[HOSPITAL / HEALTH AUTHORITY NAME]

EMERGENCY DEPARTMENT OBSERVATION AND SHORT-STAY CARE

Protocol 53: Eligibility and Exclusions; Named Clinical Responsibility; Protocolized Assessment and Treatment; Review Intervals; Milestones; Deterioration; Maximum Duration; Conversion to Admission; Safe Discharge; Follow-up; and Quality Governance

DRAFT FOR EMERGENCY MEDICINE, NURSING, INTERNAL MEDICINE, SURGERY, PAEDIATRICS, PHARMACY, ALLIED HEALTH, DIAGNOSTIC SERVICES, BED MANAGEMENT, AMBULANCE / TRANSFER SERVICES, INFORMATION SERVICES, AND CLINICAL GOVERNANCE

STATUS: This is a draft clinical-governance document. It must be reconciled with the hospital admission policy, local staffing and monitoring capability, approved condition-specific pathways, medication formulary, paediatric and maternity arrangements, infection-control requirements, diagnostic availability, transport systems, and national law before implementation.

CORE RULE: Observation is active, time-limited care for a defined clinical question or treatment goal. Every patient must have explicit inclusion criteria, a named responsible clinician, scheduled reassessment, measurable milestones, and pre-agreed discharge and admission triggers. Observation must never become passive waiting.

TIME-LIMIT RULE: Use a same-day track only when care is likely to finish within 8 hours. Use a bedded observation / short-stay track only when the expected total observation episode is 24 hours or less. At 24 hours the patient must be discharged, formally admitted, or transferred; lack of a bed does not justify continuing “observation” status.

NO-BOARDING RULE: The observation area is not an overflow ward, discharge lounge, elective treatment unit, social holding area, or place to conceal access-standard breaches. Once inpatient admission or transfer is decided, the observation episode ends and the patient enters the admitted / transfer-waiting pathway with the corresponding standard of care.

Document control	Details
Document owner	Emergency Department / Medical Services Directorate / Nursing Services / Clinical Governance
Clinical leads	Emergency Medicine; Nursing; Internal Medicine; Surgery; Paediatrics; Pharmacy; Allied Health; Diagnostics; Bed Management; Quality and Risk
Applies to	Adults and, only where locally approved, children or adolescents selected for structured emergency observation or short-stay care after initial ED assessment and stabilization.
Exclusions	Patients requiring definitive inpatient admission, critical care, operative intervention, protected mental-health care, prolonged social placement, elective treatment, routine post-procedure recovery, or monitoring beyond unit capability.
Interfaces	Protocols 1-17 and all presentation-specific protocols; Protocol 40 Paediatric Emergency Assessment; Protocol 42 Mental-Health Crisis; Protocol 44 Frailty and Falls; Protocol 48 Airway and Ventilatory Support; Protocol 50 Procedural Sedation; Protocol 51 Capacity and Departure; Protocol 54 Infection Prevention; Protocol 55 Crowding and Boarding.
Version / status	Draft 1.0 for local multidisciplinary, operational, pharmacy, information-governance and executive validation.
Approval date / review	Approval: _____ Review: _____ Earlier review after serious deterioration, delayed admission, missed result, medication harm, excessive length of stay, complaint, staffing change, or national guidance update.
Mandatory local documents	Approved observation pathways and order sets; escalation policy; nurse staffing model; diagnostic turnaround agreement; medication reconciliation policy; discharge and pending-results policy; downtime and surge plans.

1. Purpose

To provide a safe, efficient and auditable framework for active emergency-department observation and short-stay care, so that selected patients can complete time-sensitive assessment or treatment without unnecessary inpatient admission while avoiding delayed recognition of deterioration, prolonged stays, unsafe discharge, or misuse of the unit as a holding area.

2. Core principles

- Observation is a clinical service, not a location or administrative status. The patient remains under active medical and nursing management throughout the episode.
- Select only patients with a defined diagnostic or therapeutic objective, a realistic probability of discharge within the track time limit, and needs that match the unit’s staffing, monitoring and rescue capability.
- Complete initial emergency assessment, stabilization and essential risk-stratifying tests before transfer. Unstable or incompletely differentiated patients remain in the resuscitation / acute ED area.
- Use written, condition-specific pathways wherever possible. Pathways must specify inclusion, exclusion, tests, treatments, milestones, reassessment intervals, deterioration triggers, discharge criteria and admission criteria.
- Name the responsible clinician and nurse. Responsibility must never be ambiguous during specialty consultation, handover, overnight care, downtime or crowding.

