# ACCELERATE THE ED INTAKE PROCESS

## JOHN MUIR MEDICAL CENTER

**Publication Year:** 2005

## Summary:
Changes to the triage process were made to accelerate ED intake, focusing on three initiatives: direct-to-bed, mini-triage and mini-registration, placing patients into the system faster. The position of a floating triage nurse was also instituted to support these initiatives.

## Category:
- A: Arrival
- B: Bed Placement
- C: Clinician Initial Evaluation & Throughput

## Key Words:
- Door-to-Doc
- Patient Satisfaction
- Rapid Intake
- Registration
- Wait Times

## Hospital:
John Muir Medical Center

## Location:
1601 Ygnacio Valley Road
Walnut Creek, CA 94598

## Hospital Metrics:
*(Taken from the FY2005 AHA Annual Survey)*
- Annual ED Volume: 43,902
- Hospital Beds: 324
- Ownership: Not-for-profit
- Trauma Level: 2
- Teaching Status: No

## Tools Provided:
- **Protocols on triage float nurse**
  This tool is a two-page document explaining the procedures of the triage float nurse, and is used by management and potential staff to understand the responsibilities and role of the floating triage nurse.

- **Triage Policy and Procedure**
  This tool is a nine-page document explaining the policies and procedures of the triage, and is used by management and all staff involved in triage as a tool to understand the triage process.

## Clinical Areas Affected:
- Emergency Department
- Registration
- Triage

## Staff Involved:
- Nurses
**Innovation**

John Muir Medical Center made several changes to its triage process in order to accelerate ED intake. These changes focused on three initiatives: direct-to-bed, mini-triage and mini-registration. These initiatives allow the patient to be placed into the system faster. In order to avoid confusion of roles and procedures, the triage protocol clearly states how these initiatives work together and in support of one another to accelerate the intake process. The position of a floating triage nurse was also instituted to support these initiatives.

One of the key drivers to patient satisfaction is “time to the physician.” It is well known that patients do not appreciate and value the time it takes to conduct traditional triage and registration processes. In addition, the value of these traditional processes is not clear when during certain times of the day, an ED bed exists. John Muir Medical Center’s ED leadership team recognized this when they began to accelerate the ED intake process.

Another factor they considered in targeting the intake process was that many other elements of the entire ED flow process (e.g. speed of inpatient admissions) is not controlled by the ED. However, the ED does control the ED intake process. The ED already established a five-minute triage standard, which bypasses triage altogether when beds are available. Another challenge was meeting the five-minute triage standard when there was a backup of patients due to no beds and during periods when there is a surge of patients. Having just one nurse perform this function was not going to allow them to meet their five-minute standard consistently during peak times.

**Results**

The door-to-physician initiative has been incredibly successful. Importantly there has been a substantial reduction to door-to-physician time (58 percent) which has been the overarching focus of the Quick Fix Committee. Their previous averages for door-to-physician time were averaging about 45 to 50 minutes and are now averaging in the low 20-minute range. Patient satisfaction remains at an all-time high of 95 percent of peer group. Overall efficiency and effectiveness of the ED has improved.

**Innovation Implementation**

The Quick Fix Committee identified direct-to-bed, mini-triage and mini-registration initiatives. While culturally these are big moves for the department’s staff and traditional operating methodology, buy-in was enhanced due to the fact that nurses, coordinators and emergency physicians were represented on the Quick Fix Committee (QFC). In addition, a floating triage position was established. “The float triage position was a big help because this person can move to where they are needed” says Julie Crouse, RN, MS, Director of Emergency Services. This includes triage, should there be a backlog. It is an additional resource that is valued by the staff and helps with the other new accelerated intake protocols (See Floating Triage Nurse Procedure and Triage Policy & Procedure).

**Advice and Lessons Learned**

Changing cultures away from traditional triage and traditional registration is a big challenge. The collaborative effort that formed the QFC was a big reason for its success. The float nurse position that was added from 7 a.m. to 1 p.m. was a crucial component because it allowed necessary resources to be moved to where the work was. This helped the staff see the value of the re-engineering intake process. Additionally, a robust patient tracking system allowed staff to quickly see the improvement changes in intake times.

