QUALITY IMPROVEMENT ACTIVITY REPORT FORM

This form
- provides evidence that you and your team are evaluating and improving your services;
- outlines each step of the process / practice improvement method;
- has guidelines attached and an example to follow.

Division/ Stream: Surgical Services		**Unit/Program/Ward:** Emergency Department, Canberra Hospital
Date QI activity started: September 2007	**Date QI activity finished:** ongoing	**Project delays** ***(how long was the delay and reason for delay):*** PCN scope of practice variance with subsequent trial period
Contact person ***(include name, position & phone number)***: Michele Evans, Project Officer, Emergency Department, 6244 2611		
Division / Stream Line Manager ***(include name and position title):*** Sharon Lewis, ADON Emergency Department		
Team ***(names and positions of people involved):*** Kate Jackson, DON ED Tania Dufty, DON Ambulatory Care Sharon Lewis, ADON ED Megan Wall, Nurse Manager ED Michele Evans, Project Officer ED		
1. Title ***(Name of QI activity)***	Effective Triage and Waiting Room Management	
2. Links to organisational objectives: ***(Itemise relevant reference documents that the activity primarily relates to)***	**EQuIP4 criterion number:**	2.1.1 The organisation's continuous quality improvement system demonstrates it's commitment to improving the outcomes of care and service delivery.
	Business Plan item number:	
	Other standards ***(specify)***:	Nil
3. Problem ***(Briefly describe the problem identified; include baseline data)***	1. Delay between initial rapid triage assessment and focused triage assessment. 2. Limited monitoring of clinical status for waiting room and ACTAS patients. 3. Triage practices need to be more adaptable for busy periods.	
4. Aim ***(What did you intend to achieve? SMART-O acronym applies)***	To review current practices regarding (i) time to triage assessment (ii) monitoring of waiting room and ambulance stretcher patients and develop best practice guidelines in the management of presenting and waiting patients. Implimentation should occur within	

	1 month with review and trial period for 12 months. Trial period to be extended with scope of practice changes.
5. Method *(describe evaluation methods & measurement tools)*	ED records demonstrated a significant interval between rapid assessment and focused assessment with delay in detection of condition deterioration. A limited audit showed few vitals or ongoing assessments occurred in the waiting room. A focus group identified that staff had differing views of triage responsibilites.
6. Comparison with Evidence Based Practice or Industry Standards *(eg. literature review; compared practice with other services)*	The Victorian Auditor General's Report on Emergency Departments recommended: 1.Triage practices are flexible and adaptable to busy periods. 2. Patients who are triaged and in the ED waiting room are monitored for any changes in their clinical status. 3.ED's have strategies for effective waiting room management. Four staff visited John Hunter hospital (benchmark) and Nepean looking at triage, waiting room and ambulance release practices.
7. Action *(What did you do to address the problem? Was there a pilot study?)*	The triage roles were modified to provide an earlier focused assessment of patients. Both triage nurses were stationed at the front desk to improve efficiencies and earlier patient contact. A senior nursing role was moved from 'float' in acute to attend waiting room and ambulance monitoring in line with ATS benchmarks. The scope of each role was trialled and staff feedback encouraged.
8. Results / Outcomes *(Describe the change you implemented. What were the results or impact? Expected or unexpected? Include remeasuring against baseline data.)*	Results: -The senior and junior triage roles were redefined to provide better patient assessment. Greater clinical responsibility is now accepted. -A more significant triage presence for patients presenting to the department has reduced confusion for patients and families. This has been found anecdotaly -Triages nurses demonstrate greater awareness of the department's standards. -With 2 nurses at the front desk, queue management is attended in times of need. Patients with significant illness are identified earlier and moved to treatment areas as a priority. -The creation of Preliminary Care Nurse (PCN) role who now monitors waiting patients between 0930-0130. This role is assumed by the triage nurses overnight. -Communication with waiting patients has improved; this has been measured through a reduction in patient complaints. -Nursing interventions in the waiting room has been debated. This has impacted on the seniority required to fulfill the role. The well established NSW Health Clinical Initiative Nurse role has a broad scope of practice and we appraised our scope against this. Reasonable interventions were defined as a result. -Unexpectedly the workload for the PCN became unmanageable over winter. This was related to access block with ambulance stretcher patients. The PCN was unable to monitor the waiting room and numerous ambulance patients requiring pans, analgesia and observation for those confused. As a consequence, in October 2008 the role of PCN came under review. All staff performing the role were asked to participate in the review. Currently the scope of practice has been re-written and is currently under trial. Ambulance release is considered a separate duty and filled by other staff on a shift by shift basis. Staff are significantly happier with this modification.
9. Future Considerations *(Describe mechanisms to sustain the improvement. Identify future monitoring and review. Could the activity be replicated in other areas? Consider a quality award*	To sustain the improvement we intend to support working groups established to monitor 'front of house' practices. Auditing of the roles will occur as required. Staff feedback will also be encouraged in the weekly staff meetings.

