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Christiana Care Health System OB/Gyn Triage Unit

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In the last decade, the use of emergency rooms and urgent care centers has increased dramatically in the United States. This is due to the inability of physicians to add unplanned patient visits into their office hours and the patient's desire for immediate care. Emergency departments around the nation are seeing increasing numbers of patients who do not need the full resources of an emergency department.

The emergency department at Christiana Care Health System is no exception. In order to provide for appropriate care for obstetrical patients, the OB/Gyn department felt it necessary to provide a separate unit where the special needs of these patients could be addressed. In 1995, Christiana Care Health System opened an OB/Gyn Triage Unit to meet the needs of an expanding new Women's Health Services Wing, which supported an active OB/Gyn Department providing maternity services to more than six thousand women per year. The OB/Gyn Triage Unit provided relief to a busy labor floor and met the special needs of women, who would otherwise be seen in the system's large emergency department. Its effectiveness and preferential use by OB/Gyn physicians caused the unit to quickly meet and exceed capacity. An increasing volume of patients compounded by a lack of effective revenue capture strained the existing resources.

In 2002, an interdisciplinary team, led by Dr. Joseph Patruno, was convened to address the following issues: patient satisfaction related to delays during peak hours; patient elopement; and physician, resident, and nursing dissatisfaction related to backlog and volume. The team identified environmental and process opportunities to facilitate the movement of patients from registration to admission or discharge in a quick, efficacious, and caring manner.

A triage area was designated and the role of the triage nurse was formalized to enable quick, thorough and confidential evaluation of patient status. A physician director was instated to oversee resident medical staff in providing appropriate care for the patients. In addition, a comfortable patient lounge, separate from the general waiting room, was constructed for patients waiting for lab results or for reevaluation of labor status. This was needed because patients, who remained in exam rooms while awaiting lab results, received continuous fetal monitoring, vital signs and assessments by the resident and nursing staff. Discontinuing this unnecessary evaluation and moving them to a waiting lounge increased patient comfort, eliminated unnecessary work for the staff, and made the exam room available for patients waiting to be evaluated.

An onsite, time of service patient satisfaction survey was designed to provide the team with insight into how to improve communication with patients and families. A patient flow algorithm was designed for the area to improve communication between hospital staff and OB/Gyn providers. A review of patient types and services provided in the area enabled identification of care management and process improvement opportunities. A subgroup of the task force addressed delays in lab results and consults. An interdisciplinary team developed a Preterm Symptomatic Uterine Contractions Diagnostic Algorithm employing evidence-based indicators that support the process of using fetal fibrinectin evaluation to determine preterm labor status.[1,2]

An evaluation of patient acuity and development of an improved documentation tool provided an opportunity to bill for services based on an appropriate level of care. Projected revenues made it possible to provide a medical director for the area. Staffing for peak volumes and provision of a triage nurse increased patient throughput and facilitated improved communication to patients, families, and providers.

Following completion of environmental improvements, a two-week pilot test was performed, with the medical director and triage nurse in place. The pilot test was preceded by education for nursing, resident and physician groups. The new provider record and algorithm were implemented. Documentation and level of care assigned were reviewed to ensure that billing was appropriate. The onsite patient satisfaction survey was repeated during the pilot and demonstrated improvement. Patient elopement did not decrease during the two-week pilot; however, follow-up was provided for these patients. Individual follow-up discussions with physician, resident, and nursing staff revealed improved satisfaction with the quality of care and efficiency of the unit.

The pilot validated the need for physician/nurse practitioner presence in the OB/Gyn triage area and a triage nurse in place during the peak hours of 12:00 p.m. to 10:00 p.m. Improved communication resulted in increased patient satisfaction and decreased delays in decision making of attending physicians. Improved documentation and appropriate level of care assignment resulted in adequate revenue to support all patient care activities in the area.

As a result of these changes, we were pleased to see improvement in patient satisfaction, patient care, and efficiency of care, as well as improvement in physician, resident and staff satisfaction. Due to the successes of this pilot test, the improvements were operationalized to provide ongoing attainment of quality outcomes.

References

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About the Authors

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