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Development of Nursing Education for an Observation Unit

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
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2018

Abstract

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MS, Walden University, 2009

BS, Salem State University, 1987

Project Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

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Abstract

As healthcare continues to face scrutiny related to the cost and quality of patient care,

organizations are challenged with providing the right care to patients in the right setting.

Some healthcare organizations are implementing observation units to provide appropriate

care to a specific subset of patients. The purpose of this project was to develop education

for nursing staff who will work on the dedicated observation unit and are unfamiliar with

the care requirements. Benner's novice-to-expert theory was used as the framework for

the project. This theorist posits that nurses transitioning to a new area require new

knowledge and skills to help guide their practice. The education program was based on

available evidence, including peer-reviewed journals, consensus white papers, evidence-

based studies, and expert opinion. The evidence was organized and analyzed using the

Johns Hopkins nursing evidence-based practice model. An educational product for staff

members new to an observation unit was developed and shared with stakeholders,

including professional development staff, hospital administration, nurse managers, and

nursing staff for questions and feedback; feedback was incorporated into the final

product. The recommendation is for the education to be incorporated into the orientation

for nurses who will work on an observation unit. The project holds significance for the

field of nursing practice as it may support the educational needs of nursing staff working

on an observation unit in the local setting as well as other acute care setting and benefits

hospitals and patients by leading to improved patient care and nurse retention. The

project can foster positive social change by improving practice at the local level and on a

broader level if other organizations use the education.

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Dedication

This project is dedicated to my family, including my husband, daughter, son and my dad. I would not have been able to succeed in completing this project without the unwavering support from them. My husband pulled me up when things seemed insurmountable and my children gave me the strength to see what I could accomplish. I also want to thank my father for being my biggest cheerleader. My only regret is that he is not here to share in my joy.

Acknowledgments

I would like to acknowledge Dr. Anne Vitale for her ongoing support, encouragement, and patience throughout this project. The guidance of the chair is immeasurable, and I can look back now and see the impact Dr. Vitale has had on my growth as a DNP scholar. I also need to acknowledge my coworkers and my director for keeping me focused, while offering to help in any way they could. They all had a hand in helping me to complete this project, even if it was just listening to me as I let off some steam.

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Section 1: Nature of the Project

Introduction

As healthcare economics evolve, organizations continue to work on ways to deliver the right care for patients in an efficient and effective manner (Baugh et al., 2012; Gabele, Bugais, & Laguna, 2016; Plamann, Zedreck-Gonzalez, & Fennimore, 2017). While some patients presenting to the emergency department (ED) can be admitted to an inpatient unit and others can be safely discharged home, there is a group that would benefit from a short period of observation. Placing this population of patients who require more observation on a dedicated unit is an alternative way to provide high-quality care that is efficient and less costly than being dispersed among inpatients (Baugh, Liang, Probst, & Sun, 2015; Murphy, Willetts, Duphiney, Dalton, & David 2016; Pena et al. 2013).

Centers for Medicare and Medicaid Services (U.S. Department of Health and Human Services, 2015.) defined *observation care* as detailed care that includes ongoing assessment, treatment, and reassessment. This care is conducted prior to the medical team's decision on the next level of care, inpatient or safe discharge home (CMS, n.d.). Although CMS has offered a definition for observation care, it has not identified where the care should be provided. Research has identified three locations where observation patients are cared for: in the ED, on an inpatient unit, or in a dedicated observation unit (Baugh et al., 2015; Napolitano & Saini, 2014; Pena et al. 2013).

This DNP project involved the development of education for nursing staff who will be caring for patients on a new, dedicated observation unit in an acute care hospital.

This group of nursing staff will require specific training in order to develop strong assessment skills, knowledge of protocols developed for specific diagnoses, understanding of how to communicate proactively with providers, and a focus on discharge planning that starts upon admission to the observation unit (Baugh et al., 2012; Murphy et al., 2016).

This DNP project has the potential to foster positive social change in addition to having a local impact. The nursing staff education that will be developed for this project can improve practice and lead to improved patient outcomes on the dedicated observation unit (Gabele et al., 2016; Plamann et al., 2017). The broader social change may be achieved if other organizations that need to educate nursing staff working on an observation unit use the education developed for this project.

Problem Statement

As the use of observation status has increased, more hospitals have implemented dedicated observation units. The project setting does not currently have a dedicated observation unit, and according to a July 2017, interview with its director of case management, it has an observation rate of almost 24%. As the organization begins project planning for construction in the acute care building, there is a strong likelihood that it will develop a dedicated observation unit, which will require the nursing staff to be educated. A new observation unit involves a change in the model of care delivered by nursing staff. The current practice is to place patients in observation care on inpatient units, which literature has shown is an ineffective way to manage the care of these unique patients (Aston, 2012). The goal of placing a patient in observation status is to continue to

monitor the patient for up to 24 hours if discharge from the ED is not yet warranted (Gabele et al., 2016). When observation patients are comingled with inpatients, the nursing staff do not differentiate the model of care, which results in longer lengths of stay for the patients in observation status (Baugh et al., 2012). As the hospital evaluates the potential to develop a new dedicated observation unit, the focus of this capstone was to develop nursing staff education based on existing evidence that is focused on caring for patients on an observation unit.

When patients are cared for in an observation unit, nurses are able to provide specific care that can lead to decreased length of stay, decreased readmissions, decreased costs, increased ED throughput, and improved patient satisfaction (Baugh et al., 2012; Bradas, et al., 2016; Cooke, Higgins, & Kidd, 2003; Gabele et al., 2016). Another advantage of placing observation patients on a dedicated unit is the decreased opportunity for patients to develop complications that are usually associated with inpatient admission (Baugh et al., 2012; Murphy et al., 2016; Pena et al., 2013).

The project holds significance for the field of nursing practice as it may support the educational needs of nursing staff working on an observation unit in the local setting and in other acute care settings that make the same change. Caring for patients on a dedicated unit based on a specific education program can improve practice and lead to improved patient outcomes (Gabele et al., 2016; Plamann et al., 2017).

Purpose

Administrators at the local site are considering the addition of a new observation unit and this will result in a gap in nursing practice because the nursing staff are not

familiar with how to care for this population of patients. The purpose of this project was to develop nursing education, based on available evidence for nursing staff who will work on the new unit and are currently not familiar with the care requirements. The practice-focused question was the following:

PFQ: What existing evidence can be used to develop nursing staff education for observation units in an acute care setting?

The local site does not have a dedicated observation unit with staff who have received education specific to the patient population. The literature on observation units identifies the need for dedicated, trained staff to care for patients on an observation unit (Napolitano & Saini, 2014). When nursing staff are competent in relation to the workflow, high turnover, and frequently seen diagnoses on an observation unit, patients receive better care with improved outcomes (Napolitano & Saini, 2014; Plamann et al., 2017). This project used evidence to address the identified gap in nursing knowledge for nursing staff working on a dedicated observation unit in an acute care hospital.

Nature of the Doctoral Project

The sources of evidence that were reviewed for this project were identified using Internet databases. The databases used for the review and synthesis of best practice for staff development included Cumulative Index to Nursing and Allied Health Literature, ProQuest Nursing & Allied Health Source, PubMed, and Medline. When reviewing journals, I focused on journals pertaining to nursing leadership, quality, research, and education, such as *Journal of Nursing Administration, Journal for Nurses in Staff Development, Nursing Quality Care,* and *Journal of Nursing Education.* In addition, I

reviewed information from nursing organizations and associated websites, including any resources available on training for nursing staff working in an observation unit. The organizations targeted in this review included the American Nurses Association and the Association for Nursing Professional Development.

For this doctoral project, the approach that I used to address the practice problem was a review of the literature for evidence to support the development of nursing education. The first step was to review primary and secondary sources related to the practice question. This was followed by synthesis of the information using a literature decision making matrix. The Johns Hopkins nursing evidence-based practice model (JHNEBP) was used to guide the literature review process. I anticipated that the literature analysis would indicate that there is enough evidence to address the gap in nursing practice by contributing to the development of education for staff caring for patients on a dedicated observation unit.

Significance

Numerous stakeholders will be impacted by this project. The primary stakeholders will be the nursing staff, leadership, and patients of the observation unit. The implementation of a dedicated observation unit will change the way that care is provided for this subset of patients because the nursing staff will be educated on this model of care. The project's impact on the chief nursing officer (CNO) and director involves their ability to support the nursing staff working on this new unit with the appropriate education to ensure that the care provided is evidence-based, is current, and has the potential to achieve positive clinical outcomes. The impact on the patients will be in the

delivery of appropriate care by staff who have had education specific to the patients' care needs. When appropriate care is provided, there is the potential for improved patient outcomes. Secondary stakeholders who were impacted included the medical director, staff, and patients of the ED. Research has shown that opening a dedicated observation unit leads to improved throughput and less overcrowding in the ED (Bradas et al., 2016; Gabele et al., 2016). This project has the potential to impact these stakeholders by ensuring that all patients are provided the most appropriate care in the best setting.

This doctoral project has the potential to contribute to nursing practice by providing the education and support needed for the nursing staff who will be caring for patients on a new dedicated observation unit. According to the standard of performance of American Nurses Association (ANA, 2010), nurses need to attain the competence required for current practice. Specific orientation and nursing staff education will lay the groundwork in the competencies needed for a change in care delivery and will contribute to nursing practice because it will improve practice and lead to better patient outcomes (Gabele et al., 2016; Plamann et al., 2017).