- Do not allow the observation unit to absorb admitted patients, transfer waits, unresolved safeguarding placements, elective infusions, routine postoperative recovery or patients kept solely for convenience.
- Decisions are based on clinical need and equity, not insurance, social status, ability to pay, personal connections or pressure to meet performance targets.
- Preserve the patient's dignity, nutrition, hydration, sleep, mobility, usual medicines, communication needs and family involvement during any extended stay.
- At every review, ask whether the patient still meets observation criteria. When criteria are no longer met, discharge, admit or transfer without waiting for the maximum time.
- Track total time from hospital arrival as well as time in the observation area. Moving a patient must never reset or hide the true duration of care.

3. Definitions

Term	Working definition
Observation care	Active, protocol-driven assessment or treatment after initial ED care, used to determine whether the patient can be safely discharged or requires admission / transfer.
Same-day / ambulatory track	A chair-, recliner- or trolley-based pathway for a stable patient whose care is highly likely to finish within 8 hours of placement and without an overnight stay.
Bedded observation / short-stay track	A designated monitored bed for a stable patient expected to need more than routine ED time but no more than 24 hours of structured care.
Clinical question	The specific uncertainty observation is intended to resolve, such as response to treatment, exclusion of evolving disease, serial examination, repeat testing, functional recovery or safe oral intake.
Milestone	A measurable clinical, diagnostic, treatment, functional or disposition target that must be achieved by a stated time.
Conversion to admission	Formal end of observation because the patient now needs inpatient care, specialty ownership, surgery, critical care, longer monitoring or treatment beyond the unit's capability or time limit.
Boarding / holding	Waiting in the ED or observation area after the decision for admission, transfer, procedure or discharge has already been made. This is not observation care.
Outlier	A patient whose diagnosis, acuity, care needs, location, duration or responsible team falls outside the approved observation model and requires immediate senior review.

4. Service models and time limits

Feature	Track A: Same-day / ambulatory	Track B: Bedded observation / short stay
Purpose	Complete focused diagnostics or treatment while the patient remains stable and generally ambulatory.	Complete structured overnight or extended assessment / treatment when a bed and continuous nursing are required.
Expected duration	Usually 2-8 hours after placement.	Usually 6-24 hours after placement.
Maximum duration	8 hours; no overnight stay.	24 hours. At 24 hours, discharge, formal inpatient admission or transfer is mandatory.
Typical environment	Dedicated chairs / recliners with examination trolley, oxygen, monitoring and emergency call access.	Designated beds with appropriate observation, toileting, pressure care, sleep and emergency-response capability.
Selection threshold	High likelihood of discharge within the service opening period.	High likelihood of discharge by 24 hours after one defined episode of assessment or treatment.
If target is missed	Reassess immediately; discharge, convert to Track B if eligible and capacity exists, or admit / transfer.	Do not extend status. Convert to admission / transfer or discharge, even if the patient remains physically in the same bed.

5. Eligibility: all criteria must be met

PLACEMENT TEST: "What exactly are we observing or treating, what must happen next, by when, and what result will cause discharge or admission?" If the team cannot answer all four parts, the patient is not ready for observation placement.

- Initial ED assessment is complete enough to identify the working diagnosis, important alternatives and immediate risks.
- Airway, breathing, circulation, neurological status, pain and temperature are stable or improving, and no resuscitation-level intervention is anticipated.
- The patient meets an approved pathway or a senior emergency clinician documents why individualized observation is safe.
- There is a single principal clinical question or a small, coherent set of problems that can reasonably be resolved within the track time limit.
- The required monitoring, medication, nursing care, diagnostics, specialist input and rescue response are available during the entire planned stay.
- The probability of discharge is sufficiently high to justify observation rather than direct admission. As a local governance target, most pathway cohorts should discharge at least 70% of patients.

- The patient and family understand the plan, expected duration, possibility of admission and how usual medicines, food, mobility and communication needs will be managed.
- Consent / capacity, safeguarding, infection-control, mobility, toileting, behavioural and communication needs can be safely met in the unit.
- A named responsible clinician accepts care, a named nurse receives handover, and an observation order / entry note with milestones is complete.