**Tools to Download**

**Protocols on triage float nurse**

This tool is a two-page document explaining the procedures of the triage float nurse, and is used by management and potential staff to understand the responsibilities and role of the floating triage nurse.
Triage Policy and Procedure
This tool is a nine-page document explaining the policies and procedures of the triage, and is used by management and all staff involved in triage as a tool to understand the triage process.
This is a work in progress. Any feedback on how the Triage A_Triage B two triage RN system can work better is appreciated!

**Purpose:** To facilitate patient flow by moving patients into a treatment area ASAP so that assessment and treatment can begin (get rid of the Triage bottleneck). Adding another RN to Triage and obtaining the Primary RN intake information can help to speed up the front-end processes.

**Definitions**

*Triage:* To sort...assesses the minimum information necessary to determine the **acuity and bed placement** of the patient. That is: chief complaint, level of distress, pain rating, skin signs (color/capillary refill), pulse palpation (fast/slow, thready/full), respiratory effort (normal/rapid/shallow).

Triage’s next focus is to GET THE PATIENT IN A TREATMENT ROOM ASAP. He/she assigns and moves the patient to the treatment area/bed (and communicates patient movement to the Charge RN). If there is an empty treatment space, the triage information is the ONLY information that is obtained at Triage booth.

*Primary RN Intake:* The rest of the Primary RN intake...HPI, full set vital signs, PMHx, Meds, Allergies, Initial RN survey. It is the first patient interview...plus assessing/examining what is easily visible/accessible.

*Secondary RN Intake:* Should be done in a treatment area if at all possible. RN Secondary intake should be chief complaint(s) specific. Should include more in-depth interview if applicable and full assessment/examination of the patient. Should always include assessment of ALL complaints (for example, here with knee pain after a fall, needs head to toe exam for abrasions...found some on the elbows).

**Roles**

*Triage A:* Primarily stationed in the Triage booth, Triage A’s role is to “sort” and quickly determine acuity and bed assignment. If there is an empty bed/gurney/chair, Triage A takes the patient there and does the Primary RN Intake. She notifies the Charge RN that she is taking the patient there.

Triage A also notifies Triage B to go out to Triage booth for next patient. THERE SHOULD ALWAYS BE A NURSE IN THE TRIAGE BOOTH! DO NOT LEAVE THE TRIAGE AREA UNMANNED! After the Primary RN intake is accomplished, the Secondary RN assessment can be done. This can be done by Triage or if Triage has more patients or is complicated, give report to the Primary RN. Let Primary RN know that the Secondary assessment has not been completed. Transfer the care of the patient to the Primary RN.
Triage B:

Triage is “slow”: Triage B is stationed in the patient care area/EDN. Triage B’s responsibility is to focus on discharges…to get a bed available for the next person that arrives.

Triage is “steady”: He/she rotates into the Triage booth as patient’s are brought back into rooms by Triage A.

Triage is “slammed”: He/she assists with the “sort” and gets the patient’s to their treatment areas. May need to defer Primary RN intake to Primary RN…be sure to communicate this…and put up the Primary RN intake needed icon.

There are no more available treatment beds/gurneys/chairs: Utilizes the NEW triage space in the family room to do Primary RN intakes, and easy Secondary Assessments.

Charge RN:

Primary focus is to coordinate the care and patient movement within the main ED. Works closely with Triage A and Triage B. Facilitates bed placement by focusing on patient discharges. Tries to get “a bed ahead” by always creating a treatment space for both a monitored and a non-monitored patient.

Near future:

We are getting some walkie-talkies with an open channel for Triage A, Triage B, and the Charge RN to communicate patient movement.

We will change the Triage Tab in the computer to more closely emulate these procedures (once we’ve got the bugs in the new process all worked out).
TRIAGE POLICY AND PROCEDURE

PURPOSE

A. The primary purpose of triage is to expedite patient care to patients presenting to the emergency department (ED) with medical, injury and/or psychiatric complaints.
B. To prioritize patient needs and expedite patient flow and care.