Another potential contribution to nursing practice may be seen in decreased turnover rates at the organization. Research has shown that when nurses have unit specific orientation, they have lower stress levels as well as heightened comfort levels. An orientation program can provide nursing staff with the knowledge they need to be successful, which may impact overall retention rates by having a positive impact on nurses' self-esteem. (Ward, 2009).

This project has the potential for transferability at the local site across the different disciplines represented by staff working on the unit. The patients on the unit will be cared for by a multidisciplinary team that includes providers, nursing assistants, physical therapists, and pharmacists. Although the education will be developed for nursing, the information can be used by other disciplines to ensure that teams are providing appropriate care for this set of patients. In addition, the project has potential for transferability for use in other organizations that are planning on implementing a dedicated observation unit. The education program can also be shared and used to educate nursing staff in other organizations with observation units.

This project has the potential to foster positive change in nursing practice by providing the education that nurses need to care for a population of patients. The ANA *Standards of Professional Nursing Practice* (ANA, 2010) address the nurses' responsibility for attaining necessary knowledge for their practice. The education developed for this project will support nurses in acquiring knowledge and skills that are appropriate for the specific population of observation patients. This will have further implications for the population of patients in observation status because nurses will have the knowledge base needed to care for this population.

Summary

As hospitals are challenged to improve efficiency, lower costs, improve outcomes, and positively impact patient satisfaction, their leaders are looking for new ways to deliver care. The literature has shown that having a dedicated observation unit is one way for organizations to provide care for this subset of patients that results in

positive quality of care and financial outcomes. When a new unit with a new way to deliver care is implemented, staff may lack familiarity with the care needs of patients; in this situation, orientation and education of nursing staff are needed. The gap in local nursing practice involved staff not being familiar with patient care requirements on an observation unit in an acute care setting. The scope of this DNP project was the development of evidence-based education for nursing staff on an observation unit in order to address a gap in nursing practice and improve patient outcomes.

In Section 2 I further explore the project by describing the background and context of the practice problem. Topics in Section 2 include relevant concepts, models, theories, the project's relevance to nursing practice, and my role as the DNP student.

Section 2: Background and Context

Introduction

Medical care and treatment are best provided in an appropriate setting with staff who are educated on the needs of the population. When an organization implements a new observation unit, there is a need to educate the nursing staff who will be caring for the patients in observation status. The practice problem that was identified is the lack of staff familiarity with how to care for patients on a dedicated observation unit in an acute care hospital. The purpose of this project was to use literature-based evidence to improve the nurses' knowledge for this model of care.

Section 2 begins with an exploration of Benner's (2001) novice to expert theory which was the framework for the doctoral project. I clarify terms that may have more than one meaning to enable a common understanding. I supply more background with relevance to nursing practice as well as local background and context. In the final topic of this section I describe my relationship as a DNP student to the project, including my role, motivation, and potential biases.

Concepts, Models, and Theories

The theoretical framework that I used for this project is Benner's novice to expert theory (2001). Benner developed a decision-making theory based on the Dreyfus model of skill acquisition in which experiential learning happens in the presence of an engaged learner (Benner, 2004). For nursing, Benner identified that when nurses acquire skills through experience, there is an increased understanding of the clinical situation. This

leads the nurse to recognize the clinical situation from a more intuitive way instead of an abstract way (Benner, 2004).

Benner (2001) describes nursing skill acquisition by defining five different stages: novice, advanced beginner, competent, proficient, and expert. A nurse advances from one stage to the next as they more readily pull from past experiences when in a new situation (Stinson, 2017). In the earlier stages, the nurse's behavior is rule-based because they have no experience to guide their practice (Benner, 2001). This is followed by the nurse who can see the whole picture and finally by the expert nurse who no longer needs to rely on the rules when making decisions about patient care (Benner, 2001; Stinson, 2017).

When nurses transition to a new area of practice, new knowledge and skills are required. Benner (2001) noted that recent graduates are not the only ones categorized in the novice stage. Nurses transitioning to a new clinical setting have no prior experience to pull from, resulting in the need for new knowledge and rules to guide practice for the new care setting (Benner, 2001; Dellasega, Gabbay, Durdock, & Martinez-King, 2009). According to Benner's research, staff development programs should promote the development of clinical knowledge. This clinical knowledge then supports the nurse's continued learning gained from each clinical experience (Benner, 2001).

Clarification of Terms

Observation status: An outpatient billing status with detailed care that includes ongoing assessment, treatment, and reassessment, and that is conducted prior to the medical team's decision on the next level of care (U.S. Department of Health and Human Services, 2015).

Dedicated observation unit: A distinct area of care where patients in observation status are managed using evidence-based protocols (Baugh et al., 2015).

Relevance to Nursing Practice

The education of nurses can be traced back to Florence Nightingale who has been hailed as the founder of modern-day nursing (Dickerson, 2017; Faison, 2012). After the publication in 1860 of her *Notes on Nursing* (Nightingale, 1946), she opened the Nightingale Training School for Nurses in England. This training school filled the gap for the need for trained nurses to care for the sick (Dickerson, 2017; Faison, 2012). In the early part of the century in America, nurses cared for patients in their homes, but this changed after the Great Depression. Improved techniques and advances in technology moved the patients into the hospital, which required a new focus on staff development (Dickerson, 2017). When large numbers of nurses joined the armed forces during World War II and there was an influx of new nurses, it created another gap in staff development needs (Dickerson, 2017).

On a broad level, ongoing nursing education needs to support the profession in adapting to changing healthcare environments (Melnyk, Gallagher-Ford, Long, & Fineout-Overholt, 2014). In their landmark report, *The Future of Nursing: Leading Change, Advancing Health,* the Institute of Medicine (IOM, 2010) recognized the changing needs of a diverse population and the connection with healthcare reform. Nursing must be prepared to meet these needs by participating in the redesign of a patient-centered healthcare system with an aim to improve care and reduce costs. IOM (2010) recommended that nursing be involved in improvements in practice and

transforming how nurses deliver care in all settings so that the unique needs of each

patient are met.

Currently in the 21st century, healthcare is encountering a shortage of nurses that

is predicted to be more substantial than at any other time in history (Travale, 2007). In

addition, there are economic, social, and environmental challenges in the environment.

These issues are impacting the way nurses are educated, with a focus on cultivating

clinical reasoning instead of teaching facts (Tiwari, Lai, So, & Yuen, 2006). This is

further supported in the IOM report, *Crossing the Quality Chasm* (2001). The report

identified the need to prepare the healthcare workforce for the many changes ahead in the

delivery of healthcare. New teaching strategies that educators are employing in the acute

care setting include problem-based learning, experiential learning, the use of case studies,

and technology-based learning (Chunta & Katrancha, 2010; National Council of State

Boards of Nursing, 2007).

The *Core Curriculum for Nursing Professional Development* (Dickerson, 2017)

described the role of the nursing professional development staff in identifying gaps in

practice and conducting needs assessments. These help to inform and identify the

educational and developmental needs of nursing in today's healthcare environment. Other

data sources that inform a needs assessment may come from research, healthcare trends,

regulatory agencies, professional literature, and standards of practice.

Organizations that have opened a new unit reported that it can be challenging, and

the success can depend on having a vision and a plan based on available evidence

(Plamann et al., 2017; Torres, 2006). While the care required on an observation unit is

specialized, the literature has identified that no two observation units are alike (Plamann, et al., 2017). As a result, the education programs and the strategies used have varied based on the needs of the unit and staff. What was identified in the literature as foundational to opening new units was the assessment of skills needed for the patient population (Napolitano & Saini, 2014; Plamann et al., 2017; Torres, 2006). One of the skills included in the orientation program was a focused and frequent assessment that is specific to the few diagnoses managed on the unit. These may include chest pain, shortness of breath, heart failure, and syncope (Conley, Bohan, & Baugh, 2017; Napolitano & Saini, 2014). The orientation programs also focused on the care model for the observation units, which was built upon frequent assessments followed by a prompt intervention and evaluation. This was accomplished with an emphasis on collaborative teamwork with the providers covering the unit (Plamann et al., 2017). The different teaching strategies employed in this situation included lectures, demonstrations, and case studies with a focus on the standards of care for the specific patient population (Plamann, et al., 2017).

This doctoral project fills a gap identified in the local site as exploration begins for new inpatient units. A new observation unit will need staff that are familiar with the patient care requirements for this population. By filling the gap, nurses are provided education focused on a specific cohort of observation patients, which has been recognized as a best practice that facilitates safe and efficient nursing care (Conley et al., 2017).

Local Background and Context

Across the nation there has been an increase in the use of the observation billing status as hospitals are trying to control costs and avoid what CMS has identified as unnecessary short stay admissions (Baugh et al., 2012). As stated in the previous section, the practicum site has an observation rate of 24%, which has increased over the past 3 years. Administrators at the site are considering implementing a new unit as part of a redesign project for the inpatient area. Once opened, this unit will be where patients requiring observation care would be managed.

The practicum site is a 100-bed community hospital serving the region on the seacoast in the northeast. The hospital provides medical and surgical health care services, including emergency care. According to a September 2017 conversation with the chief financial officer, the percentage of patients covered by Medicare ranges from 42%–46%. It is this population of patients who may require a period of observation before the ED provider is able to determine the appropriate next level of care. The practicum site does not currently have an observation unit and because of this there is no standard education for nursing staff in how to care for this population of patients.