6. Exclusion criteria

Exclude / remove from observation	Required pathway
Physiological instability; rising early-warning score; recurrent syncope; ongoing chest pain with high-risk features; severe respiratory distress; active bleeding; new focal deficit; status epilepticus; severe sepsis / shock; need for vasopressors, invasive ventilation or intensive monitoring.	Remain in acute / resuscitation care; activate the relevant emergency protocol and critical-care / specialty pathway.
Clear need for inpatient admission, surgery, procedural intervention, continuous IV therapy beyond the time limit, prolonged oxygen, dialysis, transfusion, obstetric admission, or specialty management.	Formal admission or urgent transfer.
Patient already accepted for admission or transfer, awaiting an inpatient bed, theatre, procedure, ambulance, residential placement or discharge transport.	Boarding / admitted-patient or transfer-waiting pathway; observation clock ends.
Acutely confused, delirious, severely intoxicated, violent, absconding risk, high-risk self-harm, or protected mental-health need beyond the unit's staffing / security capability.	Protocol 42 / 44 and appropriate protected, medical or mental-health setting.
Unresolved safeguarding threat, unsafe home, lack of essential caregiver or social barrier that is unlikely to resolve within the planned episode.	Safeguarding / social-work escalation and appropriate admission or safe-placement pathway.
Airborne / high-consequence infection or isolation need that the unit cannot safely accommodate.	Approved isolation area under Protocol 54.
Need for one-to-one nursing, continuous cardiac monitoring, frequent neuro-observation or paediatric / maternity monitoring beyond locally approved ratios.	Higher-acuity or specialty setting.
Elective infusion, scheduled procedure, routine post-anaesthetic recovery, routine dressing / blood test, outpatient treatment, or admission solely for convenience.	Correct elective, outpatient, procedure or community service.
Expected care duration exceeds 8 hours for Track A or 24 hours for Track B at the time of placement.	Direct admission / transfer or alternative pathway.

7. Placement and acceptance workflow

1. Complete initial ED evaluation, stabilization, medication reconciliation, infection screen, safeguarding screen and essential risk-stratifying tests.
2. Confirm approved pathway and track; document the clinical question, differential diagnosis, current status, treatment already given and unresolved risks.
3. Write observation orders that include monitoring frequency, permitted diet / activity, regular and PRN medicines, investigations, repeat examination, consultation, VTE / falls / pressure precautions and escalation triggers.
4. Set time-stamped milestones and a planned disposition deadline. Record the maximum end time at the top of the chart / electronic tracking board.
5. Provide patient-facing explanation: why observation is recommended, where care will occur, expected duration, who is responsible, what tests or treatments are planned and what may lead to admission.
6. Obtain verbal acceptance from the designated nurse and clinician. Transfer with structured handover and all results, ECGs, images, property, medicines and communication needs.
7. Record baseline observations on arrival to the unit within 15 minutes unless a complete stable set was documented within the preceding 60 minutes.
8. Update the tracking system and maintain visibility of total hospital time from original arrival.

8. Minimum observation care plan

Domain	Required content
Clinical question	One sentence defining what observation must determine or achieve.
Working diagnosis / risks	Leading diagnosis, dangerous alternatives considered, and why immediate admission is not currently required.
Monitoring	Vital signs / early-warning score, cardiac / oxygen / neurological monitoring, pain, intake / output, mobility, behaviour or other pathway-specific measures.
Investigations	Tests already completed; repeat or serial tests; exact timing; responsible person for review; action thresholds.
Treatment	Medication, fluids, inhaled therapy, wound care, mobility, oral challenge or other intervention; response target and rescue plan.
Milestones	Time-stamped targets for symptoms, physiology, tests, function and readiness for discharge.
Escalation	Specific deterioration or non-response triggers; who must be called; required destination.
Disposition deadline	Planned decision time and absolute track maximum.

Domain	Required content
Discharge needs	Medicines, education, follow-up, transport, caregiver, mobility aid, pending-result plan and return precautions.
Responsible team	Named clinician, nurse and any specialty / allied-health involvement; next mandatory review time.

9. Review intervals and reassessment standard

FREQUENCY RULE: The intervals below are minimum operational safeguards, not substitutes for clinical judgment. Use more frequent observations and reviews whenever required by physiology, pathway, treatment, age, comorbidity or concern. Any staff or family concern triggers immediate reassessment.

