**CMS Definition of Observation Classification**

A well-defined set of specific, clinically appropriate services, which include … treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital … (and) in the majority of cases, the decision … can be made in less than 48 hours, usually in less than 24 hours. In only rare and exceptional cases do … outpatient observation services span more than 48 hours.

Salem Health uses InterQual criteria to help determine patient classification as IP vs. Observation so that appropriate classification occurs. Documentation of patient assessment, tests, and evaluation of treatment are key criteria to help make the appropriate determination.

Observation classification is billed hourly, and there is an out-of-pocket associated with this patient class that impacts the patient financially. We should be thinking of their care in hours versus days to minimize cost to the patient associated to their care.

**Nursing Documentation to support Medical Progression**

* O2 Saturation Stability
  + Documentation of baseline oxygen use
  + Why does the patient remain on O2? Have you trialed them without?
  + Document RA, or the amount of O2 – don’t leave blank
* Mobility – Attempt early and often
  + Success or failed by RN **prior** to PT eval. If patient at baseline mobility, the need for PT eval is not necessary. Talk with the provider to get the order discontinued.
  + Include why patient failed ambulation (pain, desats, dyspnea, dizziness, etc)
* Oral intake - Fluids, Diet, Meds
  + Document patient response, tolerating, not tolerating (N,V)
  + Need some form of a trial charted and advance quickly if tolerating when appropriate
* Changes (unexpected) in vital signs.
  + For example, persistent tachycardia
* Use of SCD’s
* Seizure precautions
* Contraindications to treatment
* Correct documentation of holding meds with a comment not that a patient refused.
* Reassessment of pain
* Mental Status changes
* Documentation at 1:1 observation has stopped
  + Not just a stopping of the charting

**Milestones to Discharge**

* If you do not know the milestones to discharge you should ask the provider
  + Ex. Admission for hypernatremia – what is their goal Na+ for discharge
  + Ex. Admission for N/V – What is their goal for PO intake
  + Ex. Admission for knee pain and needs knee tap – What is the goal INR for procedure
* When you meet goal(s), notify the provider immediately