The strategic mission of the practicum site is based on the *triple aim* proposed by the Institute for Healthcare Improvement in 2008 (Whittington, Nolan, Lewis, & Torres, 2015). The triple aim comprises three interdependent goals: improving the patient experience, improving the health of the population (community), and reducing the overall cost of care (Whittington et al., 2015). Redesigning care so that it is patient focused, produces quality outcomes, and is provided at lower costs aligns with the triple aim

strategy (Berwick, Nola, & Whittington, 2008). This could be accomplished with a dedicated observation unit where care is provided by educated and competent nursing staff (Plamann et al., 2017).

The practicum site is surveyed annually on the CMS (n.d.) Conditions of Participation standards, which is required to participate in the Medicare and Medicaid programs. CMS (n.d.) has identified a minimum standard of care that participating hospitals must meet to improve the quality and safety of their recipients. One of the standards states the CNO must review the processes around nurse staffing and assignments (CMS, n.d.). Part of the review required by the CNO includes looking at competence of the nursing personnel caring for specific patient populations.

There have been changes to the CMS regulations around inpatient admission criteria. As a result, the number of patients admitted under observation status has increased substantially in the last decade because of Medicare's strict inpatient criteria (Napolitano & Saini, 2014). This could have an impact on a hospital's finances and patient satisfaction (Plamann et al., 2017). As a result of this shift in the regulatory environment, some organizations are implementing observation units as a way to provide cost effective, quality care.

Similar to CMS regulations, the Joint Commission (Joint Commission Standards, 2017) standards for compliance focus on patient safety and quality. Joint Commission standards address how the hospital has determined the competencies needed for all staff, including nursing. Competency can be defined in many ways and usually includes the knowledge and skills that are needed to perform the job (Whelan, 2006). The competency

of the nursing staff can be supported by education programs like the one created for this doctoral project.

The practicum site has achieved Magnet status, which recognizes hospitals for quality patient care, nursing excellence, and innovations in professional nursing practice. One of the components of a Magnet organization is the category of new knowledge, innovations, and improvements (American Nurse Credentialing Center, 2013). The practicum site has processes set up that support nurses in using and implementing evidence-based practice, which is a requirement of Magnet. The creation of evidence-based education for this project aligns with the established processes in the organization, along with the Magnet category of new knowledge, innovations, and improvements.

On a state level, a nurse must meet defined requirements to maintain and renew a nursing license. In the state of New Hampshire, the Revised Nurse Practice Act (2015) outlines the requirements for licensure. The licensure requirements state that nursing practice is guided by certain standards that ensure safe and effective care. The scope of practice also states that a registered nurse shall acquire and apply new knowledge to their practice attained with education and training.

Role of the Doctor of Nursing Practice Student

I am currently the vice president of acute care and cancer services at the practicum site. I have responsibility for the inpatient units, ED, Respiratory Department, Pharmacy, Case Management, Cancer Center, and Sleep Center. While the practicum site is also where I am employed, the DNP project is not a requirement of my position. The staff in the professional development department at the practicum site report to the chief

nursing officer for nursing development and the vice president of human resources for organizational education.

My role in the project was to review the evidence and develop nursing education for the orientation of staff to a new dedicated observation unit. I partnered with the professional development staff for input on the education program and ensured it aligned with the ongoing staff development work in the organization. The final step was to present the staff development program to the chief executive officer, CNO and other leaders for inclusion in the future project plan and design.

My motivation for this DNP project came from my belief that all nurses have a role in improving the care of our patients. As a nursing leader, I have a responsibility in supporting staff who care for the patients. The Scope and Standards for Nurse Administrators (2004) stated the "nurse administrator is accountable for providing a professional environment" (p. 26). If the organization decides to open a new unit, I wanted to have a staff development program available that supports nursing by fostering excellence in nursing practice.

Potential bias may have occurred during my project if I relied on past experience as a nurse as opposed to what is found in the evidence when I was developing the education. In order to minimize this bias, I worked closely with the nursing education staff who are the content experts in staff development. In addition, the education was based on the evidence, not personal experience. Lastly, the doctoral chairperson assigned to this project reviewed for any potential bias.

Role of the Project Team

For this DNP project, the project team consisted of staff from the professional development department, hospital administration, nurse managers, and nursing staff. The core team of the professional development staff was used to offer feedback and insight, as well as to ask questions that helped to guide the project. As experts in the area of staff development, the professional development team shared their expertise as it related to developing a new program and incorporating the most appropriate strategies**.**

The processes I used for sharing any necessary information with the professional development department, hospital administration, nurse managers, and nursing staff included power point presentations, handouts, and email communication when needed. I met with stakeholders to identify what specific gaps in knowledge there were, which were then incorporated into the program development. I gathered input from the stakeholders at the beginning of the project and once again when the program was ready for presentation. Once I developed a draft of the program, the team was asked to review and provide feedback on the doctoral project within a week. If the organization implements the project plan for the acute care building, the members of the staff development team will be responsible for working with leadership to educate the nursing staff using the newly developed program.

Summary

Throughout history, gaps in nursing staff development needs have been identified and addressed in a variety of ways. At times the gap is a result of the changing healthcare environment or it can be a result of the changing needs of the nurse. In addition, how

nursing education is provided has evolved and includes a focus on clinical reasoning using experiential learning, case studies, and other strategies. In the acute care setting, nursing education needs to be developed to meet the needs of the patient population. For example, the patient on an observation unit requires frequent and focused assessments centered around the specific diagnoses seen in the department. Benner's novice to expert theory was used to inform the project with the theory's focus on the different stages of skill acquisition.

The proposed project supported the ongoing education and competency needs of nursing as the healthcare requirements change. It also met the regulatory requirements and standards of care that the organization is required to uphold, including CMS and other independent healthcare surveyors. Lastly, the project aligned with the organization's strategic mission to improve the health of the community while reducing the cost of care. I worked with a team of different stakeholders and incorporated feedback, suggestions, and expertise or contextual insight as applicable.

Section 3 will address the data that was collected for this project, including the sources of evidence. The section will also consist of the processes that were used to search, collect, and analyze the data as well as any tools used during the process.

Section 3: Collection and Analysis of Evidence

Introduction

Part of the planning process for implementing a new department or nursing unit is the educational needs of the staff. Staff working in a new observation unit may not be familiar with the care requirements for this patient population, which can create a gap in nursing practice. The purpose of this project was to develop the education needed, based on evidence, for the staff in this new unit.

The practicum site is evaluating the potential of opening a dedicated observation unit to care for the subset of patients needing a short period of observation. When staff are educated to competently care for this population of patients, the care is patient-focused, with quality outcomes, and lower costs (Berwick et al., 2008; Plamann, et al., 2017). This care redesign aligns with the strategic mission of the organization, whereas the development of the educational program supports standards outlined by CMS (CMS, n.d.) and the Joint Commission (Joint Commission Standards, 2017).

In this section, I identify the sources of evidence that I used to address the practice-focused question. These sources included the databases and strategies that I used to collect the evidence. In the final portion of this section, I describe the methods that I used to organize, analyze, and synthesize the evidence.

Practice-Focused Question

The practice focused question for this project study was:

PFQ: What existing evidence can be used to develop nursing staff education for observation units in an acute care setting?

The administrators at the local site are evaluating the potential addition of a new observation unit to the acute care building. This new unit will need nursing staff educated on the specific needs of the patient population. A gap existed in nursing practice because the staff were not familiar with how to care for this population.

The purpose of this project was to develop nursing education that filled the identified gap. The nursing education was based on available evidence and provided the knowledge needed to support the nursing staff who will be caring for patients in a new dedicated observation unit. The purpose of the project aligned with the practice-focused question because it addressed the gap in nursing knowledge for nursing staff working in a new unit.

I do not discuss new aspects or use any terms in the project that require definitions.

Sources of Evidence

I used evidence-based literature to address the practice-focused question. I identified the sources of evidence using Internet databases, including the Cumulative Index to Nursing and Allied Health Literature, ClinicalKey, ProQuest Nursing & Allied Health Source, PubMed, and Medline. Some of the journals that I reviewed for this project included the *Journal of Nursing Administration, Journal for Nurses in Staff Development, Emergency Medicine Journal,* and *Journal of Nursing Education*. I also looked for evidence by reviewing information from nursing organizations and associated websites. The organizations included the American Nurses Association and the Emergency Nurses Association. I also examined strategies found in the literature related

to the care requirements for patients in an observation unit along with protocols or clinical pathways.

The key search terms for this project included *observation unit, dedicated observation unit, short stay unit, clinical decision unit, education for a new unit,* and *nursing education for a new unit.* The date range for the literature search was limited to 10 years, which included 6 years prior to the CMS regulation change related to observation status. The types of literature included articles from scholarly, peer-reviewed nursing and medical journals, and systematic reviews that have evidence to support the practice-focused question. The search was exhaustive, because I incorporated the key terms in different combinations, including the problem and population in the search phrases, while restricting the date range.

As stated previously, the purpose of this project was to develop an educational program for nurses working in a dedicated observation unit. The evidence that I collected contains the information about the skills needed to care for the specific population of patients. I analyzed and synthesized the data so that I constructed the appropriate staff education program that fills the gap in knowledge for nurses working in an observation unit.

Analysis and Synthesis

I tracked the evidence gathered in an organized tool based on the JHNEBP (Dearholt, Dang, Sigma Theta Tau International, & Johns Hopkins University, 2012). The matrix held the summary of the evidence, including evidence type, setting, and findings that help support the practice-focused question, and observable measures. I used

the evidence rating scale (see Appendix A) along with the appraisal criteria tool

developed for the JHNEBP model (Dearholt et al., 2012). I used the rating scale for this

model to evaluate the strength of both quality and evidence, using research and

nonresearch evidence (Schaffer, Sandau, & Diedrick, 2013).

Once the analysis was complete, the next step was the synthesis of the evidence.