of conference abstract submission)	Scope of practice will be regularly reviewed.
10. Location of Evidence	Triage Working Party Folder PCN minutes kept in the CDN office.

	Name	**Signature** *(hand or electronic)*	**Date**
Submitted by Contact person	Michele Evans		28.1.2009
Approved by Director	Sharon Lewis		28.1.2008

Action to take now the report has been completed:

1. Retain a copy of this report in your department (Accreditation Evidence Folder).
2. Send this form to your Director, who will read it and then forward it to the **Patient Safety and Quality Unit (PSQU), Level 3, 1 Moore Street, Civic** or email **qualityathealth@act.gov.au**
3. The PSQU will then record the information on this form on the ACT Health Quality Register and provide certificates of completion to the team.
4. Submit this report to your Quality Committee or Clinical Meeting (if required).

Report from Triage Meeting Wednesday 24th October – 1230 – 1330

Present: Michele Evans, Megan Wall, Sharon Lewis, Kate Jackson

Concerns raised about the Nepean Flowcharts.

- Lack of referencing for descriptors
- Considerable amount of work to be done to review flowcharts according to ATS guidelines
- There needs to be medical consultation
- There are too many to implement at one time at triage

Actions
Find out if Nepean have references for the descriptors **Action: Michele**

Top five presentations to ED have been identified as:

- Abdominal Pain
- Chest Pain
- Vomiting
- Asthma
- Febrile

The Emergency Triage Education Kit will be used as the reference for all education and therefore the flowcharts need to be adapted to this kit. As this is the National Triage education program we should be teaching based on ATS.

After discussion we feel that if the Nepean flowcharts are to be used then we need them to more accurately reflect the ATS and the amount of work for this to occur is considerable. Therefore we have agreed that we take the top 5 presentations to the ED and develop the SOP and flowchart in conjunction with medical consultation. We can then implement each SOP and flowchart as we finish them.

We have also identified the need for a policy manual at triage. This manual will hold the policies regarding the referral of patients to other services and any other policy that impacts on the triage nurse role.

The Education of nurses to perform the triage role in TCH ED continues to be inadequate. To address this problem we have organised a one-day triage workshop. We are aiming this workshop at nurses who have recently commenced working in the triage role and/or more experienced staff who wish to renew and share their skills.

An education pathway is being developed for nurses who work in ED that will be implemented in 2008. Triage education will be the last step in this pathway.

EMERGENCY TRIAGE EDUCATION KIT (ETEK)[1]

FAQS SHEET

15TH NOVEMBER 2007

1. What is the ETEK?

The Emergency Triage Education Kit (ETEK) is a teaching resource that aims to provide a consiste nt approach to the educational preparation of Australian emergency clinicians for the triage role. In particular the ETEK has been designed to promote the correct use of the Australasian Triage Scale (ATS).

The ETEK is the product of collaboration between the Commonwealth Department of Health and Ageing Acute Care Division (DoHA), and a number of key stakeholders including:

- The Australasian College for Emergency Medicine (ACEM);
- The College of Emergency Nursing Australia (CENA);
- The Australian College of Emergency Nursing (ACEN);
- The Council of Remote Area Nurses Australia (CRANA); and
- The New South Wales Rural Emergency/Critical Care Nursing Consultants Planning Group.