Review	Minimum standard
Arrival to observation area	Nursing reception and safety check immediately; full observations / early-warning score within 15 minutes unless a complete stable set was recorded within the previous 60 minutes.
Vital signs / early-warning score	At the pathway-defined frequency and at least every 4 hours in a bedded observation patient. Repeat sooner after abnormal findings, medication, fluid, bronchodilator, analgesia, oxygen change or clinical concern. Continuous monitoring only when indicated and supported.
Nursing reassessment	After every significant intervention; at least every 4 hours for symptoms, mental state, pain, mobility, intake / output, skin, falls risk, access devices and progress toward milestones.
Treating clinician	Observation entry note before placement; review within 2 hours of placement when not performed contemporaneously; then at least every 6 hours and immediately after deterioration, critical result, failed milestone or nurse escalation.
Senior emergency clinician	Approval before placement when the patient is complex or outside a standard pathway; mandatory disposition review by 8 hours for Track A and by 12 hours and again before 24 hours for Track B.
Medication / pharmacy	Reconcile usual medicines at placement; review high-risk medicines, renal dosing, anticoagulation, insulin and antimicrobial plan during each clinician review and at every transition.
Handover	Bedside / structured handover at every nursing and medical shift change, including observation start time, absolute deadline, unresolved risks, pending results and next milestones.
Special populations	Use age-specific PEWS / NEWTT, obstetric observations, neuro-observation, withdrawal scale or other validated pathway when applicable; the pathway interval overrides the generic minimum.
No-progress trigger	If no meaningful progress by the first planned milestone or if a key test / consultation cannot occur within the remaining time, obtain senior review and revise disposition immediately.

10. Time-based milestones

Time from placement	Mandatory actions
0-2 hours	Confirm handover, baseline observations, orders and deadline; begin planned treatment / serial testing; correct pain, nausea, hydration, mobility and usual-medication omissions; verify patient understanding.
2-4 hours	Review response and first results; repeat focused examination; identify diagnostic delay; escalate abnormal physiology or failed response. Track A patients should be clearly progressing toward discharge.
6-8 hours	Senior disposition review for Track A. Discharge when criteria are met; convert to eligible Track B only through a new documented acceptance; otherwise admit / transfer. Do not keep an ambulatory patient overnight under Track A.
8-12 hours	For Track B, complete overnight plan, medication reconciliation, nutrition / hydration, mobility, falls / pressure measures and pending-test ownership. Senior review by 12 hours.
12-18 hours	Confirm that remaining tasks can be completed by 24 hours. Resolve specialty advice, imaging, functional assessment and discharge support. Failure to progress should usually trigger admission.
18-24 hours	Final senior review and disposition. Complete discharge or formal admission / transfer before the 24-hour observation limit. Record any system delay and manage the patient under the admitted / boarding standard after conversion.

11. Deterioration and immediate conversion triggers

- Any airway threat, worsening oxygen requirement, respiratory fatigue, haemodynamic instability, acute neurological change, seizure, significant bleeding, severe allergic reaction or other emergency.
- Rising early-warning score, repeated abnormal observations, new fever with sepsis concern, recurrent severe symptoms, uncontrolled pain or repeated need for rescue medication.

- Critical laboratory / imaging / ECG result or a new diagnosis that requires inpatient, operative, invasive, specialist or critical-care treatment.
- Failure to meet a time-stamped milestone, inability to complete essential diagnostics or consultation before the deadline, or expected treatment now exceeding track capability.
- New delirium, agitation, self-harm risk, absconding risk, safeguarding concern, functional decline or inability to maintain oral intake / medication / mobility safely.
- Patient or family preference for admission when clinically reasonable, or refusal of the observation plan requiring reassessment under Protocol 51.
- Any clinician or nurse judgment that observation is no longer the safest setting.

Action: move the patient to the appropriate acute-care area, activate the relevant emergency protocol, notify the senior emergency clinician and accepting service, document the time and reason, and end observation status. Do not wait for the next scheduled review or the maximum duration.

12. Condition-specific pathway library

Observation is safest when delivered through locally approved pathways. The following are examples for governance consideration, not automatic indications. Each condition requires its own risk stratification and must cross-reference the relevant clinical protocol.