The synthesis process included different steps before making a recommendation for the

practice-focused question. The process began with a review of the quality appraisal of the

evidence, then an assessment of the consistent findings, and finally an evaluation of the

meaning and relevance of the findings. The last steps were to combine all the findings

that supported the answer to the practice-focused question and develop a final

recommendation (Schaffer et al., 2013). I assured the integrity of the evidence through

careful analysis of each piece and inclusion of the evidence retrieved from peer-reviewed

journals that supported the doctoral project.

Summary

A gap in safe and quality nursing practice exists for patients when a new

observation unit is opened at the practicum site. My doctoral project, the development of

nursing education, filled this gap. I collected the evidence for the project through a

review of the literature, using Internet databases and websites of professional

organizations. I used the JHNEBP model and associated tools to track, analyze, and

synthesize the evidence to answer the practice-focused question and develop the nursing

education. In Section 4, I report on the results of the analysis and synthesis, concluding

with the implications and recommendations as they relate to the practice-focused question.

Section 4: Findings and Recommendations

Introduction

Healthcare organizations are challenged to find ways to deliver care that is most appropriate for each patient and provided in the right location, all while managing costs (Baugh et al., 2011). Hospitals with dedicated observation units have been able to meet these challenges with suitable resources and staff. For those organizations planning on implementing a dedicated observation unit, staff education is a necessary step in the process due to the unique needs and workflow related to this patient population (Napolitano & Saini, 2014; Plamann et al., 2017). Nurses who are new to the unit, regardless of years of experience, have a gap in knowledge of how to care for this population of patients due to a lack of prior experience with this population (Stinson, 2017). This DNP project addressed the gap by identifying in the literature the knowledge that new staff need prior to working on an observation unit. Using this information, I created a nursing education seminar to present at my practicum site. The Walden IRB approval number for this project is 03-29-18-0119501.

I found the sources of evidence used to develop the nursing education for staff working on an observation unit in a literature review using internet databases that I accessed through the Walden University Library. The primary databases I used were Cumulative Index to Nursing and Allied Health Literature, ClinicalKey, ProQuest Nursing & Allied Health Source, and PubMed. The key words used for the search included *observation unit, dedicated observation unit, short stay unit, clinical decision*

unit, education for a new unit, and *nursing education for a new unit.* In addition, I

reviewed the bibliographies of pertinent articles for further sources of evidence.

I reviewed the websites of a few applicable organizations for evidence that could

be incorporated into the education program. These organizations included Emergency

Nurses Association, American College of Emergency Physicians, Agency for Healthcare

Research and Quality, and American Nurses Association. Last, I attended a conference

on Observation Medicine that was hosted by the Center for Emergency Medical

Education. At the conference, I spoke with organizational leaders, including both medical

and nursing directors, who had successfully implemented and sustained observation units

throughout the United States to gain further insight on knowledge that is needed to create

an education program.

I used the JHNEBP to organize, rate, and score the various sources of evidence

found in the literature search (see Appendix A). The JHNEBP model was updated in

2017 and further strengthens the original model, which is based on three elements:

identifying a practice question, reviewing the most recent evidence, and translating it into

practice (Dang & Dearholt, 2017). The JHNEBP was helpful in my process to analyze the

research presented in the literature in an evidence-based way. Evidence was evaluated

first to determine a level of evidence, from a low of 1 to a high of 5, based on the strength

of the evidence. Then it was given a quality rating of A-high quality, B-good quality, or

C-low quality which related to the quality of the evidence that supported the practice

recommendations (Dang & Dearholt, 2017).

Findings and Implications

For the initial literature search I used the identified key words, the specific time range of 2007 to 2017, and included only articles written in English. This process yielded over 200 articles for review. The article titles and abstracts were further reviewed for applicability to the DNP topic. An article by Brillman et al. (1995), which is outside the time range, is included because it presents the most current guidelines for observation care-based recommendations from the American College of Emergency Physicians (1988). This work by Brillman is referenced by a majority of the articles and speaks to key elements that are still seen in the literature today. After my review, I used 15 articles to develop an evidence-based nursing development project for staff working on an observation unit.

Most evidence rating models recognize that research produces the strongest evidence, but these models also allow for the inclusion of a variety of nonresearch evidence to inform practice (Dang & Dearholt, 2017). The JHNEBP model allowed for both research and nonresearch evidence, but also showed that there is greater confidence in recommending a practice change when much of the evidence is level I or II out of V (Dang & Dearholt, 2017). See Appendix B for a list of each article I used to create the educational program and their ratings according to the JHNEBP model. In Appendix C, I synthesized the details regarding operationalization of levels I through V. I included a total of fifteen research articles in my final review. I identified no research that met level I or II criteria. Four of the articles met level III, three met level IV, and the remaining eight met scoring criteria for level V. The quality review of the literature revealed five

articles that met the quality rating of A, which is considered high, and the rest were rated at the quality rating of B, which is good. The evidence I used to fill the identified gap in knowledge for this project included some research with most of it coming from applicable nonresearch.

Many of the articles reviewed studies focused on the need for and development of appropriate protocols for observation units (Baugh et al., 2011; Baugh et al., 2015; Napolitano & Saini, 2014; Ross et al., 2011). The use of protocols by the care team in an observation unit encourages consistent and efficient care with a focus on condition-specific management (Ross et al., 2011). While this is an important aspect of the care of this population of patients, protocol development will be another step in the process for the organization. The protocols can be developed by the providers who will be overseeing the observation unit and then approved by the appropriate hospital committee. Once the protocols are developed, they can be incorporated into the staff education as a supplement to the project.

In 1995, Brillman et al. presented guidelines that were developed by the American College of Emergency Physicians that spoke to the management of observation units. Some of the key elements identified as needed for a successful observation unit are still seen in current literature and applicable today. Orientation of the nursing staff to goals, philosophy, and policies of the observation unit was identified as critical. In addition, the guidelines acknowledged the need for clearly defined admission and discharge criteria, care that is time limited and with a focused goal. These elements are discussed below as they are found in current research.

One of the first topics that most of the literature discussed is the need for nursing to be familiar with the philosophy, goals, principles, and policies of the observation unit. The American College of Emergency Physicians (Ross et al., 2011) updated the original guidelines that were published in 1994. The new guidelines stated that the orientation of nurses to the philosophy, goals, and principles of observation care is important for the proper use of an observation unit and the achievement of the expected outcomes. This is further supported by a white paper released by the Society of Cardiovascular Patient Care (Peacock et al., 2014). In addition, both publications listed certain metrics that should be tracked to monitor quality of care on the unit (Peacock et al., 2014; Ross et al., 2011).

Another topic seen in many of the articles referenced the nursing workflow in the observation unit, which is different than what is seen in the ED or an inpatient unit. An essential feature of observation units is that patients are actively managed by following a specific diagnostic and treatment algorithm to determine if the patient requires an inpatient admission (Baugh et al., 2011; Protocol-Driven, 2017). This is accomplished with protocols, order sets, criteria for discharge, and standard frequency of assessments and interventions (Baugh et al., 2011, Bradas, 2016; Murphy et al., 2016; Napolitano & Saini, 2014; Plamann et al., 2017; Ross et al., 2011). Accurate documentation is part of the workflow and should capture the assessments, interventions, and teaching provided to the patient (Baugh et al., 2011; Conley et al., 2017; Peacock et al., 2014; Plamann et al., 2017; Snyder and Voss, 2018).

In addition, team communication and frequent rounding were specified in the nursing research as necessary elements due to the faster turnover in the observation unit

(Murphy et al.,2016; Plamann et al., 2017). The multidisciplinary team should be communicating in a clear, concise, ongoing, and structured manner, including during rounds, at shift change, and when giving an update on the treatment plan (Baugh et al., 2015; Conley et al. 2017; Murphy et al., 2016; Plamann et al., 2017). Using a structured tool for communication has been found to improve care and facilitate efficient multidisciplinary rounds in an observation unit (Cornell, Townsend-Gervis, Vardman, & Yates, 2014; Dingley, Daugherty, Derieg, & Persing, 2014).

In summary, the literature review identified some consistent themes around what nursing staff need to be oriented to when working in an observation unit. First, staff should be oriented to the philosophy and goals of the unit, including unit specific policies and procedures (Peacock et al., 2014; Ross et al., 2011). Next, staff need to be familiar with the protocols that are used based on the patient's presenting diagnosis. The nursing staff need to be oriented to the nursing workflow, including frequency of assessments, interventions, teaching, and documentation (Bradas, 2016; Murphy et al., 2016; Napolitano & Saini, 2014; Plamann et al., 2017; Ross et al., 2011). In addition, the methods of communication within the team should be part of the orientation. For observation units, this includes different types of rounding and the use of a structured tool (Baugh et al., 2015; Conley et al. 2017; Cornell et al., 2014; Dingley et al., 2014; Murphy et al., 2016; Plamann et al., 2017).

An unanticipated limitation of the findings was a lack of evidence fitting into level I or II related to a clearly defined nursing development program for an observation unit. In addition, another unanticipated limitation was the need for evidence-based

protocols, which are not yet developed at the site, to be included in the education. What was seen in the findings was consistency in the description of the different elements that were found in the literature falling into levels III, IV or V. The review and the findings provided the evidence needed for the staff development project that will be used to orient nurses working in an observation unit. The implications from the findings for the system or the practicum site include the need for a multidisciplinary team to develop the appropriate protocols and the clinical informatics team to develop the structure needed for the documentation requirements.