Representatives of these groups formed the National Triage Working Party (NTWP) and were responsible for assisti ng DoHA with the development and implementation of the ETEK.

The program comprises 12 individual learning units which are liste d below.

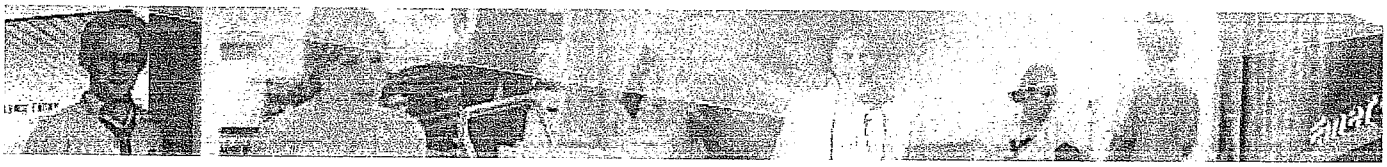
1. Introduction
2. The Australasian Triage Scale
3. Communication issues at triage
4. Triage basics
5. Mental health triage
6. Rural and remote triage
7. Pain assess ment at triage
8. Paediatric triage
9. Obstetric triage
10. Medico legal issues at triage
11. Consolidation
12. Self test

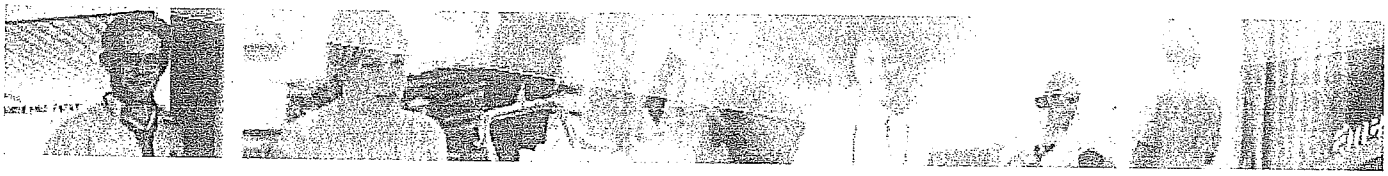
Each chapter provides a condensed summary of key issues related to the topic, lesson plans, and individual learning activities. Resources such as web-based materials and evidence-based reviews are also included in the kit.

2. Who should have a copy of the ETEK?

All emergency departments have been sent two copies of the ETEK.
These copies are for those clinicians/educators who run triage training in the workplace.

Universities have also been sent copies of the ETEK. University lecturers who teach emergency nursing can use the information contained in the ETEK to inform the delivery their specialist programs.





3. *How do I obtain the ETEK?*

If you would like a copy of the ETEK, please send your request to triage.kit@health.gov.au or call Belinda Yates on 02 6289 8324.

4. *How should clinical educators use the ETEK?*

Although the ETEK provides a framework to guide clinicians in the application of the ATS, all workplaces will differ in the way their in-service/staff development programs operate.

The ETEK is divided into 12 modules that can be taught in one hour blocks.

We anticipate approximately 12-16 hours of time will be spent by educators delivering these units.

Participants who take part in the ETEK program are also expected to undertake some self directed learning activities.

In situations where there is no clinical educator, individuals can work through the program by completing the recommended readings and learning activities. The consolidation and self test chapters (Chapters 11 & 12) can then be used by individuals to perform a self assessment.

5. *Can I photocopy and distribute the ETEK?*

6. *What has been done so far to role out the ETEK?*

The ETEK was launched by DoHA at the 6th International Conference of Emergency Nursing on the 11th of October.

As part of the ETEK launch DoHA a 90 minute workshop to introduce the kit.

