The Obstetrical Triage Improvement Project (OB TIP)
Management of an Increasing Triage Census and Assessing Patient Acuity In a High Risk Prenatal Unit

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1 Background

The triage unit, not the office would appear to be the setting of choice for patient evaluation. This phenomenon has been demonstrated by seeing an increase in census and acuity for The Johns Hopkins Hospital’s (JHH) Labor & Delivery (L&D) triage and volume is projected to grow 12% in Fiscal Year 2015. Staff identified the current triage process as a patient safety issue and potential risk. Currently, when a patient presents for triage, there is reliance on unlicensed personnel to greet, register, and, at times, assess the patient (i.e. Security and Patient Service Coordinator). Generally, patients are assessed, registered, and assigned to a triage room in order of arrival. If patient triage disposition is delayed, a more acute patient may present when all triage rooms are occupied. At times all triage rooms may be occupied by less acute patients. Additionally, the Federal Government mandates through EMTALA that all women who present to any triage facility must receive a timely assessment and treatment that all women who present to any triage facility (1). This along with the growing population.

2 Goals and Objectives

To develop & implement an evidence-based OB triage acuity process at JHH L&D
To develop, implement and evaluate and acuity based triage tool.
To decrease patient wait times by 50% from baseline data.

3 Methods

- Developed A3 to track process
- Completed SWOT analysis

4 Results

Survey Results: RN Perception of Current Process

<table>
<thead>
<tr>
<th>Acuity Level</th>
<th>Immediate</th>
<th>Urgent</th>
<th>Semi Urgent</th>
<th>Less Urgent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st RN perceives</td>
<td>37.95</td>
<td>40.2</td>
<td>14.7</td>
<td>7.2</td>
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<tr>
<td>2nd RN perceives</td>
<td>38.3</td>
<td>40.5</td>
<td>14.2</td>
<td>7.0</td>
</tr>
<tr>
<td>3rd RN perceives</td>
<td>37.2</td>
<td>40.7</td>
<td>14.5</td>
<td>7.6</td>
</tr>
<tr>
<td>4th RN perceives</td>
<td>36.1</td>
<td>41.2</td>
<td>14.8</td>
<td>7.9</td>
</tr>
</tbody>
</table>

Proposed OB Triage Acuity Tool

Average Wait Time (Pre-Implementation Jan-Feb 2015) vs. Arrival Time to RN Assessment

5 Conclusions

After looking at the data, it is evident that we must make changes to the current triage system at the JHH L&D unit. These changes include:
- Decreasing wait times
- Changing the assessment protocol (triage tool and patient flow)
- Modifying staffing
- Creating a culture of safety

AWHONN Professional Practice Guidelines

- Initial triage process (10-20 minutes) requires 1 RN: 1 woman (includes fetal assessment)
- Ratio can change to 1:2-3 as maternal-fetal status is determined to be stable
- Ratio should be 1:2-3 during non-stress testing

6 Future Directions

- Trial proposed “best practice” triage process and acuity tool for 4 weeks
  - Dates: September 28, 2015 to October 23, 2015
  - Time frame: Monday to Friday from 11am -11pm
- Educate triage RNs on use of triage acuity system using clinical case scenarios
- Staff additional RNs in triage to ensure that patient is first seen and triaged by an RN (similar to ED model)
- 1st RN performs initial triage, assigning acuity. 2nd RN provides care once patient is assigned to a triage room
- Create heightened awareness of triage patient status
  - Develop a visual cue for all team members to know triage census and acuity (to include the waiting “on deck” patients)

7 References


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