The potential implications for positive social change include nurses' increased knowledge about what is needed to care for observation patients at the practicum site. Providing education to nurses that is focused on observation patients has been recognized as a best practice that facilitates safe and efficient nursing care (Conley et al., 2017). In addition, the findings will also have an impact on other organizations as they will be able to use the evidence-based staff development project at their site. Positive social change will be realized as the staff become educated and competent to care for patients in an observation unit. Improving the competence of the nursing staff by providing education aligns with both CMS (CMS, n.d.) and Joint Commission standards (Joint Commission Standards, 2017).

Recommendations

The gap in nursing practice that was the focus of this DNP project was a lack of knowledge for nursing practice and care of patients on an observation unit. The literature review identified evidence-based nursing practice and knowledge needs, when

supplemented with education on protocols, which will address the gap that nurses new to an observation unit will have. The recommendation to fill this gap is an educational product which could be incorporated into the orientation of nurses who will work on an observation unit. The education plan (see Appendix D) I developed includes a power point (see Appendix E) to be used in a classroom setting which can be supplemented with diagnosis specific protocols and case reviews. The teaching methods that can be used are lecture, discussion, and case studies. The lecture method can be used for all levels of learners with questions and discussion being allowed throughout, not just after the lecture (Dickerson, 2017). These methods allow for sharing of information and involvement by the learners. In addition, by participating in case study discussions, the learner will be able to synthesize the information presented and apply it to real-life clinical cases (Dickerson, 2017).

The outline of the educational product was built based on the summary of the findings from the literature review. The outline and the course objectives include understanding what observation care is (CMS, n.d.), what the different elements of the nursing workflow are (Baugh et al., 2011, Bradas, 2016; Murphy et al., 2016; Napolitano & Saini, 2014; Plamann et al., 2017; Ross et al., 2011), and what the documentation needs are for an observation unit (Baugh et al., 2011; Murphy et al., 2016; Napolitano & Saini, 2014; Peacock et al., 2014; Plamann et al., 2017; Ross et al., 2011).

The scope of this doctoral project was the development of education for staff working on an observation unit and will be supplemented with unit specific protocols once they are developed by the site. Evaluation on the effectiveness of the education

program can be accomplished with a few methods. The first one is by using a pre/post-test for the nurses who receive the education (see Appendix F). According to Pepsnik (2017), this is a summative evaluation, which occurs after the education is done and assesses what the student has learned. This method can measure if those receiving the education have retained the information provided. In addition, a type of formative evaluation can take place when the professional development staff assesses the student learning during the case review section of the education. This method assesses the nurses' level of knowledge in the moment and allows the professional development staff to reexplain concepts if needed. Also, the organization's annual evaluation process contains elements that are part of the education, including hand-off of care and documentation, which can provide ongoing evaluation.

Project Team

The main project team included members of the professional development department who have knowledge and experience in putting together education. These team members were instrumental in reviewing the various elements of the product at different stages of development. The team met regularly with me, reviewed the product, asked clarifying questions, and offered input and suggestions. Examples of suggestions included recommendations to change some wording, thoughts on how to update formatting, and ideas on appropriate teaching methods. Several of the suggestions offered by the team were incorporated into the final product.

The secondary project team consisted of nurse leaders and staff nurses from the ED and the inpatient units, and members of senior leadership. Their role was to review

the staff development project and provide feedback. Various meetings were held where I gave a summary of the project and presented the educational product. For these groups, the feedback and questions were centered around evaluation of the education as well as evaluation of the staff after completing the education. I shared the evaluation process I have recommended in the project with the team and they were pleased to know it was part of the overall project. With the timeline for implementing an observation unit being pushed up, leadership was appreciative of the work done on developing the needed education for the new unit.

Since the scope of the DNP project was the development of staff education only, the recommendation and plan to extend beyond the project are to have the staff development department maintain the product. Once the plan for the new observation unit implementation is developed, the staff development department will work with the unit leadership on staff orientation, to include the newly developed education. The professional development department will use the DNP project as part of the teaching, along with any associated unit specific competencies.

<div align="center">**Project Strengths and Limitations**</div>

There are a few strengths and limitations identified for this project. One of the strengths of the project is that it was developed and based on recommendations found in white papers, position statements, and literature reviews from experts in observation care. One of the original published guidelines on observation care by the American College of Emergency Physicians (Brillman et al.,1995) identified core elements of observation care that are consistently referred to and accepted in current literature. Also, this project is

ready for the practicum site to use as part of the organizational plan to open an

observation unit in the coming months, after the addition of protocols. Finally, the

education program is developed in such a way that it is transferable to other

organizations, that would only need to make minor updates related to unit specific

protocols.

A limitation of the project is the lack of high-level evidence. As stated above, the

evidence found in the literature fell into the JHNEBP level 3, 4, or 5. The types of

evidence included literature review, white papers, position statements, and some

descriptive statistical analysis of evidence-based projects. High-level evidence was seen

in the research related to protocol development and this will become part of the education

once it is completed.

Based on this limitation, future projects and studies are recommended to continue

to add to what is currently known about nursing staff development for an observation

unit. A future project should look to evaluate the impact of the education provided on

quality outcomes in the unit. In addition, another recommendation is to evaluate various

teaching and educational strategies to identify which will lead to ideal learning.

Section 5: Dissemination Plan

Dissemination Plan

This project will be disseminated at the practicum site as part of the institution's implementation of an observation unit. The organization is in the early phase of planning, starting with identifying the location and provider group who will oversee the observation unit. As the implementation project continues and the nursing staff is hired, the orientation process will be scheduled so that it is completed prior to the opening. The education program that was developed for this project will be used by the professional development staff as part of the onboarding and orientation of the new staff.

As stated above, the intended audience for dissemination of the project will be the professional development staff and the nursing staff hired to work in the new unit. Other stakeholders who will be included in the dissemination are the nurse manager, the providers working on the unit, and any other staff who will be working on the observation unit, including case management and nursing assistants. I also intend to present my project at various conferences, extending my intended audience to include professionals in the field.

Just as my dissemination plan includes both a specific practicum-based audience and a broader audience, the venues for dissemination are both specific to the practicum site and also broader in scope. The primary venue for dissemination will be my practicum site, as a part of the organization's orientation process for staff hired to work on the observation unit. On a larger scale, I will pursue presenting the staff development product at the next Observation Care Conference where other organizations could see the product

and potentially use it in their organization. To further disseminate the project, I could present at the North East Organization of Nurse Educators or the state meeting of the Emergency Department directors where the intended audience would be professionals in the field. In addition, I could seek publication in a nursing journal such as *Nursing Administration* or the *Journal of Emergency Nursing*.

Analysis of Self

As I come to the end of the DNP experience and reflect on my roles of practitioner, scholar, and project manager, I am excited to see the gains I have experienced. As a nurse leader and practitioner, I strive to enhance those leadership competencies that help to guide my professional practice; the DNP experience has helped to develop these competencies. The American Organization of Nurse Executives (2018) identified relationship management, communication, and knowledge of the healthcare environment as a few of the necessary leadership competencies. As I worked on my DNP project, I gained experience building relationships with others in the organization, especially the various stakeholders. Throughout the project, I needed to communicate effectively with quite a few individuals and did this with written materials, oral presentations, and by leading group discussions. In addition, the DNP education increased my knowledge of health systems, change management, and implementation of evidence-based practice. In my leadership role I now approach challenges with a different viewpoint, evaluating the evidence for the best way to deliver care to the patient in a multidisciplinary system.

The role of scholar is one I feel the most comfortable in because of my ongoing desire for new knowledge. The DNP project and accompanying classes built on all the education and knowledge acquired prior to my DNP education. I had previous classes on research and evidence-based practice, but the DNP courses required a higher level of understanding and were challenging at times. This was enhanced by the various projects I worked on in the different courses. For each of these projects, I needed to search the literature, identify a best practice approach, and implement the associated plan. One area of growth as a scholar was in learning how to use feedback from others and self-reflection when working on the DNP project. It was important that I remained open to new ideas to continue to make progress. My DNP education is in line with the IOM (2010) recommendation that nurses engage in lifelong learning and that schools of nursing double the number of nurses with a doctorate by 2020. After I complete my DNP, I will continue to participate in additional learning opportunities as part of my ongoing professional practice.

The role of project manager is where I made the most gains throughout the DNP project. I have been the lead on other projects while in my leadership role in my organization, but I recognized that I had areas where I needed to improve when it comes to project management. The project management competencies where I improved the most were collaborating with others, engaging key stakeholders with ongoing communication, and keeping the project on schedule. In addition, as the project manager I did not have the experience in developing educational programming, so I had to rely on

the professional development staff as the educational experts. I did this by asking questions and keeping an open mind throughout all discussions.

Project Completion

The completion of my DNP project feels like the end of a journey that was both challenging and enlightening. One of the challenges I faced was overcoming the apprehension I sometimes felt about developing the educational product. The apprehension was due to worrying about being dependent on others, especially the professional development staff. In the end, I trusted the process and accepted the input from the project team, which had a positive impact on the overall product. It was enlightening to know that I could successfully overcome challenges and work on a project that had both personal and organizational importance.

Summary

Staff orientation and education are key steps when an organization plans on opening a new observation unit (Napolitano & Saini, 2014; Plamann et al., 2017). After reviewing the literature and synthesizing the evidence, I developed an educational product that will close the gap in knowledge for nurses in how to care for the patient population on an observation unit. This product will be incorporated into the orientation of new nursing staff hired to work on a newly implemented observation unit. The completion of this DNP project aligns with my goal as a nurse leader to support staff in providing safe, quality care to all patients.

