

# OB Triage Improvement Project (OB-TIP) Phase II

## MANAGEMENT OF INCREASING CENSUS AND ASSESSING PATIENT ACUITY IN A HIGH RISK PERINATAL UNIT

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### 1 Background

There has been an increase in census and acuity at Johns Hopkins Hospital (JHH) Labor and Delivery (L&D) triage. Current practice relies on unlicensed personnel (Patient Service Coordinators (PSCs) and security) to greet and sometimes assess presenting patients. The patient registration and triage assessment process is first come and triage rooms are occupied accordingly. One RN oversees the triage area (1-6 patients) and the L&D PACU operates as overflow. Triage efficiency is dependent on unit workload.

Phase II of this project is a continuation of OB-TIP Phase I completed in 2015. Phase I included the development and piloting of a nurse driven triage "acuity tool" and the identification of increased RN staffing to meet the AWHONN (Association of Women's Health Obstetric and Neonatal Nurses) staffing guidelines.

### 2

Phase II included putting Phase I into practice by involving bedside experts, getting stakeholder buy-in, piloting the program while running and sharing data.

### 3

#### Process

##### OP TIP Part 1: Triage Assessment

- Completed literature review
- Developed and piloted EB OB triage acuity tool
- Obtained expert review/stakeholder participation
- Educated RNs and L&D team
- Surpassed pilot goal of 50% decrease in time from patient arrival to initial triage RN assessment
- Presented findings to leadership & CUSP

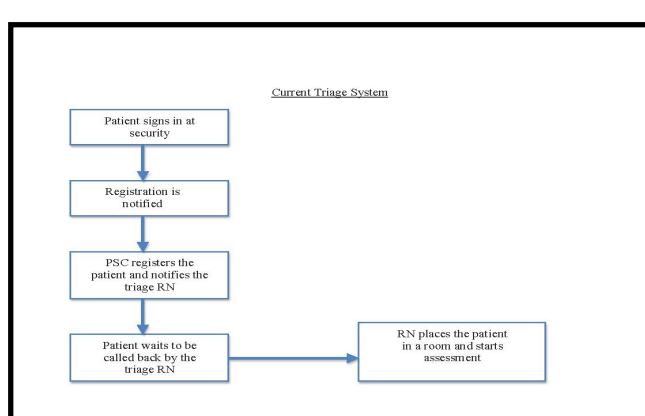
##### OB TIP Part 2: RN staffing Requirements

- Conducted 2-hour RN needs assessment
- Managed data collection via Individual data forms identifying patient presenting complaints and visit timelines from Nov 2017 to December 2017
- Identified required RN staffing to support
- Recommended triage process

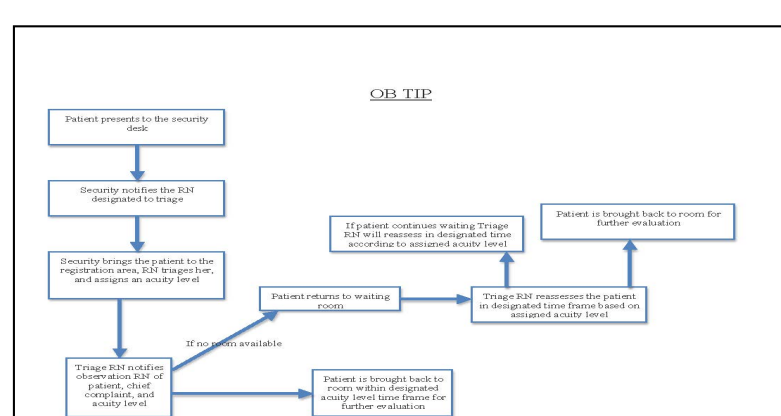
##### AWHONN Professional Practice Guidelines

