

Physician's Weekly

Emergency Department Edition



[Home](#) [Past Issues](#) [Other Editions](#) [Search](#) [PW E-News](#) [Subscribe](#) [Advertise](#) [Contact Us](#)

The Nurses' Station

[Email this link to a colleague](#)

[View Printable Page](#)

Improving Patient Satisfaction Begins at Triage

Patient satisfaction in the ED generally depends on whether they are given timely care, are kept informed, and receive quality care. Perhaps most importantly, satisfied patients believe caregivers are genuinely concerned about their well-being. The ability of caregivers to remain empathetic is often in direct proportion to the amount of chaos in their work environment. Therefore, an efficient triage system may reduce errors in clinical decision-making regarding patient acuity, disposition, and reassessment. Inefficient triage systems may delay medical screening exams, increasing physician/facility liability.

Streamlining Registration & Expediting Care

In most EDs, registration can easily take place during wait times. Streamlining registration becomes critical for expediting care in those cases when the patient moves so swiftly through the system that there are short or no wait times. In an effort to facilitate patient throughput, many facilities have rightly incorporated "bedside registration" (BSR) and some even "eliminating triage." The misuse or misunderstanding of these concepts has moved the bottleneck from the point-of-entry to the diagnostic phase of the patient's care in the ED. Therefore, when instituting new or untried techniques into your system, a responsible and clear definition of that process is necessary to truly improve a system without disruption.

Patients who wait for a treatment room (low-acuity, no beds available) can be registered while they wait, providing that the medical screening exam is not delayed. If the patient immediately goes to a bed, significant others may be able to provide registration information outside the treatment area. BSR should be thought of as the same process used for patients arriving by ambulance. Using 100% BSR is not efficient or cost-effective. A better goal is 80%.

Tips for Improving ED Access

While many techniques improve process, each facility has its own culture and distinct issues. Here are some solutions that may be helpful to all facilities:

1. Use Lean Principles and quality improvement tools to identify root causes and viable solutions. For example, Value Stream Mapping may be used to map ED processes (eg, patient journey by acuity, patient management by physician, chart management) to help illustrate and eliminate waste.
2. Train nurses to consider "worst-case scenario" on every patient and to use critical thinking skills when performing triage assessments.
3. RN or an RN/technician team should greet patients and elicit chief complaints immediately upon arrival. Quick registration should elicit name, DOB, and perhaps SSN.
4. Use bedside registration appropriately.
5. Incorporate a combination of rapid and comprehensive triage assessments to replace the traditional full triage assessment on every patient at entry. Advocates of eliminating triage actually mean that rapid triage should be performed until all the beds are full, and at that point, comprehensive triage assessments should resume.
6. Ensure that triage nurses understand that the use of rapid triage is based on specific criteria. ALL of the following conditions must be met: an open bed is available, a care provider is available, and the patient is obviously critically ill or injured (caveat: If many lower acuity patients present and cause a backup at triage, and by a rapid assessment the triage nurse is confident of an acuity and disposition decision). If a bed or care provider is unavailable or if further assessment is needed to determine the acuity and/or disposition, then a comprehensive triage assessment should be performed.
7. Explain the ED process to patients/significant others and provide information at regular intervals.
8. Require increased education/experience for nurses working at triage. Develop a core group and encourage others to aspire to this level of expertise.
9. Incorporate a five-level triage acuity scale.
10. Ensure reassessments of all waiting patients as needed.
11. Consider the use of a computerized triage system.

12. Incorporate appropriately* developed and implemented protocols and guidelines.

* (Appropriate development, approval, and implementation of protocols and guidelines and order sets at triage should be associated with an order on the patient's chart (order set or handwritten), be approved by medical staff, have evidence of user competency, be reviewed annually and should contain specific orders (no choice or range orders). The patient's permission must be obtained, the patient's privacy maintained, the medical screening exam must not be delayed, the intervention must be clearly explained to the patient, documented and comply with organizational guidelines for nurse-initiated practice.)



REFERENCE LINKS:

For more information on Triage First, Inc., and its educational initiatives, visit www.triagefirst.com or www.triageeducation.com.

American College of Emergency Physicians (New York Chapter). *Guidance Document for Hospitals: Overcrowding/Emergency Preparedness Hospital obligations & Responsibilities* [Henry, Mark]. 2002.

Chinnis A, White K. Challenging the dominant logic of emergency departments: Guidelines for chaos theory. *J Emerg Med*, 2000;17:1049-1054.

McNair R. Triage Process and Disposition. In: *TRIAGE First Education: A Comprehensive Emergency Department Triage Course* [Patient Throughput Impact]. Triage First, Inc. 2004.

National Academy of Engineering and Institute of Medicine; Reid P, Compton D, Grossman J, Fanjiang G. *Building a Better Delivery System: A New Engineering/Health Care Partnership*. Washington DC: The National Academies Press. 2005.


To sign up for our **FREE PW e-newsletter**, click **HERE**

To get **Physician's Weekly** posted in your hospital, click **HERE**

Home | Past Issues | Search | Subscribe | Advertise | Contact Us

[Back To Top](#)

© 2009 Physician's Weekly, LLC
Web Applications by Spindustry Systems

 **Email this link to a colleague**