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Appendix A: Johns Hopkins Nursing Evidence-Based Practice Model

Evidence Levels	Quality Ratings
Level I Experimental study, randomized controlled trial (RCT) Explanatory mixed method design that includes only a level I quaNtitative study Systematic review of RCTs, with or without meta- analysis	QuaNtitative Studies A <u>High quality</u>: Consistent, generalizable results; sufficient sample size for the study design; adequate control; definitive conclusions; consistent recommendations based on comprehensive literature review that includes thorough reference to scientific evidence. B <u>Good quality</u>: Reasonably consistent results; sufficient sample size for the study design; some control, fairly definitive conclusions; reasonably consistent recommendations based on fairly comprehensive literature review that includes some reference to scientific evidence. C <u>Low quality or major flaws</u>: Little evidence with inconsistent results; insufficient sample size for the study design; conclusions cannot be drawn.
Level II Quasi-experimental study Explanatory mixed method design that includes only a level II quaNtitative study Systematic review of a combination of RCTs and quasi-experimental studies, or quasi-experimental studies only, with or without meta-analysis **Level III** Nonexperimental study Systematic review of a combination of RCTs, quasi-experimental and nonexperimental studies, or nonexperimental studies only, with or without meta-analysis Exploratory, convergent, or multiphasic mixed methods	QuaLitative Studies No commonly agreed-on principles exist for judging the quality of quaLitative studies. It is a subjective process based on the extent to which study data contributes to synthesis and how much information is known about the researchers' efforts to meet the appraisal criteria. *For meta-synthesis, there is preliminary agreement that quality assessments of individual studies should be made before synthesis to screen out poor-quality studies[1].* A/B <u>High/Good quality</u> is used for single studies and meta-syntheses[2]. The report discusses efforts to enhance or evaluate the quality of the data and the overall inquiry in sufficient detail; and it describes the specific techniques used to enhance the quality of the inquiry. Evidence of some or all of the following is found in the report: • Transparency: Describes how information was documented to justify decisions, how data were reviewed by others, and how themes and categories were formulated. • Diligence: Reads and rereads data to check interpretations; seeks opportunity to find multiple sources to corroborate evidence. • Verification: The process of checking, confirming, and ensuring methodologic

studies Explanatory mixed method design that includes only a level III quaNtitative study QuaLitative study Meta-synthesis	coherence. • Self-reflection and scrutiny: Being continuously aware of how a researcher's experiences, background, or prejudices might shape and bias analysis and interpretations. • Participant-driven inquiry: Participants shape the scope and breadth of questions; analysis and interpretation give voice to those who participated. • Insightful interpretation: Data and knowledge are linked in meaningful ways to relevant literature. C Low quality studies contribute little to the overall review of findings and have few, if any, of the features listed for high/good quality.
Level IV Opinion of respected authorities and/or nationally recognized expert committees or consensus panels based on scientific evidence Includes: • Clinical practice guidelines • Consensus panels/position statements	A High quality: Material officially sponsored by a professional, public, or private organization or a government agency; documentation of a systematic literature search strategy; consistent results with sufficient numbers of well-designed studies; criteria-based evaluation of overall scientific strength and quality of included studies and definitive conclusions; national expertise clearly evident; developed or revised within the past five years B Good quality: Material officially sponsored by a professional, public, or private organization or a government agency; reasonably thorough and appropriate systematic literature search strategy; reasonably consistent results, sufficient numbers of well-designed studies; evaluation of strengths and limitations of included studies with fairly definitive conclusions; national expertise clearly evident; developed or revised within the past five years C Low quality or major flaws: Material not sponsored by an official organization or agency; undefined, poorly defined, or limited literature search strategy; no evaluation of strengths and limitations of included studies, insufficient evidence with inconsistent results, conclusions cannot be drawn; not revised within the past five years
Level V Based on experiential and nonresearch evidence Includes:	Organizational Experience (quality improvement, program or financial evaluation) A High quality: Clear aims and objectives; consistent results across multiple settings; formal quality improvement, financial, or program evaluation methods used; definitive conclusions; consistent

• Integrative reviews • Literature reviews • Quality improvement, program, or financial evaluation • Case reports • Opinion of nationally recognized expert(s) based on experiential evidence	recommendations with thorough reference to scientific evidence B <u>Good quality</u>: Clear aims and objectives; consistent results in a single setting; formal quality improvement, financial, or program evaluation methods used; reasonably consistent recommendations with some reference to scientific evidence C <u>Low quality or major flaws</u>: Unclear or missing aims and objectives; inconsistent results; poorly defined quality improvement, financial, or program evaluation methods; recommendations cannot be made **Integrative Review, Literature Review, Expert Opinion, Case Report, Community Standard, Clinician Experience, Consumer Preference** A <u>High quality</u>: Expertise is clearly evident; draws definitive conclusions; provides scientific rationale; thought leader(s) in the field B <u>Good quality</u>: Expertise appears to be credible; draws fairly definitive conclusions; provides logical argument for opinions C <u>Low quality or major flaws</u>: Expertise is not discernable or is dubious; conclusions cannot be drawn

Appendix B: Individual Evidence Summary Tool

Author, Date, and Title	Findings That Help Answer the EBP Question	Evidence Level, Quality
Ross, M. A., Aurora, T., Graff, L. G., Suri, P., Ojo, A. O., Bohan, S., & Clark, C. L. (2011). State of the Art: Observation units in the emergency department.	Orient to: goals, philosophy, policies and procedures, transfer of care, documentation, metrics. Observation unit should have guidelines describing MD and RN roles, admission and discharge criteria, how transfer of care and documentation will occur, when a physician will be contacted, and utilization and quality metrics. Protocols encourage consistency, which leads to better care. Principles of observation care include focused patient care goals, limited duration and intensity of services, and intensive review. Elderly are more complex, and research has shown that they benefit from the shorter stay of an observation unit. Metrics: length of stay, percent discharged, census per day, return visits within 7 or 14 days, complaints, patient satisfaction, protocol compliance, ICU admissions.	Level IV Quality B
Protocol-Driven Emergency Department Observation Units. (2017). *JEN: Journal of Emergency Nursing*	Key elements for a successful observation unit: dedicated unit, protocols, administrative oversight, and appropriate staffing with qualified professionals (experienced emergency nurses). Active mgmt. of patients Protocols and order sets for consistent mgmt. Purposeful rounding Progress updates Education Elderly patients are more complex, requiring longer ED visits. As more hospitals implement observation units, education and research will further optimize the use of these units.	Level IV Quality B
Baugh, C., Liang, L., Probst, M., & Sun, B. (2015). National cost savings from observation unit management of syncope	Best Practice: Care optimized to patient condition in a dedicated unit. Protocols reduce unwanted variation. Variation can lead to overuse and misuse. Using protocols also improves communication between clinical staff and the patient especially around expectations for the stay with an endpoint for discharge. Stat orders	Level III Quality B

Author, Date, and Title	Findings That Help Answer the EBP Question	Evidence Level, Quality
Baugh, C. W., Venkatesh, A. K., & Bohan, J. S. (2011). Emergency department observation units: a clinical and financial benefit for hospitals.	Benefits of observation care: more accurate diagnosis, discharged home faster, cost avoidance, improved bed capacity, increased patient satisfaction and safety. Avoiding an inpatient stay reduces exposure to hospital acquired conditions, medication errors, and physical deconditioning. Care being provided in the setting most appropriate for the patient needs by matching resources to patient needs. Right care to all patients in the right place at the right time. Efficient diagnostic and treatment algorithms for specific patients. Payment for observation care includes fee for service for diagnostics and therapeutics, which could include IV fluids, catheters, and some medications. Patient selection is critical: Inclusion/Exclusion criteria and diagnostic and treatment algorithms. Metrics: length of stay average is 24 hours, 80% discharged home, occupancy rate	Level V Quality B
Bradas, C. (2016). Characteristics and Predictors of Readmission to a Medical Short-Stay Unit	Short stay units are for treatment of mild conditions by dedicated staff focused on a patient centered model of care. Common characteristics of SSU: stay from 24-72 hours, dedicated nursing staff, narrow range of diagnosis, manageable comorbidities, no anticipated transfer to a higher level, no complex discharge needs, focused care. Discharge instructions from nursing must be clear, concise, structured and include information to help prevent readmission. Discharge to home rate 79%	Level III Quality B

Author, Date, and Title	Findings That Help Answer the EBP Question	Evidence Level, Quality
Murphy, G., Willetts, K., Duphiney, L., Dalton, J., & David, D. (2016). Implementation analysis of a nurse-led observation unit.	Observation units decrease costs, decrease length of stay, and increase hospital bed availability. Most of the care in observation units is delivered by nurses. Sample admitting diagnosis: asthma, infections, gastroenteritis, seizures, heart failure, and chest pain. Observation patients need additional testing and medication to secure a clinically safe discharge. Selective inclusion and exclusion criteria are needed. Characteristics: strict admission criteria, limit to 24 hours, dedicated space, protocol driven, discharge-oriented care. Initially used experienced nursing staff on the unit. Orientation was not focused on clinical orientation. Orientation focus included: Welcoming patient to unit, clear communication within the team, early discussion of discharge planning with the patient, importance of beginning teaching on admission, a focus on assessment of barriers to discharge, multidisciplinary approach, documentation	Level III Quality B
Napolitano, J. & Saini, I. (2014) Observation units: definition, history, data, financial considerations, and metrics.	Dedicated nursing staff. When the nurses become experts in the common diagnosis, care becomes better. Nursing workflow is different, Shorter, focused assessments with faster turnover. Awareness of standard operating procedures of the unit, the unique workflow, and frequently seen diagnosis improves efficiency of the unit. Case management skills important. Discharge: follow up consults and appts within days of discharge. Good follow up impacts the rate of readmissions. Importance of arranging follow ups to decrease readmissions Metrics and CQI: patient satisfaction, AVG and Median LOS, conversion to inpatient, readmissions Oral medication process: reimbursement policies for observation patients assume the patient will administer their own meds so Medicare will not pay for these. But for patient safety reasons most organizations' policies don't allow patients to take home medications. Optimal environment: team-based care. Common diagnosis: chest pain, syncope, TIA, heart failure, asthma.	Level V Quality B