Potential pathway	Required safeguards before local approval
Low-risk chest pain	Validated risk pathway, serial ECG / troponin timing, recurrent-pain trigger, clear stress / imaging / follow-up arrangement where indicated.
Syncope / transient collapse	Exclusion of high-risk cardiac, neurological, bleeding and orthostatic causes; rhythm monitoring capability; documented risk tool and follow-up.
Mild-to-moderate asthma / COPD	Objective response measures where feasible, oxygen target, bronchodilator / steroid plan, deterioration criteria, inhaler technique and discharge bundle.
Dehydration / vomiting / diarrhoea	Fluid plan, electrolytes / glucose when indicated, oral challenge, infection precautions, urine / renal targets and vulnerable-patient exclusions.
Renal colic / selected abdominal pain	Analgesia target, urinalysis / pregnancy testing, renal function and imaging criteria, serial abdominal examination, sepsis / obstruction / surgical triggers.
Cellulitis / selected infection	Sepsis excluded, approved antimicrobial pathway, comorbidity / immunosuppression limits, response criteria and outpatient follow-up.
Minor head injury	Approved neuro-observation schedule, anticoagulation / age criteria, imaging and deterioration thresholds, competent supervision after discharge.
Allergic reaction after treatment	Anaphylaxis excluded / treated; defined post-reaction observation interval based on severity and risk; adrenaline education and follow-up.
Recovered seizure / low-risk toxicology	Return to baseline, cause-specific testing, recurrence / antidote / monitoring thresholds, poison-centre or specialist advice where available.
Paediatric short observation	Separate paediatric-approved staffing, PEWS, weight-based medicines, safeguarding, caregiver presence and age-specific discharge criteria under Protocol 40.
Frailty / falls assessment	No delirium or occult high-risk injury requiring admission; medication, mobility, orthostasis, caregiver and safe-environment assessment under Protocol 44.

13. Supportive and preventive care during observation

- Continue clinically important usual medicines unless intentionally withheld; document reasons for every omission. Avoid medication duplication after ED doses.
- Provide food, fluids and assistance unless restricted for a defined clinical reason. Reassess fasting regularly and avoid prolonged unnecessary nil-by-mouth status.
- Assess falls, pressure injury, mobility, toileting, continence, sleep, sensory aids and communication. Mobilize when safe and avoid leaving older or frail patients on trolleys for prolonged periods.
- Assess VTE risk when reduced mobility or stay duration makes this relevant, following local policy; observation status does not remove preventive-care responsibilities.
- Use infection-prevention precautions and appropriate isolation. Do not place communicable disease in a shared observation area that cannot safely contain transmission.
- Ensure analgesia, antiemesis and symptom relief are prescribed with reassessment. Persistent severe symptoms are a reason for senior review, not repeated indefinite rescue dosing.
- Protect privacy and dignity; provide interpreter, disability accommodation, chaperone and family / caregiver participation as appropriate.
- For overnight care, provide a safe sleep environment, call bell, lighting, security, medication storage, access to hygiene and a plan for night-time deterioration.

14. Diagnostic tests, consultations and pending results

- Order only tests that can change the observation decision or treatment. Record who will review each result and by what time.
- Diagnostics for observation patients must have turnaround times that allow completion within the track limit. A predictable delay beyond the deadline should trigger alternative disposition, not passive waiting.
- Critical results must be communicated immediately through the laboratory / imaging escalation process and acknowledged by a clinician.
- Specialty consultation must include a clear question, expected response time and responsibility while advice is pending. Observation must not become a waiting room for an undefined specialty opinion.

- At discharge, all results required for immediate safety must be reviewed. Any genuinely pending result needs a named owner, verified contact details, action threshold, documented patient explanation and closed-loop follow-up under the hospital pending-results policy.
- At handover, the outgoing clinician and nurse must explicitly identify outstanding results, consultations, milestones and the observation deadline.

15. Discharge criteria: all applicable elements must be met

Domain	Discharge standard
Clinical stability	Vital signs appropriate for age and baseline; no concerning trend; symptoms controlled with a sustainable home plan; no new emergency finding.
Clinical question resolved	Required serial examination, treatment response, diagnostic test or functional trial is complete and supports discharge.
Function	Safe mobility / transfers, oral intake, urination, cognition and self-care at baseline or supported level; essential aids and caregiver capacity confirmed.
Medication	Reconciliation complete; prescriptions and first doses arranged; patient understands changes, high-risk medicine precautions and when to restart withheld medicines.
Follow-up	Appropriate primary, specialty, virtual, community or return appointment arranged with realistic access and responsibility.
Results	All immediate-safety results reviewed; pending-result owner and callback plan documented.
Communication	Diagnosis and uncertainty explained; written instructions, red flags and return route provided in understandable language; teach-back used for high-risk plans.
Logistics	Safe transport, destination, supervision and access to medicines / equipment confirmed. Discharge is not delayed solely for convenience when a safe alternative exists.
Documentation	Final clinician examination, observation course, results, treatment, diagnosis, follow-up and discharge time recorded; discharge summary sent through the approved system.