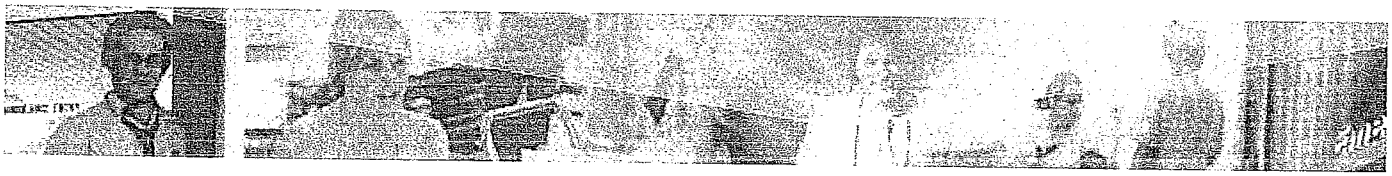
Copies of the ETEK have now been distributed to all hospitals in Australia. In addition, all hospitals that have an emergency department have been sent an extra copy.

Copies have also been sent to Schools of Nursing in Australian Universities.

7. *Who should I speak with if I have further questions about the ETEK?*

Contact Belinda Yates on 02 6289 8324 or email Belinda.Yates@health.gov.au

1. Gerdtz MF, Considine JC, Sands N, Stewart CJ, Crellin D, Pollock WE, Tchernomoroff R, Knight K, Charles A: **Emergency Triage Education Kit**. Canberra, Australia. : Casemix Development Projects Section, Australian Commonwealth Department of Health and Ageing; 2007.



TRIAGE WORKSHOP 19.11.07

0830 – 0930	History of Triage Overview of ATS Marissa Young
0930 – 0945	Triage Scenarios
0945	Morning Tea
1000 – 1100	Pain Assessment Paediatric/Adult Sharon Lewis
1130 – 1200	Paediatric Triage Sharon Lewis
1200 – 1230	Obstetrics at Triage Helen Blake
1230	Lunch
1330 – 1400	Sharon's: Mental Health Sharon Lewis
1400 – 1430	Triage Medico- Legal Aspects
1430	Afternoon tea
1445 – 1600	Triage Flow Charts / Policy's / SOP's Michele Evans

Venue: ED Tutorial Room

Triage Education Planning Workshop.

- Welcome.
- 0910- 1000 Where are we now? (3 minutes each).
- 1000 – 1100 Where do we want to go? (brainstorming a priority matrix)
    - What is one thing you would like to change about the Triage system as it is now? [using post-it notes]
- 1110- 1300 Pulling apart the system.
    - What is the core business of a triage nurse?
    - What educational support does a nurse need to achieve this?
        - Workbook
            - What should be included? TCH specific.
        - Competencies (including RPL)
        - Workshop day
        - Supernumerary and Green|Blue support.
        - E-learning / ETEK.
        - Flowcharts.
- 1300- 1333 Lunch
- 1333-1500 Putting it all together.
    - Producing mentors/preceptors.
    - Working towards L2.
    - What's in it for me?

Triage Education and Planning Workshop.

Where are we now?

Each participant was given 3 minutes to talk about the challenges and problems that face our Triage nurses at this time.

Common themes that were identified included:

- Need for updated Triage Workbook and increased education accessibility. Need for more training for junior as well as more experienced Triage nurses.
- Need for increased level of teamwork between T1, T2 and PCN.
- The need was identified to get back to a rapid focused assessment of aprox 5 minutes for each patient.
- Poor design and layout of the triage area including access/egress, glass partition and assessment areas. OH&S issues surrounding beds/equipment in the corridors.
- Poor documentation by Triage nurse.
- High workload/responsibility of the PCN role. Oftentimes allocated to junior staff member.
- Problems meeting ATS KPI's due to access block.
- Could work on improving professional conduct of Triage nurses.
- ? need for Triage refresher course similar to ALS that would be an annual mandatory requirement.

Pulling apart the system.