- 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

#### Current Practice at JHH L&D

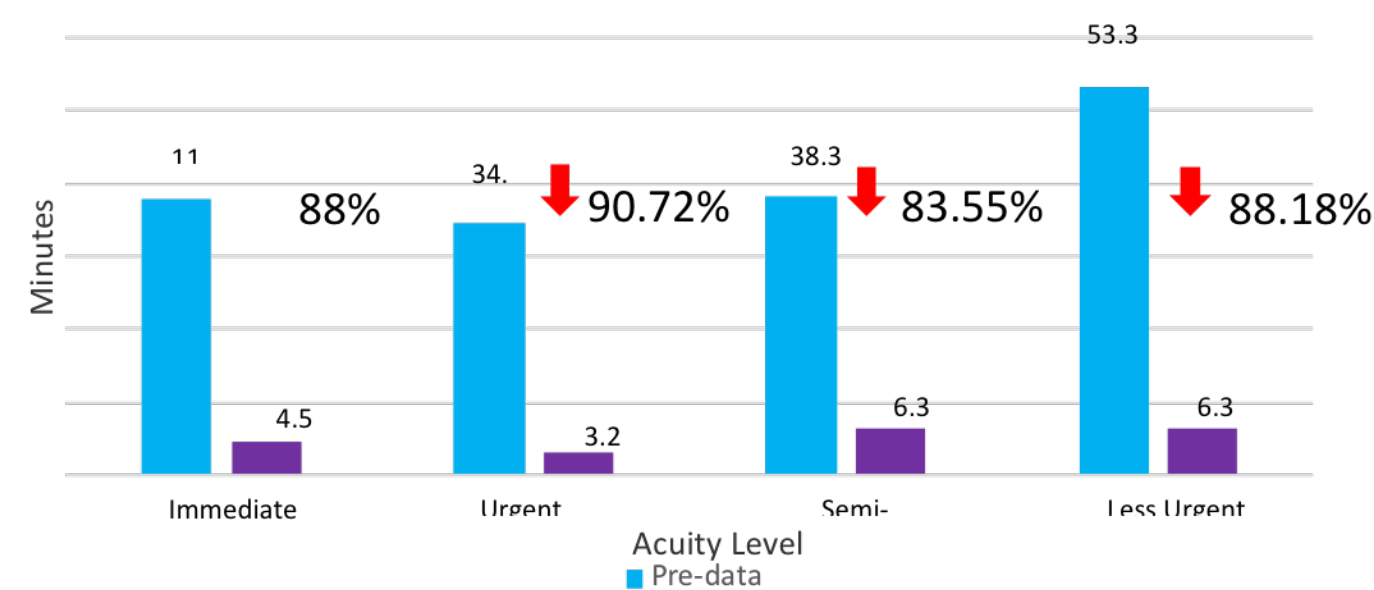


#### Proposed Lead Practice

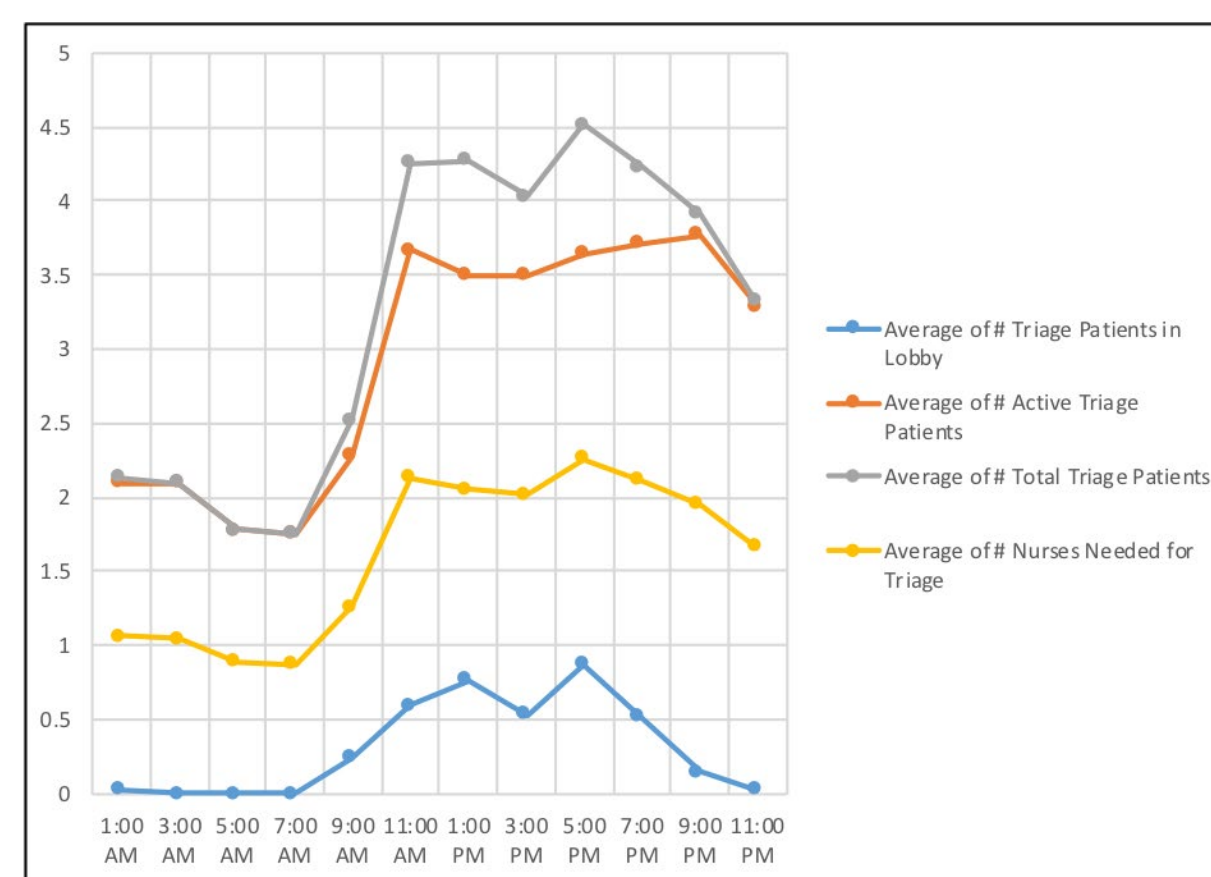


