Background:
Low risk chest pain (LRCP) patients being ruled out for acute coronary syndrome were frequently placed in observation status with an average length of stay (LOS) of 30.5 hours, far higher than the national standard for this subset of patients. The placement of LRCP patients to a standard telemetry unit proved challenging to all professional staff due to inadequate education and existing policies and procedures that were non specific concerning observation patients’ priority status. This resulted in delayed testing which increased LOS. Our goal was to decrease the length of stay through evidence-based expedited care of observation patients.

Methods:
In April 2015, a multidisciplinary Process Improvement (PI) committee was formed and met for 3 consecutive weeks at 4 hour intervals to identify all issues surrounding the prevention of an acceptable LOS. A process mapping was developed to track a LRCP patient from arrival to ED to final disposition and the results revealed a 27.5 hour LOS. Barriers to improvement were discovered and the team was asked to grade them utilizing an occurrence scale and formulate action plans for the highest ranking barriers. Flowcharts were developed for nurse to nurse communication between departments focusing on testing triage and patient expedition. Stress testing protocols were established to educate physicians and nursing and placed in 3 ring binders on all floors where LRCP patients were located. Case management reviewed TIMI score criteria for inpatient verses observation patient to reduce denial for services due to inappropriate status. Accelerated diagnostic testing protocols, such as off hours testing and accompanying teaching tools were introduced and, with administrative support, an Observation Module was developed and in-services were conducted to all nursing staff.

Results:
The implementation of best practice models and collaborative team efforts through process improvement provided the following outcomes: • Six months after implementation of the PI initiative, a reduction of 10 hours from patient placement in Observation to final disposition was realized. • Reduction of inappropriate inpatient status orders for low risk chest pain patients. • Improved collaboration with interdisciplinary team. • Decreased stress testing times from order to results. • Accelerated diagnostic protocols were adopted by attending physicians and resulted in 2 patient cases that were 56 and 49 hours under the 72 hour best practice model. • Cost avoidance and bed allocation for the more acute patient.
Conclusion:
The Process Improvement approach to the expedited care of the LRCP patient created a platform for introducing initiatives that improved the overall flow of these targeted patients. Decreased LOS and cost savings through enhanced patient care methods proved successful after a brief period of implementation. Although we have not realized our goal of 15-18 hours to final disposition, the team is confident the target will be met.