We next discussed our vision of the ideal Triage nurse. What s/he might look like and how s/he might operate. The attributes and competencies that were identified included:

Resource management
Assessment skills
Interview skills
Communication skills
Interpersonal skills
Time management skills
Multi-tasking.
Leadership.
Organizational knowledge

Disaster knowledge
Documentation excellence.
Understanding of flowcharts.
Ability to perform basic and simple interventions.
Critical thinking.
Educator of junior staff / health promotions.
Ability to de-escalate, prioritize.

Then we talked about what we could do to produce such a nurse in our department.

Pre-requisites for undertaking Triage skilling:

- Must have attained proficiency at level GREEN.
- Must have completed all relevant mandatory competencies.

- Must be provision for recognition of prior learning for staff transferring from other units.

We should develop a core group of preceptors/mentors for the Triage speciality. There should be time allocated for the student and preceptor to develop a relationship and provide feedback.

Application to undertake Triage course:

Participants felt that staff should have to undertake a set process to commence the triage course.
1 intake every 3 months (?number in each intake)
This would allow more consistency in rostering to work at triage.
Students would initially only work morning shifts.

Course would run 5 days: including a 2 day workshop and 3 days supernumery.

Education would come from CDN's as well as the T1 role (as a level 2 position; should engage in teaching process)

Education options:

- Workbooks
- E-learning
- Specific targeted inservice.
- Integration with ETEK materials.
- ? separate streams of education for basic and advanced levels.

Competencies will be provided in the workbook for pre-reading and will be tested on day 2 of the workshop in the form of skill stations and role plays.

System competencies / pearls will be briefly outlined in workbook and then covered in more depth by guest speakers and educators.
Also to be covered on day 1 will be Documentation, Flowcharts and Organizational knowledge.

Community:

Generating a triage identity within the ED was discussed including a specific Triage newsletter so that staff could keep up with related changes and updates to practice.

Breakdown of course elements.

Workshop:
Prescriptive competency assessments.

System based.

Roleplays.

Skill stations, vivas and scenarios.

Interview techniques.

Expert Guest speakers:

- Paeds
- Gyne
- Neuro.

Supernumery shifts.

Combination of shifts with CDN/T1

Initial orientation to triage, layout and procedures/policies.

CDN for first half of day then work with T1.

Increasingly T1 to step back and let student triage.

Preceptor.

Self assessment and reflective practice.

360 degree feedback at monthly meetings.

Reflective practice to be used after each assessment to explore the reason ATS was scored.

Competency assessments used during workshop now used on real patients.

Workbook:

To be updated in the existing workbook: Include list of mentors and preceptors.
? include a logbook to record time spent at triage.

CD ROM of ETEK workbook will be incorporated in our workbook (similar to COMPASS)

There will be a large number of scenarios that will link to our flowcharts.
A small pocket guide to triage may also be produced.

The workbook will be due on completion of the supernumery shifts.
Certificate of achievement will be awarded.

Important to incorporate an evaluation process to each element of the course.

Putting it back together.

The plan is for the triage course to be implemented January 2009.

To move the whole process forward the following tasks were allocated. Most have to do with updating the current workbook.

Task	Name:
Update RAN and FAN to R1 and R2. Include definition of roles and responsibilities.	Michelle E.
Fast track.	Kelly J.
Ambulance offload policy. (cut'n'paste)	Ian M
Escalation plan.	Sharon L
Psych (in consultation with Liz T)	Ian M.
Professional conduct at triage.	Ian M
Flowcharts.	Michelle M.
R/V specialty clinics.	Kelly T and Leonie B.
NSW tracking screen	Jo
EDIS	Ian M.

Search and find activities	Leanda.
Standing order development	Felicity.
Legal matters at triage including signing of triage forms, police requesting patient notes and documentation.	Leonie B.

Triage education program for TCH ED
Introduction of the Triage Flowcharts

The following changes have been implemented at Triage
Change in RAN and FAN role to T1 and T2
Move of RAT from Back of House to Front of House

See Power point presentation

In response to the changes implemented at triage

My proposal would be that the Triage component be structured as follows:

1. **Selection of appropriate participants**.
   This would be based on the new staff classification system and we would need to develop some prescriptive requirements that would flag eligibility of a clinician to undertake the program.