16. Conversion to admission or transfer

1. Document the reason observation criteria are no longer met, the clinical status, treatment given, unresolved risks and urgency.
2. Notify the senior emergency clinician, nurse in charge, bed manager and accepting service. Use the escalation pathway if acceptance or bed allocation is delayed.
3. Enter a formal admission / transfer order and time. The patient is no longer counted as an observation patient, even when physically remaining in the same area.
4. Upgrade monitoring, staffing, medication, nutrition, VTE, pressure, infection and specialty-review standards to those required for an admitted / transfer-waiting patient.
5. Give structured handover and ensure continuity of all time-critical treatment and pending results.
6. Track and report post-decision boarding time separately. Do not use the observation unit to conceal exit block.

17. Special populations

Population	Additional safeguards
Older adults / frailty	Screen for delirium, falls, baseline function, polypharmacy, pressure injury, continence, nutrition and caregiver capacity. A social barrier likely to outlast the episode is an admission / safe-placement issue, not observation.
Children / adolescents	Use paediatric-approved pathways, staffing, PEWS, weight-based medicines, caregiver presence and safeguarding. Neonates require Protocol 41 and specialty oversight.
Pregnancy / postpartum	Use obstetric-specific thresholds, fetal / maternal monitoring and early obstetric consultation. Do not substitute general observation for required maternity admission.
Mental-health or substance-related presentations	Medical observation may be appropriate only when behaviour, self-harm and absconding risks can be safely managed and the clinical objective is defined. Protected mental-health waiting is not routine observation.
Disability / communication needs	Provide reasonable accommodations, interpreter / communication aids, sensory equipment and caregiver participation; confirm the discharge plan is accessible.
Infectious risk	Use the correct isolation environment and PPE. Shared observation space must not override infection-control requirements.
People in custody / police care	Maintain independent clinical decision-making, privacy, medication continuity and safe custody handover; police presence does not replace nursing observation.

18. Documentation standard

- Initial ED assessment, stabilization, working diagnosis, risk stratification and reasons direct discharge or admission were not chosen.
- Observation order, track, start time, absolute deadline, named clinician and nurse, patient explanation and consent / capacity issues.
- Defined clinical question, pathway, monitoring frequency, tests, treatment, milestones, escalation triggers and expected disposition.
- All nursing observations, symptom and functional assessments, medicines, intake / output, mobility, skin and response to interventions.
- Clinician progress notes at required intervals and after significant change, including review of results and continued eligibility.
- Every handover, specialty discussion, advice received, delay, critical result and escalation action.
- Final disposition decision and time; discharge criteria / summary or admission / transfer reason and accepting team.
- Pending-result ownership, patient contact details, follow-up, written advice and return precautions.
- Any breach of the track time limit, inappropriate placement, boarding episode, incident, complaint or staffing / diagnostic failure.

19. Staff roles

Role	Responsibilities
Triage / streaming staff	Identify potential candidates but do not bypass full assessment or senior acceptance; maintain visibility of acuity and total ED time.
Referring ED clinician	Complete initial assessment, risk stratification, stabilization, observation plan, orders, patient explanation and structured handover.
Responsible observation clinician	Own ongoing care; review at defined intervals; act on results; coordinate consultation; decide discharge or admission within the time limit.
Senior emergency clinician	Authorize complex / non-standard cases; conduct mandatory disposition reviews; resolve conflict; protect criteria and prevent boarding / mission creep.
Observation nurse	Receive handover, complete baseline safety checks, deliver protocol care, monitor milestones, escalate deterioration, maintain supportive care and coordinate discharge.
Nurse in charge	Match staffing to acuity, control admissions to the unit, identify outliers and time-limit breaches, and activate operational escalation.
Specialty team	Provide timely focused advice or accept admission when criteria are met; consultation does not transfer responsibility unless explicitly agreed and documented.
Pharmacist	Support reconciliation, high-risk medicines, antimicrobial plans, renal dosing, discharge supply and medication education.
Allied health / social work	Provide time-limited functional, mobility, equipment, communication or safeguarding input; escalate barriers that cannot be resolved within the episode.
Bed management / operations	Support rapid conversion to admission / transfer, preserve designated observation capacity and report boarding / access failures.
Diagnostics / information services	Provide agreed turnaround, critical-result communication, patient tracking and reliable downtime processes.
Clinical governance lead	Maintain pathways, audit outcomes, review adverse events and outliers, and oversee education and improvement.

