

Quality Improvement Activity: LIMITED TRIAGE CERTIFIED NURSES

Friday nights are usually busy in the pediatric emergency department, but this night was the worst. There had been multiple call-ins that left only four employees available plus two new graduates. While making assignments, the charge nurse noticed only one nurse was triage certified while the others were not. Based on the high acuity, she determined it was easier to send the certified nurse to triage with one GN, while everyone else help with patients in the back. As the night continued, the chaos calmed down which led the certified nurse to take a quick break. Before leaving, she instructed the GN to stay and have any patient who arrives fill out a triage form and wait for her return to be seen.

A few moments after a 16-year-old mother came in carrying her 4-month-old daughter in a car seat, which was hidden due to an overlaying blanket. The mother grabbed a form and wrote down a chief complaint that stated, "Week old cut on leg that looks worse. She is fussy, has a poor appetite, is cold, and pale." The new graduate read the form that appeared nonurgent and then asked the mother to have a seat. Fifteen minutes had passed, and the baby began to produce a nonstop irritable cry that startled the new graduate to call for assistance. The triage nurse arrived over five minutes later, grabbed the form off the desk, but rushed out the door after reading the complaint. The nurse asked the mother to uncover the child so she could inspect the wound. As the mother unraveled the blankets and removed the gauze from her child's leg, the nurses' eyes widened when she noticed not only that the child's leg was beyond infected, but her skin color was blue. The nurse immediately hurried the patient and mother to a triage room to obtain vital signs- which presented a systolic blood pressure of 60, respirations of 72, heart rate of 100, and a temperature of 98.5- confirming the child was in septic shock. Based on the sepsis protocol, a hypotension patient requires attention within an hour, so the nurse called for help while rushing the patient to a trauma room.

Describe the scenario. In what way did the patient care or environment lack? Is this a common occurrence?

In the scenario above there were many people at fault due to the unfortunate events. The environment lacked due to the available staff, but the patient care was mostly affected because of the charge nurse, triage nurse, and GN. For starters, the charge nurse made an adequate assignment based on the high acuity, available staff, and personal judgment. Furthermore, most triage centers usually require two years of experience before allowing a nurse to work there. In addition, depending on the various factors, there must be a minimum of two certified nurse's working in a triage area to provide patient care in a safe and efficient manner. Secondly, the nurse made a poor judgment of leaving the GN alone without proper supervision or experience. Since the GN lacked the basic triage knowledge, she failed to inspect the client further, recognize the emergency and act accordingly. Sepsis protocols are time sensitive and require multiple interventions, so all nurses involved must work together safely and efficiently.

Yes, this occurrence is common, and it happened to me during my preceptorship. My nurse was the only nurse licensed to work in the triage area out of the available staff. The septic story is made up, but the possibility of this occurring is terrifying. Since my nurse was the only nurse triaging, many patients were not seen in a timely manner causing built-up frustrations and a halt in their treatment. There are not many ER nurses that are licensed to work in triage due to the

requirement of experienced years and training. This issue can cause burnout in nurses who are triage certified and hurt patient care.

What circumstances led to the occurrence?

The circumstances that directly led to this occurrence were the available staff to work triage. The triage nurse's poor judgment to leave the nurse alone for an extended period was also a contributing factor. Furthermore, the GN is also at fault for not further assessing the patient before allowing them to be seated. Yet, how would the GN know to properly assess the patient to determine acuity if not properly trained to do so? Hence, the GN should encounter training to recognize when a chief complaint requires a further examination or should have not been alone in this situation.

In what way could you measure the frequency of the occurrence? (Interview nurses, examining charts, patient surveys, observation, etc.)

You can measure the frequency of this occurrence by comparing the ratio of certified triage nurses to noncertified ones. In addition, you can backtrack assignments made by the charge nurse that shows the same nurses working multiple days in the triage unit compared to on the floor. Lastly, patient surveys based on extended wait times can also be reviewed.

What evidence-based ideas do you have for implementing interventions to address the problem?

This issue can be fixed by training new graduates in triage areas sooner. If new graduates are exposed to triage areas during the orientation phase, this can help nurses who are certified to not be assigned to triage so consecutively or alone.

In addition, triage is great because it requires nurses to make critical thinking judgments based on a patient's subjective and objective data. This tool can be amazing for new nurses to be exposed to quickly so that it helps aid in care with other patients.

How will you measure the efficacy of the interventions?

Measuring the efficacy of these interventions can be accomplished by reviewing daily schedules to ensure nurses are properly rotating triage days with the appropriate staff. I would gather patient survey reports to compare the differences in lobby wait times and how quickly interventions were made to aid in treatment. I will also interview all licensed triage nurses to identify their satisfaction with the change. It would be ideal to see how total patient care changes when all nurses are trained to quickly identify the acuity of every patient.