Bypass Rapid Assessment Triage: How Culture Change Improved One Emergency Department's Safety, Throughput and Patient Satisfaction

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Problem: Emergency department waiting rooms are high risk, high liability areas for hospitals. Patients who are greeted by non-clinical personnel or who are not being placed in available beds increases wait times and prevent patients from receiving timely treatment and access to care.

Methods: A multidisciplinary team was convened to review best practice literature and develop and implement an immediate bedding process. The process included placing a greeter nurse in the waiting room who performs a quick patient assessment to determine acuity. Based on that acuity, the greeter nurse then places the patient in the appropriate available bed.

Results: We established our Bypass Rapid Assessment Triage process and improved door-to–triage, door-to-bed, and door-to-physician times while enhancing patient satisfaction.

Implications for practice: A system should be in place that allows for immediate bedding wherever possible. Transitioning to immediate bedding requires a culture change. Staff engagement is essential to achieving such a culture shift.

Communities rely on emergency departments to be available 24 hours a day, 365 days a year. With increased volumes, overcrowding, and long wait times, emergency departments are challenged to provide efficient quality care. Those challenges include millions of nonelderly persons still lacking health care insurance,[1] sustained high unemployment,[2] continued closure of hospital emergency departments,[3] inadequate preventive medical care, and lack of primary care providers.[4] In 2010, 38% of emergency departments reported they were operating at maximum or over their capacity,[3,5] and ED visits had grown to more than 125 million in the United States'. 4500 emergency departments.[3] Furthermore, ED waiting rooms are a high risk and high liability area for hospitals. Safety is jeopardized and satisfaction is decreased when patients are required to wait.[3,5–8]

In 2011 the Agency for Healthcare Research and Quality reported that 2% of ED patients leave the waiting room without being seen because of long wait times.[6] Patients come to an emergency department expecting timely treatment. Processes that expedite the quickness with which a physician sees a patient enhance our ability to care for patients sooner and build community trust. One possible solution, immediate bedding, is a process whereby patients are placed in available beds, registration and triage occur at the bedside, and physicians have the opportunity to evaluate patients sooner than would otherwise be possible. Immediate bedding expedites door-to-physician times and improves patient throughput in the emergency department.[9]

In 2009 the emergency department of our Magnet-designated, level II trauma, community hospital had 108,000 visits and was facing the same constraints and challenges that were occurring nationally. These challenges included

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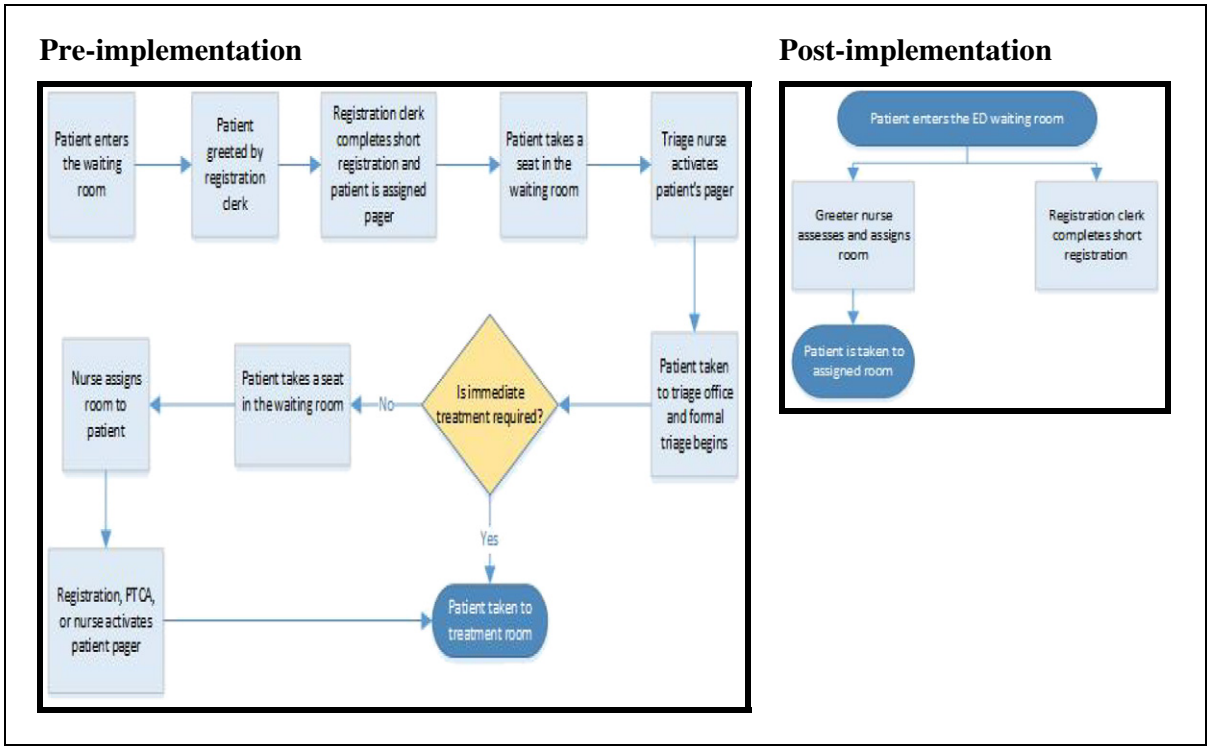

FIGURE 1
Traditional triage flow compared with Bypass Rapid Assessment Triage flow. *PTCA*, patient care assistant.

overcrowding, increased demand, longer wait times, and higher patient acuities. To address these multiple issues, ED management attempted to implement an immediate bedding process with minimal preparation and without staff engagement. The immediate bedding initiative was quickly abandoned because of strong staff resistance. The problems of overcrowding, however, continued. Thus, in 2011 we successfully implemented Bypass Rapid Assessment Triage (BRAT), our revised immediate bedding process, which produced positive results. Communication and staff engagement created the necessary culture change that was the key to success. In this article we will describe the planning, implementation, and results of our BRAT process and how we decreased door-to-triage, door-to-room, and door-to-physician time and enhanced patient satisfaction.

Planning

To achieve success with immediate bedding, ED management recognized that staff engagement was essential and delegated the implementation of the process to the Nursing ED Practice Council. The Practice Council members were sensitive to employees' previous negative experiences and agreed early on that this initiative would require a culture change prior to inception. To achieve such a change, staff buy-in would be paramount and communication would be the cornerstone.

The first step was seeing the waiting room "through the eyes of the patient." Observations on all 3 shifts revealed flaws in our traditional process, starting with entry to the waiting room through the front door. The identified problems included unnecessary wait times and inefficient use of available staff and resources. A registration clerk without any medical training greeted and registered patients when they arrived. Patients were then told to wait in our multilevel 33,000 square foot waiting room for a triage nurse and given a pager, unless the registration clerk determined they needed to be seen immediately. Patients waited on average 20 minutes to see a triage nurse without medical screening or severity classification, potentially leaving extremely sick patients unattended. Triage nurses were in adjacent rooms with the doors shut and had no view of the waiting room. They were unaware that patients needed to be seen unless they refreshed their computer track board or registration clerks notified them of a patient concern. Triage nurses typically assessed patients based on the order in which they arrived. Once triaged, patients were then asked to return to the waiting room regardless of bed availability (Figure 1).

Nurses in all ED treatment areas were tasked with monitoring the computerized track board to determine