POLICY

1. All persons presenting to the ED for unscheduled treatment and/or evaluation will be triaged by a triage professional (see Attachment C “Emergency Department Qualifications for a designated triage professional).
2. A greeter may log brief patient arrival information into the computer system. The greeter may not delay a patient to obtain information if a triage professional is immediately available to assess the patient (see Attachment B “Greeter Procedure”).
3. Triage is NOT synonymous with the Medical Screening Exam. The Medical Screening Exam is done by physicians to determine if an emergent medical condition exists. However, the triage professional may initiate components (assessments/treatments) of the Medical Screening Exam. (Refer to GPM Policy on EMTALA)
4. Standardized Procedures will be initiated at the time of triage or as time allows. (Refer to ESM policy D-17 on Standardized Procedures)

PROCEDURE

1. The triage professional provides an initial, rapid assessment to determine the patient’s triage category (see Attachment A: Definitions of Triage Categories) and need for immediate medical attention. Patients in need of immediate intervention will be taken directly to a treatment area and the RN assigned to the area and/or physician will be notified. The rapid triage assessment may include (but is not limited to):
   • the reason for visit (their chief complaint(s)),
   • skin signs,
• pulse strength and rate,
• visualization of respiratory effort and/or ability to speak,
• and overall appearance.

2. If time allows, the triage professional may provide the initial assessment (as briefly defined below and in ESM policy D-9 Patient Assessment), and initiate management and treatment (ESM policy D-6 Initial management of selected patient presentations, and D-17 Standardized procedures). The primary nurse assigned to the patient’s care may also provide the initial assessment. The initial assessment may include (but is not limited to):

• History of present illness, including physical assessment/findings and care before arrival;
• Mode and time of arrival;
• Pertinent past medical/surgical history;
• Complete vital signs (temperature, pulse, respirations, blood pressure and a pain rating). A pulse oximeter measurement may also be obtained if applicable to condition. (BP may be held on patients < 2 years old, unless indicated by medical condition);
• Current medications;
• Medication Allergies;
• Latex Allergies;
• Screening for Domestic Violence and/or abuse
• Tetanus history,
• Immunization status in pediatric patients
• Name of private physician

3. The initial assessment should occur in a treatment room/space (if an appropriate treatment room is available). This provides for a more confidential, private area for patient assessment and expedites access to the ED physician. If a treatment room is not available, some components of the assessment may be deferred until a more private space is available. The triage professional will notify the primary nurse that more assessment information will need to be obtained as soon as possible.

4. Treatment area designation is determined by the triage professional. During normal operational hours of Emergency Department North, the triage professional will consider patients of non-urgent and urgent triage category for possible ED North destination (see Attachment C “Triage Criteria and Guidelines for Patient
Destination). Communication with the charge nurse, the Emergency Department North Nurse and/or physician is encouraged to provide additional information for destination decisions. Considerations for treatment area placement include: special equipment needed for exam, triage category, and time to initial physician exam in the Main ED versus ED North.

5. The triage professional shall monitor, reassess and care of the patients in the waiting room consistent with the designated triage category. If he/she is unable to attend to the waiting room patients, he/she must alert the nurse in charge and ask for assistance.

6. All findings of the Triage nurse will be documented in the appropriate places on the ED Clinical Record. The tool utilized currently for documentation is a computerized patient care record.
Emergency Services Triage Categories

a. Emergent
Sudden onset of a medical/traumatic condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, symptoms of substance abuse, or any woman presenting with a chief complaint of pregnancy, and/or labor at a time when delivery is imminent) such that the absence of immediate medical attention could reasonably be expected to result in:
   i. placing the individual's health in severe jeopardy;
   ii. serious impairment to bodily functions;
   iii. serious dysfunction of any bodily organ or part; and
   iv. placing others at risk.

These patients will be brought immediately into the ED for evaluation, treatment and necessary stabilization, with the exception of a woman >20 weeks gestation with a pregnancy-related problem, who, barring airway instability, etc., will be taken immediately to L&D for a MSE if birth is not imminent.

b. Urgent
Acute pain, sudden injury or illness, or any woman who presents with a chief complaint of pregnancy where the prompt evaluation is necessary in order to determine if an emergency medical condition exists and/or the delay of treatment which could result in temporary or permanent disability. These patients shall be brought into the treatment area as expeditiously as possible or to L&D as noted above.

c. Non-urgent
Onset of a medical/traumatic condition manifesting itself by symptoms such that prompt physician evaluation and treatment is not a critical factor for the individual's medical safety.
Attachment B:
Greeter Procedure

If there is a greeter at the greeter's desk:

1. Greet the person(s) coming through the front door with the question: "How can I help you?" If they are unclear, ask them "Would you like to see our Emergency Department physician?"

