

STRAIGHT BACK TRIAGE
WILLIAM BEAUMONT HOSPITAL, ROYAL OAK CAMPUS

Publication Year: 2007

Summary: Instead of sending patients to the waiting room following triage, patients are sent to one of three treatment areas creating a visual cue that a patient is waiting to be seen.

Hospital: William Beaumont Hospital,
Royal Oak

Location: 3601 W. Thirteen Mile Road
Royal Oak, MI 48073

Category:

- A: Arrival
- B: Bed Placement

Key Words:

- Crowding
- Left Without Being Seen
- Queuing
- Wait Times

Hospital Metrics:

(Taken from the FY2005 AHA Annual Survey)

- Annual ED Volume: 115,894
- Hospital Beds: 1,061
- Ownership: Not-for-profit
- Trauma Level: 1
- Teaching Status: Yes

Tools Provided:

- [Straight Back Triage Policy](#)
This tool is a five-page document from the emergency policy and procedure manual explaining the policies of the Straight Back Triage system, and is used by hospital staff to understand the purpose and expectations of this system.

Clinical Areas Affected:

- Emergency Department
- Triage

Staff Involved:

- ED Staff

Innovation

Instead of sending patients to the waiting room following triage, patients are sent to one of three treatment areas under the straight-back triage policy. Sending patients to the treatment area sends a visual cue to staff that the patient is waiting to be seen. This new policy involved a major change in emergency department (ED) staff culture, so involving staff early in the process was important for a successful implementation.

ED Manager Val Gokenbach, RN, MBA, reports that under the old system of triaging patients and then having them wait in the waiting room, led to patients experiencing wait times of up to four hours. The hospital has a large waiting room that would fill up with both patients and visitors. With patients as well as their friends and family, there might be as many as 150 people in the waiting room. While patients being treated received excellent care, patients in the waiting room were sometimes “out of sight, out of mind.”

Results

The Straight Back Triage system has had a significant impact on reducing the risks of patients waiting in the waiting room, increasing patient satisfaction, and decreasing throughput time. The department’s Press Ganey scores have increased from the 52nd percentile to the 80th, their Left Without Being Seen (LWBS) rate has decreased from 6 percent to below 1 percent, and their diversion rate has gone from 40 percent to no diversion.

Innovation Implementation

The Straight Back Triage system was developed to have patients go to one of three treatment areas to be triaged and wait to be seen (See [Straight Back Triage Policy](#)).

A Care Coordinator led the change, which included dividing the ED into three separate areas. These are Prompt Care, the Pediatric (Peds) ED, and the Main ED. When a patient arrives, ED technicians use a simple protocol to direct patients to one of the three areas.

Once a patient is triaged within one of the three areas, they will often still need to wait to be seen, but they now wait within the treatment area and are visible by staff, unlike when they were out in the waiting room. Also, patients might be one of seven waiting in an area, rather than one of 150 people out in the waiting room. The staff’s awareness of the patients who are waiting also helps see them sooner.

Advice and Lessons Learned

According to Ms. Gokenbach, the Straight Back Triage process was a culture change from the way staff had worked before. Having patients go to Prompt Care and the Peds ED was easy, but it was difficult for the Main ED to accept patients who required wheelchairs or hallway beds and were waiting in the crowded waiting room. However, this process has allowed the Main ED to care for these patients sooner.

Given the impact that the Straight Back Triage system would have on staff, it was important to involve staff early on in the planning and decision-making. Staff are still involved in the process through the professional nurse practice council. Ms. Gokenbach reports that the ED continues to adjust the process and improve

Tools to Download

1. [Straight Back Triage Policy](#)

This tool is a five-page document from the emergency policy and procedure manual explaining the policies of the Straight Back Triage system, and is used by hospital staff to understand the purpose and expectations of this system.

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POLICY

ALL patients who present to the Emergency Center will be greeted and evaluated by a Triage RN, assigned triage process flow registration, and transported to a treatment area to receive further evaluation.

ALL patients who present to the Emergency Center (EC) will be triaged by the EC Clinical Nurse who demonstrates competency in triage decision-making according to the following patient classification system:

- I Adult and Pediatric Emergent Care
- II Adult and Pediatric Urgent Care
- III Adult and Pediatric Non-Urgent or Prompt Care

PURPOSE

1. To prioritize patient care needs according to severity of illness.
2. To assure a prompt initial primary survey of all patients by a health care professional.
3. To promote patient safety.
4. To facilitate expeditious care.
5. To improve public relations and promote effective communication with patients/significant others.

