Improving Efficiencies in ED Triage Documentation

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Introduction/Background:

The initial implementation of the EHR at our institution in 2007 required design and build of documentation forms and flowsheets used by nurses. These included those used in the Emergency Department (ED).The forms were used at several points of care in the ED, such as at triage and at the RN initial assessment. A bi-weekly ED interprofessional meeting determined that the forms and documentation methods were causing nurses to document duplicative information as well as more details of assessment than were necessary.

Methods

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In collaboration with the ED Clinical Nurse Specialist (CNS), the Clinical Informatics Specialist (CIS) completed an analysis of the existing Nursing Triage Form. The form had initially been designed to mirror the extensive inpatient nursing admission physical exam head to toe assessment. The inpatient unit nurses use the flowsheet documentation method, where the option to select nomenclature such as "within normal limits" is more available. This functionality was not available to the ED nurses. The CIS designed a section of the triage form that would allow for expedited assessment documentation, prompting the ED RN to more comprehensive assessment details only where needed. The form design was reviewed and approved by the ED CNS. ED nurses were informed of this change through verbal and email announcement supported by reference material.

Results

Post implementation, the ED CNS reported satisfaction from the ED nursing staff. The staff reported that the changes to the existing form were easy to use and also led to more efficient documentation during the triage. Staff also requested that additional forms used by the ED nursing staff be assessed and re-designed.

Discussion/Conclusion/Lessons Learned

The reality of informatics and our electronic health record is that it will continue to require change to support new innovations and advancements in the healthcare environment. As often these demands and advancements require additional change into our record, it behooves us as informatics specialists to continue to actively assess the existing tools in the EHR for opportunities of revisions and efficiencies.

References

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