IMPROVING PATIENT SATISFACTION BEGINS AT TRIAGE

Patient satisfaction generally depends on whether patients are given timely care, 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 will 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

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. (The treatment arena). By not applying strict criteria to immediate bedding strategies, organization unwittingly cause what many have determined to be a "Nursing nightmare". However, if set up properly, patients may be moved into the treatment area, where they can be observed and treated rapidly by the whole team instead of triage nurses carrying the responsibility of many patients who are waiting to see a licensed independent practitioner.

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. Bed-side registration (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 around 50-80%.

Tips for Improving 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 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. This drives their line-of-questioning (LOQ) They should be trained 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. No arriving patient just assimilates themselves into the correct disposition. They are all triaged, but more quickly than others.

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 triage process to patients/significant others and provide status updates 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 per the standard of care. If your organizational policy does not meet the standard of care, you will still be held responsible.

11. Consider the use of a computerized triage system.

 * (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.)