OBSERVATION UNIT
ASTHMA PATHWAY OUTLINE
Westmoreland Hospital

Exclusion Criteria: (Reason to admit to hospital)
A. New EKG changes except sinus tachycardia
B. Respiratory Rate > 40
C. Signs/symptoms of Heart Failure
D. Impending respiratory failure or history of sudden, severe exacerbation / intubation / critical care admission for asthma
E. Peak flow < 200 Liters/minute
F. ABG with pCO2 > 45 or pO2 < 70, SaO2 < 90% on room air
G. Infiltrate on CXR
H. Bronchospasm due to allergic reaction or aspiration
I. Temperature > 102 F
J. Associated Pulmonary Embolus
K. Failed outpatient treatment or second outpatient visit for asthma in past 2 days

Obs. Interventions:
A. Serial exams including vitals every 4 hours
B. Pulse oximetry monitoring
C. Supplemental oxygen
D. Repeat ABG as indicated
E. Hydration
F. Systemic steroids and Inhaled bronchodilators
G. Peak flow measurements as needed

Disposition Criteria:
A. HOME
   1) Significant improvement of symptoms / clinical stability
   2) Stable vital signs
   3) Improved wheezing with peak flows > 60 % predicted

B. ADMIT TO HOSPITAL
   1) Inability to correct symptoms within observation period
   2) Determination of a diagnosis that requires admission
Place on Observation Unit for Observation Services due to (reason): ____________

Directed H&P Dictated: [ ] YES [ ] NO
PCP: ___________________________

ORDERS:
- Nursing to check vitals with Pulse Oximetry and assess symptoms every 4 hours
  Call for respiratory rate > 35, respiratory distress, or increasing oxygen requirements
- Activity: Up as tolerated with assistance as needed and OOB to chair t.i.d.
- Allergies: ________________________________________________________________
  ________________________________________________________________
- Reinforce observation status with patient including anticipated length of stay less than 23 hours

Choose all the following that apply:

Diet: [ ] Cardiac  [ ] CCHO  [ ] NPO  [ ] Other ________________
[ ] IV Fluids  Type _______________ at ___________ml/hour

Supplemental Oxygen:
- Liter Flow___________ /minute  via ________________
  Maintain oxygen saturation of _____________

Physician Signature __________________________ Date ________ Time ________
ORDERS (continued)

Medications:
• Physician to review Admission Medication Reconciliation Form (to see allergies and continue/discontinue/clarify patient home medications and add any additional medications needed for Observation - Asthma from the list below).
*Nursing will scan all orders to the pharmacy along with Admission Medication Reconciliation Form.

- Albuterol Unit dose nebulizer every 4 hours and every 2 hours p.r.n. wheezing or dyspnea
- Atrovent Unit dose nebulizer every 4 hours
- Solumedrol mg IV every 4 hours
- Protonix 40mg now and daily  Route:  p.o.  IV
- Pepcid 20mg now and  every 12 hours  or  daily (for GFR < 50)
  Route:  p.o.  IV
- Tylenol 650 mg p.o. every 6 hours PRN pain
- Zofran 4 mg p.o. every 6 hours PRN nausea
- Compazine mg IV every 6 hours PRN nausea
- OTHERS: ___________________________________________________

Labs and studies:
- Lytes, Mg  Bun/ Cr  CBC/diff
  - Tomorrow AM or  At ____________________ (Specify date and time needed)

- Peak Flows 3 times Q Shift and record

- Chest X-ray – Reason: __________________________________________
  - Tomorrow AM or  At ____________________ (Specify date and time needed)

- Other _______________________________________________________

Physician Signature _________________ Date _______ Time _______
PROGRESS NOTES: (date, time and sign each entry)
Briefly document any interim patient encounters here.

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Disposition (If admitted as “Inpatient”, document rationale):
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

DISCHARGE NOTE/ADDENDUM TO H & P DICTATED: □ YES □ NO

Physician Signature _________________ Date _______ Time _______
PHYSICIAN (Discharge):
- Review Discharge Medication Reconciliation Form.
- Prescriptions provided for: ____________________________________________________________
- Complete Patient Discharge Instructions.
- Discharge condition _________________________________
- Discharge to _______________________________________

DISCHARGE ORDERS (Check [✓] when done and initial)

Nursing
☐ Smoking cessation packet given on admission, if patient is a current smoker or quit within the past year. RN ______
☐ Asthma Education Folder given on admission. RN ______
☐ Reinforce use of Metered-Dose Inhaler ☐ N/A RN ______
☐ Patient signs Discharge Instructions after review RN ______
☐ Patient given, verbalizes understanding, and signs Medication Reconciliation Home Instructions Form RN_______
☐ Patient verbalizes understanding of recommended follow-up RN_______

Case Management (CM)
To be done as close to start of care as possible:
☐ Reinforce observation status with patient including anticipated length of stay less than 23 hours
☐ Assess for discharge needs ☐ Assess for transportation needs
At Discharge:
*CM Contact patient’s Primary Care Physician or covering physician to inform PCP the patient was in Observation Unit for asthma. CM______
*CM Complete the “Physician Notification” form and fax to PCP. CM______
*Nursing to do after hours RN ______

Physician Signature __________________________ Date ________ Time _____
RN Signature ________________________________ Date ________ Time _____
CM Signature ________________________________ Date ________ Time _____