Triage ~ A Time to Change

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1) Purpose:
ED triage nurses complained about an ineffective triage process where arriving patients could be missed or treatment could be delayed. The goal for this evidence-based project was to create a triage process, utilizing the Emergency Severity Index (ESI) triage tool and resources to rapidly triage arriving patients, document within the electronic medical record, and direct room patients while communicating with the patient and the ED team effectively.

2) Design:
• A shared governance, volunteer sub-committee including 8 ED nurses representing day and night shift, with a range of triage experience.
• Weekly one hour meetings occurred over a six week period.
• An agreed upon agenda was created to keep "on task" with the committee work.
• Concerns with the current triage process were identified.
• An attainable, objective goal was agreed upon.
• Assigned tasks were disseminated to members of the group.

3) Setting:
• Level III Trauma Center and Primary Stroke Center located in the Pacific Northwest.
• 55,000 visits annually serving a patient population within a large rural, geographical area.
• 37 Bed ER
• 71 RN's & 35 ED Tech's

4) Methods:
A shared governance, sub-committee of ED triage nurses worked together in collaboration, each working on an assignment.

Problems Identified:
• Chaos in triage.
• Delay in triage, delay in arrival to room/ physician evaluation times.
• Inefficiency utilizing a new Electronic Medical Record (EMR).

Team Assignments:
• Analysis of the ESI triage tool/ resources.
• Interpretation of triage requirements according to Washington State law.
• Review of available research & triage recommendations.
• ED Manager and 4 ED triage nurses visited 3 nearby hospitals to assess and compare current triage work flows.
• Data Analysis: Arrival to triage times, arrival to room times, & arrival to ED Physician evaluation times.

Recommendations:
Implementation of a new triage process.
• The primary triage nurse (aka triage one or pivot nurse) works simultaneously with registration and rapidly "sorts" or triages the patient immediately after arrival.
• The secondary triage nurse (aka triage two) to complete the triage process, initiate Nurse Initiated Standing Orders (NISO's).

5) Results/Outcomes:
A two phase triage process was implemented. Upon arrival, the primary triage RN also referred to as "triage one" or "pivot nurse" immediately interviews the patient to "sort" or triage utilizing the ESI triage tool. Triage 2 nurse completes triage and implements NISO’s.

• Immediate documentation within the EMR is available for the health care team to access. Based on triage acuity and room availability patients are immediately directed to a room for evaluation by the ED physician.
• "Pull to Full" teamwork provides rapidly rooming patients.
• Arrival to triage times have improved from 4 minutes to 3 minutes.
• Arrival to room times have decreased from 23 minutes to 13 minutes.
• Arrival to provider times have decreased from 55 minutes to 22 minutes. The process continues to be evaluated.

6) Implications:
Improved staff satisfaction and morale. Education and mentoring is necessary for this to be effective and should be promoted through our professional organization and all ED leaders.

References