2. If there is a Triage Nurse present, and he/she DOES NOT have a patient, ask them to proceed to the Triage booth.

3. If there is a Triage Nurse present, and he/she is currently triaging, do the following.

4. If they do, do NOT ask any more questions (patient confidentiality). Ask them to sign in on the log, giving their name, date of birth, and reason for visit.

5. Then give them the patient information sheet and have them have a seat. Tell them the Triage Nurse will call them as soon as possible.

6. Enter the patient in HMED. Do the following:
   a. Type in their name or part of their name to do a search. IF you find them, verify by the date of birth that this is indeed the patient. Highlight the patient and then click the triage button. IF you do not find them, continue by clicking the triage button
   b. Enter the following:
      1. Waiting room bed. Do not enter the acuity or the chief complaint.
      2. Enter the "Patient arrival information"…how they arrived (e.g.) ambulatory by car with family)
      3. Enter the "Chief Complaint Quote". This is what the patient wrote down on the log is the reason for their visit. This is not subject to any interpretation…you must type what they wrote verbatim.
      4. Click the "Save" button

If there is NOT greeter at the greeter's desk:

Registration clerks will follow the above procedure. If there is not a triage RN in the booth, the clerk will call the triage RN, escort the patient into the triage booth, login to HMED and enter the patient in HMED (as described above).
Attachment C:

Emergency Department Qualifications for a Designated Triage Professional

The JMMC Emergency Services Department designated triage professional or Triage nurse must meet the following criteria:

1. Have demonstrated the ability to exercise outstanding judgment in the evaluation and treatment of patients in the ED setting;

2. Demonstrated the ability to make decision under pressure of workload or crisis;

3. Demonstrated an ability to communicate well with patients;

4. Have received didactic training consisting of orientation and education in general assessment skills as well as applicable Federal, State and local regulations pertaining to ED triage, MSE, and transfers; and