### 4 Results

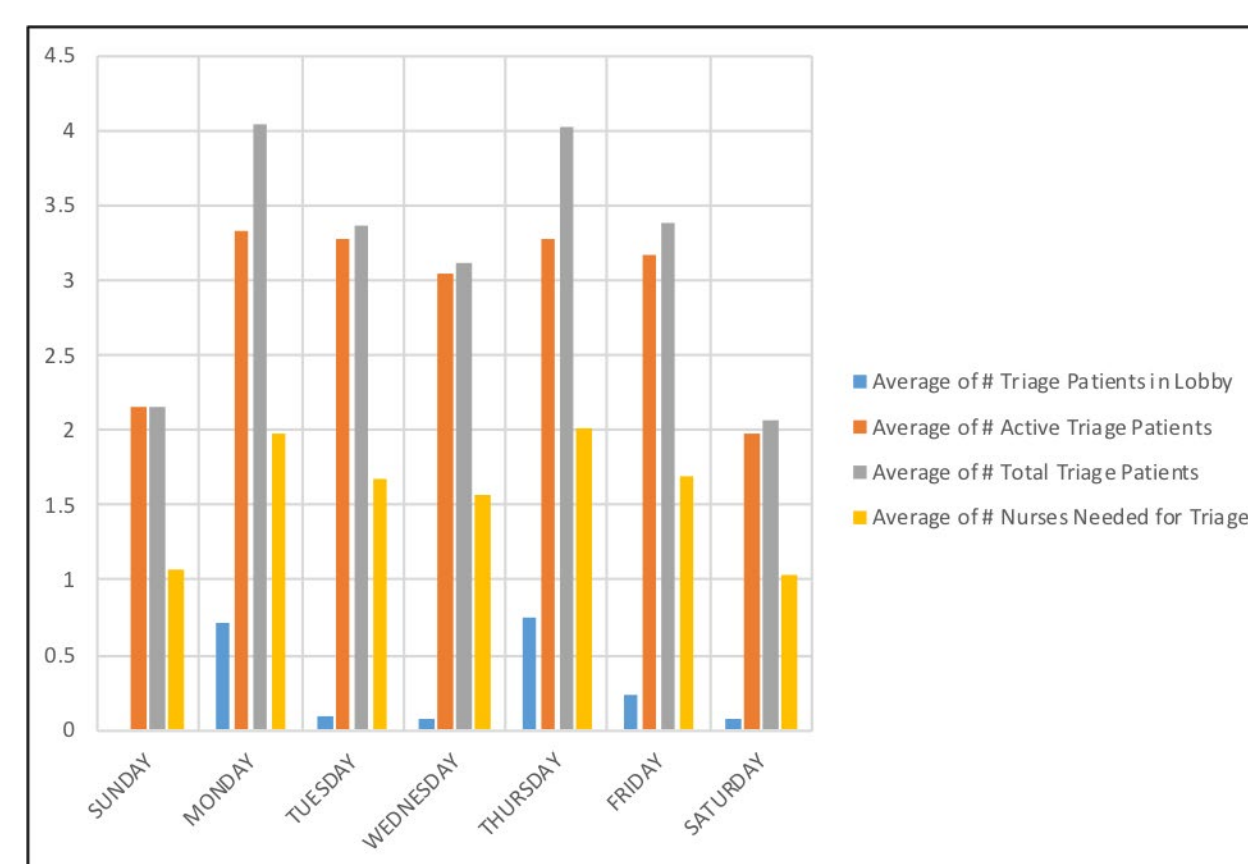
#### Part 1: Time from Patient Presentation to Assessment (Phase I Goal: Decrease time from arrival to assessment by 50%; achieved at 80%)