20. Quality and safety indicators

Measure	Suggested local standard / review
Appropriate selection	Percentage meeting all eligibility criteria; inappropriate placements and exclusions overridden; case mix by approved pathway.
Length of stay	Median and 90th percentile by track / pathway; percentage completing Track A within 8 hours and Track B within 24 hours; every breach reviewed.
Disposition	Discharge rate by pathway; conversion to admission; return to acute ED; transfer; unexpected ICU / theatre within 24 hours.
Deterioration	Rapid-response calls, cardiac arrest, unplanned ventilation, critical-result delay, severe medication event, fall, pressure injury, absconding and safeguarding incident.
Process reliability	Entry observations within 15 minutes; clinician review within 2 hours; required senior reviews completed; milestones and pending-result ownership documented.
Flow integrity	Number of admitted / transfer-waiting patients occupying observation spaces; post-decision boarding time; unit closures or bedded escalation use.
Discharge quality	Written instructions, medication reconciliation, summary sent, follow-up arranged, related 72-hour / 7-day return and subsequent admission.
Experience / equity	Patient and caregiver feedback; interpreter and disability access; outcomes reviewed by age, sex, ethnicity, socioeconomic and other locally relevant equity variables.

Measure	Suggested local standard / review
System performance	Diagnostic turnaround, specialty response, staffing gaps, pharmacy / transport delays and incidents attributed to unavailable services.
Governance	Monthly dashboard, pathway-level review, mortality / serious-incident review, action owner and completion date.

21. Training and simulation

- All medical, nursing and support staff must understand eligibility, exclusions, track time limits, observation orders, escalation, admission conversion and pending-result processes.
- Competency should include early-warning systems, recognition of deterioration, structured handover, medication reconciliation, falls / pressure prevention, capacity, safeguarding, infection control and safe discharge.
- Annual multidisciplinary simulation should include: chest pain recurrence; respiratory deterioration; delirium / absconding; critical result after handover; Track A patient not ready at 8 hours; and a patient crossing 24 hours without an inpatient bed.
- Unit leaders should review outlier cases and time-limit breaches with staff, emphasizing system repair rather than normalization of unsafe workarounds.

22. Evidence base and source guidance

Source	Key use in this protocol
Royal College of Emergency Medicine. Extended Emergency Medicine Ambulatory Care, Version 2, February 2026.	Current same-day EM selection, exclusions, high likelihood of discharge, maximum 8-hour stay, senior ownership, observation within 15 minutes, diagnostic turnaround, KPIs and warning against off-clock / dumping-ground use.
NHS England. Same Day Emergency Care Service Specification, September 2024.	Same-day alternative to admission, stable-patient selection, robust gatekeeping, exclusion of unstable / admitted / discharge-waiting patients, senior decision-making, diagnostics, discharge processes, workforce and governance.
American College of Emergency Physicians. Observation Services Toolkit, current online resource.	Service design, policy, protocol, quality-improvement, staffing, documentation and condition-specific pathway resources.
American College of Emergency Physicians. State of the Art: Observation Units in the Emergency Department, Policy Resource and Education Paper.	Foundational definition of active observation, typical 6-24-hour cohort, high discharge probability, dedicated-unit leadership, protocol-driven care, maximum duration, documentation and quality metrics.
Hospital presentation-specific protocols and approved specialty guidance.	Condition-specific risk stratification, tests, treatment, reassessment, discharge and admission criteria.
Local admission, nursing, pharmacy, infection-control, safeguarding, pending-results, transfer and information-governance policies.	Operational authority and local legal / resource configuration required before approval.

Annex A. Rapid eligibility and exclusion checklist

Question	Yes / No / details
Initial ED assessment and stabilization complete?	☐ Yes ☐ No _____
Defined clinical question and approved pathway?	☐ Yes ☐ No _____
Stable physiology / acceptable early-warning score?	☐ Yes ☐ No score _____ trend _____
No clear inpatient / operative / critical-care need?	☐ Yes ☐ No _____
Required tests, treatment, monitoring and rescue available?	☐ Yes ☐ No _____
High likelihood of discharge within selected track?	☐ Track A ≤8 h ☐ Track B ≤24 h probability / rationale _____
Behaviour, safeguarding, infection and mobility needs manageable?	☐ Yes ☐ No _____
No unresolved social barrier likely to exceed the episode?	☐ Yes ☐ No _____
Named clinician and nurse accept responsibility?	Clinician _____ Nurse _____ time _____
Start time and absolute deadline recorded?	Start _____ planned decision _____ absolute deadline _____
Patient / caregiver understands and accepts plan?	☐ Yes ☐ No / capacity issue _____
Senior approval when required?	Senior _____ time _____ comments _____