2. **SDLP.**
   The Dept of Health and Aging Triage Education kit would be given to participants as a self directed learning package.
   - It would also contain a cover document guiding the user as to which sections are to be studied and which exercises/questions are to completed.
     For example there is a rural triage module which is not particularly relevant to our ED and can be skipped.
   - The Kit would have a set due by date to coincide with the Triage Workshop Day.
   - It would also contain an additional separate module with information relevant to policies and protocols specific to our own ED. This document would also cover the new Triage/Waiting room roles currently under development.
   - It would probably be reasonable to expect the Kit to be completed by the candidate within 4 weeks of issue.

3. **Triage Workshop Day.**
   A workshop day that would follow the structure of the Education Kit as well as containing interactive Triage scenarios, and group discussion as well as a review of policies and protocols specific to our own department.
   The workshop day would also introduce and exercise (via group scenarios) the ATS flowcharts which are currently under development.
   The workshops will be structured to facilitate training of large or small groups (down to 2) in order to meet future needs.

4. **Supervised Triage.**
   I propose a minimum of 3 supervised triage shifts once the Workshop day is completed.
   During these shifts the Trainer (CDN/Educator) will work closely with the nurse and give feedback and guidance as well as encouraging reflective practice.

5. **Assessment.**
   Assessment would be based on completion of Triage Workbook as well as a competency assessment that would be completed during the supervised triage time.
   A certificate of completion would be awarded at this time.

Revisiting Triage

ED TCH like many other hospitals has numerous ongoing challenges:

1. Access block
2. Staff shortages
3. Long waiting times
4. Difficult layout
5. Aggressive patients/ relatives

So what can we do about it?

Fast Track

Fast track systems for minor injuries and illness have been proven to reduce waiting times.

A review of our Fast track stream brought significant changes:

- Selection criteria broadened
- Dedicated medical & nursing staff
- Role for Nurse Practitioner
- Advanced Care Nurses (Liverpool)
- Physiotherapy cover
- Registrar Review Clinic

The next area for consideration is **triage**.

Is triage and waiting room management effective?

To answer this we can look at standard audit criteria.

We expect to find that:

1. Triage directs pts to treatment areas within the department most appropriate to their needs.

2. Triage is assigned according to the ATS and strategies are in place to ensure consistent application of triage principles.

   Manchester/ Nepean flow charts

(This will also enable a greater number of our staff to work as triage)

3. Staff performing triage have appropriate training.
   This will be attended with the introduction of triage flow sheets.

4. Target times from triage to treatment are established and monitored.
   Fast track – SOP's
   Nurse Coordinator role

5. Triage practices are flexible and adaptable to busy periods.

6. Patients who are triaged and in the ED waiting room are monitored for any changes in their clinical status.

7. ED's have strategies for effective waiting room management.

*These points in part will be met by **RAT** moving out to **triage.***

From Monday 8th October RAT will be located at triage.

Triage will continue to be the initial contact for all patients. Where it is apparent a pt presenting is a T1 or T2 and triage is unable to attend the patient, the RAT may facilitate pt transfer to the appropriate nursing and medical care. In this instance the RAT is to complete the triaging process.

The role of the RAT:

1. Assess pts waiting for acute as needed. (FAN role)
1. Perform **limited** observations (vitals, GCS, limb) **specific** to the presenting complaint.
2. Alter the triage category as needed and update EDIS.
3. Provide analgesia for pts needing an acute bed. (oral / rectal)
4. Attend to BAL's prn.

6. Where the ACN is unable to attend fast track pts in the waiting room, the RAT may administer appropriate analgesia or other nurse initiated treatment.

7. Cannulate, take bloods and perform ECG's as required. ***

8. Provide timely communication to the waiting room where waiting time has increased (multi-trauma's etc)

9. Perform regular reassessment of pts waiting for acute with documentation on the traige record.

(T3 – when 30/60 then hrly

T4 – hourly)

A round of the waiting room on the hour is expected.

10.Liaise with triage and Nurse Coordinator on a regular basis.