5. Have been approved by the Director, Emergency Services.
# Triage Criteria and Guidelines for Patient Destination

<table>
<thead>
<tr>
<th>Chief Complaint</th>
<th>ED North</th>
<th>Emergency Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal Complaints</td>
<td>Ambulatory, normal vitals, objectively not in pain, and not ill appearing</td>
<td>Non-ambulatory, abnormal vitals, objectively in pain or ill appearing</td>
</tr>
<tr>
<td>Pain, Vomiting, Diarrhea - Adult/Peds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back Pain</td>
<td>Ambulatory, normal vitals and not ill appearing</td>
<td>Non-ambulatory, abnormal vitals or ill appearing</td>
</tr>
<tr>
<td>Chest Pain</td>
<td>Age less than 30 yrs, normal vitals, no objective pain, and not ill appearing</td>
<td>Age greater than 30 yrs, abnormal vitals, objectively in pain or ill appearing</td>
</tr>
<tr>
<td>Dizziness</td>
<td>Ambulatory, neurovascular intact, normal vitals and not ill appearing</td>
<td>Non-ambulatory, neuro-vascular not intact, abnormal vitals or ill appearing</td>
</tr>
<tr>
<td>Extremity Complaints</td>
<td>No deformity, neurovascular intact, normal vitals and not ill appearing</td>
<td>Deformity, neurovascular not intact, abnormal vitals or ill appearing</td>
</tr>
<tr>
<td>GI Complaints</td>
<td>Ambulatory, normal vitals and not ill appearing</td>
<td>Non-ambulatory, abnormal vitals or ill appearing</td>
</tr>
<tr>
<td>GI Bleeding (hematemesis, melena, hematochezia)</td>
<td></td>
<td>Emergency Department</td>
</tr>
<tr>
<td>HEENT Complaints (headache, eye pain, nosebleed, etc.)</td>
<td>Normal vitals except fever, mild pain, mild bleeding and not ill appearing</td>
<td>Abnormal vitals, moderate pain, moderate bleeding or ill appearing</td>
</tr>
<tr>
<td>Lacerations (Metal, Animal Bites, Puncture Wounds, etc.)</td>
<td>Neurovascular intact, normal vitals, and not ill appearing</td>
<td>Neurovascular not intact, abnormal vitals, ill appearing or requires sedation (i.e., pediatric face laceration)</td>
</tr>
<tr>
<td>Neck Pain</td>
<td>Ambulatory, neurovascular intact, normal vitals, objectively not in pain and not ill appearing</td>
<td>Non-ambulatory, neurovascular not intact, abnormal vitals, objectively in pain or ill appearing</td>
</tr>
<tr>
<td>Chief Complaint</td>
<td>ED North</td>
<td>Emergency Department</td>
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<tr>
<td>Pediatric/Adult Fever</td>
<td>Age &gt;3 mo, normal vitals, except for fever temp &lt;104 and not ill appearing</td>
<td>Age &lt;3 mo, abnormal vitals, or temp &gt;104 or ill appearing</td>
</tr>
<tr>
<td>Pregnant</td>
<td></td>
<td>Emergency Department</td>
</tr>
<tr>
<td>Rash (skin changes, redness, fluctuation, pus discharge)</td>
<td>Normal vitals and not ill appearing</td>
<td>Abnormal vitals or ill appearing</td>
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<tr>
<td>Seizure</td>
<td></td>
<td>Emergency Department</td>
</tr>
<tr>
<td>SOB</td>
<td>Not using accessory muscles, normal vitals, Pulse Ox &gt;95% and not ill appearing</td>
<td>Use of accessory muscles, abnormal vitals, Pulse Ox &lt;95% or ill appearing</td>
</tr>
<tr>
<td>Syncope</td>
<td></td>
<td>Emergency Department</td>
</tr>
<tr>
<td>Trauma</td>
<td>Ambulatory, No LOC, normal vitals and not ill appearing</td>
<td>Non-ambulatory, LOC, abnormal vitals or ill appearing</td>
</tr>
<tr>
<td>Upper &amp; Lower Respiratory Tract Symptoms (cough, runny nose, etc.)</td>
<td>No use of accessory muscles, normal vitals, Pulse Ox &gt;95% and not ill appearing</td>
<td>Use of accessory muscles, abnormal vitals, Pulse Ox &lt;95% or ill appearing</td>
</tr>
<tr>
<td>Urinary Complaints</td>
<td>Normal vitals and not ill appearing</td>
<td>Abnormal vitals or ill appearing</td>
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<tr>
<td>Vaginal Bleeding and/or &lt;EGA 20 weeks</td>
<td>Ambulatory, normal vitals, pink skin and not ill appearing</td>
<td>Non-ambulatory, abnormal vitals, pallor or ill appearing</td>
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<tr>
<td>Vaginal complaints</td>
<td>Ambulatory, normal vitals, and not ill appearing</td>
<td>Non-ambulatory, abnormal vitals, or ill appearing</td>
</tr>
<tr>
<td>Wheezing</td>
<td>Not using accessory muscles, normal vitals, Pulse Ox &gt;95% and not ill appearing</td>
<td>Use of accessory muscles, abnormal vitals, Pulse Ox &lt;95% or ill appearing</td>
</tr>
<tr>
<td>Weakness</td>
<td>Ambulatory, normal vitals, normal neuro exam and not ill appearing</td>
<td>Use of accessory muscles, abnormal vitals, abnormal neuro exam or ill appearing</td>
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<tr>
<td>Chief Complaint</td>
<td>ED North</td>
<td>Emergency Department</td>
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<tr>
<td>Psychiatric complaints</td>
<td>Hearing voices, depression, suicidal/homicidal without plan, non-flight risk</td>
<td>Suicidal/homicidal thoughts with plan, aggressive/violent behavior, flight risk if Psychiatric Evaluation Team.</td>
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<td>Subject:</td>
<td>Triage Policy and Procedure</td>
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<tr>
<td>Section:</td>
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