Author, Date, and Title	Findings That Help Answer the EBP Question	Evidence Level, Quality
Peacock, F., Beckley, P., Clark, C., Disch, M., Hewins, K., Hunn, D., . . . Wheatley, M. (2014). Recommendations for the evaluation and management of observation services: A consensus white paper: The Society of Cardiovascular Patient Care.	Orientation to: philosophy, goals, P&P, scope of practice. Faster patient turnover that new RNs may struggle with learning how to prioritize care to efficiently discharge patients. Orientation should include time cross-training in the ED. Even though CMS does not spell out nursing requirements, the importance of documentation cannot be overlooked. Nursing documentation plays a role in coding and billing. Nurses have a role in documenting the time spent in observation care, medications administered, and certain interventions. Tailored care plan Discharge transition and follow up Metrics: Average LOS, conversion to inpatient, average daily census, ICU admissions, returns to the ED in 7 and 30 days, patient satisfaction. Cardiac specific: serial labs, EKGs, telemetry	Level III Quality A
Plamann, J., Zedreck-Gonzalez, J., & Fennimore, L. (2017). Creation of an adult observation unit: Improving outcomes.	Efficient care can be achieved if patients receive the right care, from the right skill mix, in the right location. Observation patients need more care and treatment before they can be clinically ready for discharge. Specific, clinically appropriate services including ongoing, short term treatments, assessments/reassessments Benefits of observation units: decreased length of stay, decreased costs, increase patient satisfaction. Healthcare team on an observation unit need a new mindset in how to dare for this unique population. Inclusion/exclusion criteria Standards of care for nursing with defined: assessments, level of monitoring, multiple and frequent assessments and interventions (Q 4hr) throughout stay until discharged (consistent with Medicare expectations). Nurses commit to: rounding frequently, focused assessments, intervening, evaluating, contacting MD promptly Documentation: focused assessments based on complaint and the body system affected, functional health assessment-what is necessary to ensure a safe discharge plan vs comprehensive Metrics Main guiding principles: frequent assessments, interventions, evaluations and then repeating the cycle until ready for discharge.	Level V Quality B

Author, Date, and Title	Findings That Help Answer the EBP Question	Evidence Level, Quality
Ryan, L., Scott, S., & Fields, W. (2017). Implementation of Interdisciplinary Rapid Rounds in Observation Units.	Rapid rounds is a method of consistent, patient-centered communication among the interdisciplinary care team to communicate the plan of care for the patient. Nursing responsible for communicating, coordinating, and resolving conflicts in care planning Communication intervention to improve D/C process Interdisciplinary rounds is EBP to improve communication among disciplines. Environment of respect and safety Rounds improved patient satisfaction related to: ready for DC, speed of DC, receiving instructions for care at DC	Level V Quality B
Conley, J., Bohan, J. S., & Baugh, C. W. (2017). The Establishment and Management of an Observation Unit.	Diagnostic vs therapeutic endpoint. Diagnostic protocols focus on obtaining a diagnosis Therapeutic protocols focus on providing appropriate time-sensitive therapies. Protocol development includes: inclusion/exclusion criteria, expected interventions, and disposition criteria. Nurse staffing: need clinical skills and experience for this population. Medical decision making may be straight forward due to protocols, but nursing care may be complex. Goal is to have nursing staff familiar with the standard protocols and the unique needs of the patient population so float nurses should be avoided. Rounds are a critical aspect on the observation unit: focused on clinical management and reevaluation. Communication and documentation: order for observation care, plan of care, protocols, frequent progress notes, DC summary, teaching for discharge. Dashboard: quality assurance, LOS, occupancy rate, DC home rate, patient satisfaction	Level V Quality A

Author, Date, and Title	Findings That Help Answer the EBP Question	Evidence Level, Quality
Brillman, J., Mathers-Dunbar, L., Graff, L., Joseph, T., Leikin, J. B., Schultz, C., ... & Werne, C. (1995). Management of observation units.	*****While this paper is outside the timeframe, it was referenced in many of the papers above and the information is still applicable. Clearly defined admission criteria, well defined P&P, communication structure, carefully developed programs for quality assurance 1. Period of observation has a focused goal 2. Intensity of services is limited 3. Illness severity is limited 4. Clinical condition appropriate for observation Transfer of care should take place at bedside rounds Nurses are well versed in goals, philosophy, P&P, equipment and supplies 1. Criteria for admission 2. Time limited 3. Focused goal	Level V Quality A
Mercedes A., Fairman P., Hogan L., Thomas R., Slyer J., 2016. Effectiveness of structured multidisciplinary rounding in acute care units on length of stay and satisfaction of patients and staff: a quantitative systematic review.	Efficient and effective communication among team members is crucial for delivering quality patient care. IOM-Crossing the Quality Chasm, safe, effective patient-centered care that is timely, efficient and equitable, Use of structure tool improves care Use of SBAR tool decreased the length of the multidisciplinary rounds JBriggs rating B	Level IV Quality B

Author, Date, and Title	Findings That Help Answer the EBP Question	Evidence Level, Quality
Dingley C., Daugherty K., Derieg M., Persing R.,2014. Improving patient safety through effective communication strategy enhancements.	Study developed, implemented and evaluated a toolkit of communication strategies. 4 aims: standard tool, escalation process, MD round goal sheet, team daily huddles. Ineffective communication leads to medical errors, patient harm increased length of stay, and increased resource use. Differences in education and training can result in different communication styles. Demonstrated value of teamwork and communication strategies. SBAR was the standardized communication format implemented for communicating patient care situations. SBAR is effective in bridging communication styles. The use of SBAR recognizes nurses' expertise empowering them to offer Recommendations. Multidisciplinary rounds focus on open communication and collaboration, including decision making, information sharing, and care planning. An escalation process was used for timely communication regarding a change in a patient's condition.	Level V Quality A
Cornell P., Townsend-Gervis M., Vardman J., Yates L., 2014. Improving situational awareness and patient outcomes through interdisciplinary rounding and structured communication.	Nurses tend to communicate in a narrative form Presentation skills vary with experience SBAR tool increased consistency IDR have a strong focus on D/C planning and continuity of care	Level V Quality A

Appendix C: Evidence Synthesis Tool

EBP Question: What existing evidence can be used to develop nursing staff education for observation units in an acute care setting?			
Category (Level Type)	**Total Number of Sources**	**Overall Quality Rating**	**Synthesis of Findings Evidence That Answers the EBP Question**
Level I • Experimental study • Randomized controlled trial (RCT) • Systematic review of RCTs with or without meta-analysis • Explanatory mixed method design that includes only a Level I quaNtitative study	None	NA	
Level II • Quasi-experimental studies • Systematic review of a combination of RCTs and quasi-experimental studies, or quasi-experimental studies only, with or without meta-analysis • Explanatory mixed method design that includes only a Level II quaNtitative study	None	NA	
Level III • Nonexperimental study • Systematic review of a combination of RCTs, quasi-experimental and nonexperimental studies, or nonexperimental studies only, with or without meta- analysis • QuaLitative study or meta- synthesis • Exploratory, convergent, or	4	B+	Main guiding principles: Short, frequent and ongoing treatments, assessments, reassessments, repeating the cycle until discharge Huddles first thing in the morning Right care, right skill mix, right location Use of protocols increases efficiency, improves communication Patient teaching: expectations of stay in observation unit, what is needed for discharge and follow up Importance of inclusion/exclusion criteria, specific diagnosis, teaching begins on admission, multidisciplinary approach

multiphasic mixed-methods studies ▪ Explanatory mixed method design that includes only a level III QuaNtitative study			Documentation requirements: barriers to discharge, time in observation, teaching Characteristics of an observation unit: strict admission criteria, time limited, protocol driven, discharge oriented care, shadowing in the ED
Level IV ▪ Opinions of respected authorities and/or reports of nationally recognized expert committees or consensus panels based on scientific evidence	3	B	Orient staff to goals, philosophy, policies and procedures, documentation requirements, metrics, scope of practice, discharge/transfer of care needs Guidelines: staff roles, admission/discharge criteria, documentation, communication and metrics Protocols needed Principles of observation care: Patient focused care goals, limited duration, rounding, progress updates, discharge transition and follow up Communication is improved when using a structured tool like SBAR
Level V ▪ Evidence obtained from literature or integrative reviews, quality improvement, program evaluation, financial evaluation, or case reports ▪ Opinion of nationally recognized expert(s) based on experiential evidence	8	B+	Benefits of observation care: more accurate diagnosis, discharged faster, cost avoidance, improved bed capacity, improved patient safety and satisfaction Most appropriate setting to match the resources to the patient needs Right care, right place, right time Diagnosis or treatment algorithms Coding/payment: time in observation, IV fluids, meds, other interventions Inclusion/exclusion criteria Metrics and dashboard Workflow, standard operating procedures, team based, protocols, rounding Communication is improved with tight tools: standard tool, escalation process, regular huddles Nurses should be familiar with goals, philosophy, policies and procedures

Appendix D: Observation Unit Education Plan

Observation Unit Education Plan

Synopsis of the identified gap: a lack of knowledge for nursing practice and care of patients on an observation unit.