#### Part 2: Time of Day Analysis (Identifies 9am-11pm as peak hours)



#### P2. Day of Week Trends (11/13/2017 to 12/22/2017)



#### Data Analysis (11/13/2017 to 12/22/2017)

- 1.59 → Average # of nurses needed for triage based on AWHONN staffing guidelines
- 54% → Period with >3 patients in triage
- 12% → Period with patients waiting in lobby
- 51% → Period 1<sup>st</sup> on-call RN working
- 32% → Period 2<sup>nd</sup> on-call RN working
- 19% → Period nursing leadership in staffing numbers
- 20% → Period time slots with no data recorded; anecdotally unit very busy and charge nurse forgot or was too busy to enter data

#### Data Comparison (2015-2017)

- 2015 Data**
  - Assigned to wait-13.5%
  - Discharged-68%
  - Average time of disposition-2 hours, 54 minutes (range 17-419 minutes)

- 2017 Data**
  - Total # of forms (actual workload higher, excludes pre-ops)
  - Assigned to wait-12%
  - Discharged-53%
  - Average time of disposition-3 hours, 3 minutes (range 2-1503 minutes)

### 5 Recommendations/Reflections

#### Phase 1 Learnings:

- Change approach to triage management
- Adjusting physical space for initial assessment
- Develop IT system to support display of census and acuity of "on deck" triage patients
- Reinforce need for security to notify triage RN of patients' arrival or patients waiting
- Improved communication between triage RN and OB RN
- Need for more experienced triage RNs on night shift
- Unsustainable during high workload
- Registration PSC or Registration RN not always assigned

- Registration RN pulled into numbers
- Utilizing 2 on-call RNs, still unable to implement
- Nursing management assigned to be Registration RN

#### Phase 2 Learnings:

- Funding continues to be a limitation, but the administration has agreed to fund a triage RN
- Limited space and staff
- Construction and physical space
- Incorporation of the assessment tool in Epic
  - AWHONN module purchased
  - Proposed roll out: February 2019

### 6 Implications for Practice

Our early goals were to change the triage processing practice and encourage the use of a new RN acuity tool. Ultimately, these changes will create a safer triage process with patients being evaluated by acuity level rather than time of arrival to the unit.

### 7 References

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Thank you to the leadership and staff of Zayed 8E/W for their support throughout this process.



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