queue’ or be used to avoid a breach in an undifferentiated patient.

Recommendations

1. It is recommended that there is clarity about which clinician sees which patient in each clinical setting. In recent years there has been an emergence (particularly in England) of a push to manage lower acuity patients through Same Day Emergency Care (SDEC) facilities. There are a lot of similarities between SDEC units and observation units, to the point where they may have become the same entity in some hospitals.

2. Historically observation units have evolved physically from space adjacent to the ED. They have often not been purpose-built but have been established in a response to an identified need. This limits the standardisation of design features in such units. When designing a new or refurbished unit it is recommended that consideration is given to reducing the chance of the unit being converted into a ward which then evolves into a long stay ward in a crowded hospital system: e.g. not using a conventional ward layout with large bed spaces/curtains etc. This is a difficult balance as it needs to be recognised that patient experience and privacy and dignity issues should be taken into consideration.

3. If the observation unit is set up to take patients with a medical presentation it is recommended that support from the general medical team is agreed from the outset. One risk of an observation unit is that it is seen by specialty teams as a 'soft' admission route, avoiding their input and thus reducing workload. This should be resisted.

4. If it becomes apparent after the patient has been admitted to the observation unit that a patient needs a non-EM specialist then that specialist team should look after the patient in the observation unit until an appropriate space becomes available.

5. For an observation unit to be effective, establishing a flow out of the unit is critical. Even if unit entry criteria are robust, there will be patients in whom longer inpatient stays are required. These patients should be prioritised for admission once it is identified that longer stay admission to hospital is required.

Background

Observation units have been in existence for as long as Emergency Department care has been delivered. The original driver was the need to observe and/or treat certain cohorts of patients for longer than the typical length of stay of a patient in the ED. It was also the case that continuity of care (by remaining under the care of an emergency physician, rather than onward referral to an inpatient team) would be of benefit to the patient. The number of beds required to deliver this function effectively varied from unit to unit depending on local needs and service delivery, however the British Association of Accident and Emergency Medicine recommended that this should be one short stay bed for every 5000 attendances.

Over time the function of observation units has evolved to reflect local need depending on case-mix. There has also been a degree of variability of delivery that probably reflects local preference and/or the expertise of the clinician team overseeing the service. The advent of the four-hour Emergency Care Standard in the early 2000s probably led to a perceived opportunity to use observation units as ways of housing patients waiting inpatient beds in a 'ward' setting and therefore ensuring that they were not counted as breaches of the standard (at times of bed pressures, exit block etc).

In the last few years, the role of the observation unit has changed again in some locations as there is a national push to encourage the management of patients through non-admitted care pathways. This is referred to as Same Day Emergency Care and there is a degree of crossover between the functionality of SDEC units and observation units – they are 'off the clock' areas that focus on the lower acuity patients with a specific diagnostic or observational need, with an expectation of a less than 24-hour turnaround time.

It is likely that the local architecture of SDEC and observation units will continue to vary between hospitals. This will be driven by the local expertise and interests within the services (and the relative input of emergency physicians and acute physicians etc) as well as case-mix and physical estate restraints. Despite this there will always be a need for observation of a proportion of our patients beyond a standard four-hour ED stay, and the value of emergency physician input into managing certain groups of these patients, such as on a local ED observation unit, is significant.

References

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