Identified learning outcome: Staff will have the knowledge to care for patients on an observation unit, which will lead to improved outcomes.

Process: education will be presented in a classroom setting by Power Point with opportunity for discussion and case reviews.

Learning Objectives:

1. Student will explain what observation care is
2. Student will describe the elements of the care model
3. Student will cite the documentation and coding requirements

Teaching strategy: lecture, class discussion, and case studies.

Objective	Content	Method
1. Student will explain what observation care is	• Definition of observation care • Types • Inpatient versus observation • Concepts and benefits	Lecture, class discussion
2. Student will describe the elements of the nursing workflow	• Assessments, Interventions • Protocols • Inclusion/Exclusion • Diagnostic or therapeutic • Communication • Patient education	Lecture, class discussion
3. Student will cite the documentation requirements	• What needs to be documented • Nursing interventions that need specific documentation	Lecture, class discussion, case studies

Appendix E: Observation Care: Nursing Orientation to an Observation Unit

GOAL

Organization's strategic goal

Triple Aim plus One:

- Improve the patient experience
- Improve the health of the community
- Reduce overall cost of care
- Maintain the organization's sustainability

GOAL OF OBSERVATION CARE

In alignment with the Organization's strategic goal, the goal of observation care is to:

Provide the right care and treatment for each patient, in the most appropriate location, and doing it within a structure of controlling costs

What is Observation Care

CMS Definition

- *Observation care* is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are to be discharged from the hospital

- *Observation services* are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge

U.S. Department of Health and Human Services. (2015). *Medicare benefit policy manual* (Publication 100-02). Washington, DC: Author, Chap 6, 20.6. Retrieved from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads /bp102c06.pdf

Observation Services (Medicare Manual)

- Take place in a hospital
- Patient is in a bed with periodic monitoring by nursing
- Are reasonable and necessary
- Needed to evaluate an outpatient's condition
- Determines the need for possible admission as an inpatient

- Ordered by a physician
- Usually does not exceed one day
- May go up to 48 hours
- Must be at least 8 hours
- Only in unusual circumstances may it exceed 48 hours

U.S. Department of Health and Human Services. (2015). *Medicare benefit policy manual* (Publication 100-02). Washington, DC: Author, Chap 6, 20.6. Retrieved from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads /bp102c06.pdf

TYPES OF OBSERVATION UNITS

Our structure

Type 1: Protocol driven, closed unit

Type 2: Discretionary care, closed unit

Type 3: Protocol driven, any bed

Type 4: Discretionary care, any bed

OBSERVATION COMPARED TO INPATIENT

Observation

- Short, focused assessments
- Regular, frequent reassessment to determine response to treatment
- Stays from 8-36 hours
- Extension of the ED
- Short term therapy

Inpatient

- Complete head to toe assessments
- Reassessments per shift
- Stays more than 2 midnights
- Separate from the ED

CONCEPTS OF OBSERVATION CARE

Ongoing, frequent treatments for an episodic condition → Further testing required to make a definitive diagnosis → Evaluating readiness to discharge home or convert to inpatient

BENEFITS OF OBSERVATION CARE

- Decreased medical errors
- Increased ED throughout
- Decreased patient costs
- Increased patient satisfaction
- Decreased patient harm

Nursing Workflow

CARE TEAM

- Provider (MD or APP)
- Nurse
- Unit Coordinator/tech
- Support
  - Consult services
    - Pharmacy
    - Social Work
  - Lab
  - Transport

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- Team oriented
- Patient centered
- Experienced
- Strong teaching skills
- Strong interpersonal skills
- Independent decision making
- Ability to multi-task in a rapid-turn environment
- Understanding of case management

STAFF CHARACTERISTICS

OBSERVATION CARE PROCESS

Protocols → Inclusion and Exclusion Criteria → Diagnostic or Therapeutic Endpoint

PROTOCOLS

TIA
Syncope
Asthma
Chest Pain
A-fib
Abdominal Pain
Heart Failure

- Protocols
  - Top Diagnosis
  - Specific Order Sets
  - Consistent management
  - Care optimized to patient condition

PROTOCOLS

Encourage consistency	Decrease variation	Improves communication

|	
Better, more efficient care	Decreases overuse and misuse

DIAGNOSTIC OR THERAPEUTIC

Patients fall into two categories: diagnostic treatment or therapeutic

- Additional testing needed
  - Needed to rule out or rule in
  - Requires additional testing
    - Cardiac: serial enzymes
    - Abdominal pain: serial WBC
    - Syncope:

- Short term therapy
  - Lasix and nitrates for CHF
  - IV antibiotics
  - Medications
    - Asthma: nebulizers or steroids
    - A-fib: stabilizing medications

Nursing Assessment

- Initial assessment followed by reassessments
  - At regular intervals (every 4 hours)
  - After therapy provided
  - With any change in condition

- Condition specific focus:
  - Cardiac: cardiac monitoring, serial labs, EKGs
  - Respiratory: lung sounds, SpO2 monitoring, and labs
  - Neuro: serial neuro checks
  - Gastrointestinal: intake/output, and labs

COMMUNICATION STRUCTURE

Sender Message

Feedback

Receiver

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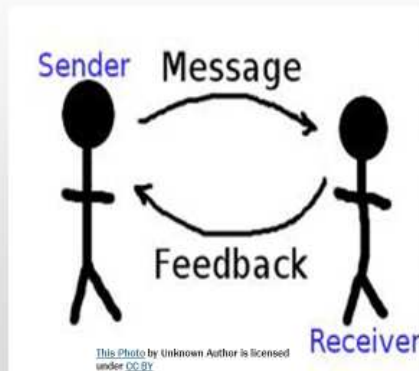
- Team rounds
- Bedside report at change of shift
- Frequent updates as appropriate
- Transfer of care

COMMUNICATION

Organization's policy on communication

Policy: PC-ADT.004 Internal
Transfer/Transport: Handoff Communication

Communication is:

Frequent

Timely

Ongoing

SBAR

S **Situation**
Briefly describe the situation.
Give a succinct overview.

B **Background**
Briefly state pertinent history.
What got us to this point?

A **Assessment**
Summarize the facts.
What do you think is going on?

R **Recommendation**
What are you asking for?
What needs to happen next?

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PATIENT EDUCATION

- What to expect as an Observation stay patient

- Diagnosis: plan, treatment, and risk factors

- Medications

- Follow up appointments and testing

- How to manage condition at home

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DOCUMENTATION AND CODING

DOCUMENTATION

- CMS does not specifically address nursing documentation requirements for observation services

- What is needed:
  - Order to place in observation status
  - Focused assessment
  - Focused, frequent reassessment
  - Response to treatment
  - Education provided, including necessary follow ups
  - Time observation starts and when medically necessary services end

CODING

- As an outpatient service, there are certain applicable charges that can be captured while receiving observation services

- Nursing documentation is needed to support certain charges
  - IV start and stop times
  - Injections
  - Finger stick blood sugars
  - Straight cath or foley
  - Guaiac and fecal occult testing
  - Arterial punctures

Summary

- Observation care is specialty care optimized to the patient condition, preferably in a dedicated unit

- It is the right care, for the right patient, in the right place

- Goal for nursing staff: familiarity with the standard protocols for this unique population

- Guiding principles: frequent assessments, interventions, evaluations, and then repeating until discharge

- Multidisciplinary, team focused care

- Strong communication within the team is key

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Appendix F: Pre- Posttest

1. Observation care is a hospital definition
   a. True
   b. False

2. Observation care falls within which timeframe
   a. Less than 8 hours
   b. 8-24 hours
   c. 8-48 hours
   d. More than 48 hours

3. What elements of observation care differ from inpatient care (circle all that apply)
   a. Short, focused assessments
   b. Complete assessments
   c. Stay more than 2 midnights
   d. Short term therapies

4. What are the benefits of observation care?
   a. Increased patient satisfaction
   b. Decreased costs
   c. Decreased medical errors and patient harm
   d. All of the above

5. Protocols allow for consistent management of a patient's condition
   a. True
   b. False

6. What are some of the diagnosis that are appropriate for observation care (circle all that apply)
   a. Chest pain
   b. ETOH withdrawal
   c. New onset renal failure
   d. Asthma
   e. TIA
   f. Bowel obstruction
   g. Pancreatitis
   h. DVT

7. Which patient with the following vital signs would fit the inclusion criteria
   a. BP 180/85, HR 120, SpO2 89 on RA
   b. BP 260/100, HR 100. SpO2 90 on RA
   c. BP 85/40. HR 80, SpO2 94 on RA
   d. BP 140/75, HR 38, SpO2 90 on RA

8. When would the standard communication tool be used?
   a. Team rounds
   b. Change of shirt report or transfer of care
   c. When giving an update on a change in condition
   d. All of the above

9. Patient education is only needed when the patient is ready to discharge
   a. True
   b. False

10. What are some of the elements covered in patient education (circle all that apply)
   a. Explanation of observation care
   b. Diagnosis
   c. Plan of care
   d. Risk factors
   e. Medications
   f. Follow up care
   g. Appointments needed
   h. How to manage at home
   i. When to call your doctor

11. What are some of the required documentation elements
   a. Assessments and reassessments
   b. Response to treatment
   c. Education
   d. All of the above

12. How often are assessments done in the observation unit
   a. Once a shift
   b. Once a day
   c. Every 4 hours