GENERAL INFORMATION

1. Triage of patients to specific categories/treatment areas may include examples of the following presenting signs/symptoms. NOTE: Patients assigned Category II or III may be treated in any area of the EC whenever stretcher spots are limited.
 - A. Category I - Emergent Care: Includes critically ill adults and children requiring immediate attention.
 - Cardiac arrest
 - Major trauma/burns
 - Grossly abnormal vital signs
 - Unconscious or severe mental status changes
 - Active cardiac chest pain
 - Respiratory distress or tachypnea
 - Massive internal or external hemorrhage
 - Active seizures
 - Anaphylaxis
 - Imminent delivery
 - CVA (with onset of symptoms less than 90m PTA)

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B. Category II - Urgent Care:

Includes patients requiring urgent care but will not cause loss of life or limb if left untreated for several hours.

- Stable angina without active chest pain
- Stable supraventricular arrhythmias with history of same
- Stable trauma/moderate burns
- Moderate respiratory compromise or moderate tachypnea
- Migraine headache
- Acute abdominal/flank pain/kidney stone
- Weakness and dizziness
- Psychiatric patients
- Alcohol intoxication
- Isolated one bone open fracture

C. Category III - Non-urgent Care:

Includes patients requiring evaluation and treatment but time is not a critical factor

- Chronic headaches
- Constipation
- Vaginal/penile discharge
- Refer to Prompt Care Guidelines (Policy # 810) for additional CAT III inclusion criteria.
- Minor Motor Vehicle Accidents - with isolated injury only (extremity, lacerations, abrasions), "just want to be checked", or diffuse muscular pain from MVA occurring > 24 hours ago. NO NECK PAIN, HEAD INJURED, OR BACK BOARDED PATIENTS. No chest, abdominal, or pelvis/hip trauma. No pregnant patients > 20 weeks gestation.

2. Uncertainty About Triage Decisions

The Triage Nurse will discuss uncertain triage decisions with a Physician or Nurse colleague (eg., Nurse Clinician or Charge Nurse) before determining patient destination.

3. Post-Triage Decisions:

Either the Clinical Nurse or Physician may reassign a patient to a higher category/ treatment area.

Reassignment of a patient to a lesser category/treatment area will require a Physician's verbal or written order.

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4. The triage team will be comprised of the following:
- a. RN Requirement: At least one (1) RN during low census hours; 3-4 RN's during peek hours.
 - b. EDT Requirement:
Ambulatory: one (1) EDT
Greeter Desk: Two (2) EDT's
 - c. Three Escorts between the hours of 12pm and 12am, as needed.
5. Triage team assignments:
- a. Greeter
 - 1. Greets patients and inquires about chief complaint.
 - 2. Routes patients to appropriate Triage area based on established criteria.
 - b. TCC (Triage Care Coordinator):
 - 1. According to the apparent severity of presenting complaint/clinical condition, determines order of triage.
 - 2. Determines availability of beds and stretcher hallway spots in department through constant verbal interaction with the areas with use of Lucent phones.
 - 3. Assigns all incoming patients to treatment areas/beds based on acuity and availability, on a rotational basis.
 - 4. Communicates with primary Clinical Nurses in the treatment areas as needed to clear stretcher spots for potential/actual use
 - 5. Oversees patient flow from triage to designated treatment areas (including registration detail).
 - 6. Receives incoming patient messages and communicates with Administrative
 - c. RN
 - 1. Completes the initial primary survey on ambulatory patients presenting to Triage and records findings on the Triage Record (Form #8600).
 - 2. Assigns Acuity (category 1,2,3) to those triaged.
 - 3. Communicates higher acuity patients to TCC and expedites bed assignment when needed.
 - 4. Assesses distal limb injuries and sends to x-ray (refer to Advance Triage Guidelines P & P #1015).

ECP.

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5. Assesses outpatients and notifies TCC on acuity level of bed placement.
 6. Provides direction to patient/significant others relative to process flow (including registration).
 7. Assumes TCC role as needed.
- d. EDT (Emergency Department Technician)
1. Performs vital signs and elicits demographic data
 2. Stocks triage area
 3. Transports patients as directed
 4. Applies first-aid techniques according to job description and RN direction
6. The Triage Record (Form #8600) will accompany all patients assigned to a treatment area. The Registration copy should be handed directly to a Registration Clerk, at which time, notification of a high priority registration will take place (a driver's license and insurance card will be provided to the Registration Clerk if available/accessible at the time of presentation). The patient's name/birthdate and location will be indicated on HDS. The initial primary survey will be completed by the receiving Clinical Nurse in the treatment area.
7. Outpatients: Refer to Policy & Procedure #160.
8. Pregnant patients: Refer to Policy & Procedure #768.
9. The Triage area will be attended by an RN 24 hours per day.
10. The triage team shall determine, according to Visitor Policy (#955), who may accompany patient to the treatment area.

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