Annex B. Observation care plan and milestone form

Field	Record
Patient / encounter	Name _____ DOB _____ number _____ date _____
Track / times	Track A ☐ Track B ☐ start _____ planned decision _____ absolute deadline _____
Responsible staff	Clinician _____ Nurse _____ Senior reviewer _____
Clinical question	_____
Working diagnosis / dangerous alternatives	_____
Baseline status / early-warning score	_____
Monitoring orders	_____
Investigations and review owner	_____
Treatment / response target	_____
Milestone 1 / time	_____
Milestone 2 / time	_____
Escalation / admission triggers	_____
Discharge requirements	_____
Next clinician review	Time _____ reviewer _____
Patient / caregiver explanation	Completed by _____ at _____ interpreter / aid _____

Annex C. Review and escalation timetable

Time / trigger	Review / action	Completed
Arrival	Nurse reception, baseline safety check, observations within 15 min unless recent stable set.	_____
Within 2 h	Clinician review if not completed at placement; verify plan and milestones.	_____
After intervention / abnormal result	Repeat relevant observations, symptoms and focused examination.	_____
At least q4 h	Nursing reassessment and vital signs for bedded patient, or more frequently per pathway.	_____
At least q6 h	Clinician progress review, results, continued eligibility and next milestone.	_____
8 h	Mandatory Track A senior disposition: discharge / new Track B acceptance / admit / transfer.	_____

Time / trigger	Review / action	Completed
12 h	Mandatory Track B senior review; verify remaining plan can finish by 24 h.	_____
18 h	No-progress check; unresolved diagnostic / specialty / social barrier usually triggers admission.	_____
Before 24 h	Final senior disposition; end observation status.	_____
Any deterioration	Immediate acute review, relevant protocol, move to suitable area and convert status.	_____

Annex D. Discharge or admission conversion checklist

Discharge checklist	Admission / transfer checklist
☐ Stable observations and symptoms	☐ Reason observation criteria no longer met
☐ Clinical question resolved	☐ Senior and accepting service notified
☐ Final examination documented	☐ Formal admission / transfer order and time
☐ Function, intake, mobility and support safe	☐ Monitoring / treatment upgraded as required
☐ Medication reconciliation and supply complete	☐ Pending results / consultations handed over
☐ Required results reviewed	☐ Structured nursing and medical handover
☐ Pending-result owner documented	☐ Patient / family updated
☐ Follow-up arranged	☐ Observation status and clock ended
☐ Written red flags / return route / teach-back	☐ Boarding time tracked separately
☐ Transport / destination confirmed	☐ Incident / escalation record if delay or breach
☐ Summary sent and discharge time recorded	Accepting team _____ time _____

Annex E. Condition-specific pathway approval template

Required pathway element	Approved content / document location
Presentation / target cohort	_____
Inclusion criteria	_____
Exclusion / high-risk criteria	_____
Required ED assessment before placement	_____
Track and expected duration	_____
Monitoring / review frequency	_____
Investigations and exact timing	_____
Treatment and response targets	_____
Deterioration / rescue plan	_____
Discharge criteria and follow-up	_____
Admission / specialty triggers	_____
Medication / pharmacy validation	_____
Owner, approval and review date	_____
Audit measures	_____

Annex F. Local configuration before approval

Item	Approved local rule / contact / document location
Observation unit name, location and capacity	_____
Track A opening hours / 8-hour process	_____
Track B bedded capability / 24-hour process	_____
Clinical ownership and senior cover	_____
Medical and nursing staffing ratios / skill mix	_____
Approved early-warning thresholds	_____
Monitoring and emergency equipment	_____
Approved condition-specific pathways	_____
Diagnostic turnaround agreements	_____
Specialty response and admission escalation	_____
Medication reconciliation / pharmacy support	_____

Item	Approved local rule / contact / document location
Food, hydration, mobility, falls / pressure care	_____
Paediatric / maternity eligibility	_____
Mental-health / safeguarding arrangements	_____
Isolation / infection-control capacity	_____
Pending-results and callback policy	_____
Discharge summaries / primary-care communication	_____
Transport / community / virtual-care links	_____
Surge, downtime and unit-closure plan	_____
Dashboard owner and governance meeting	_____