The Triage Project: Implementing a new model of care by adopting a formal triage assessment tool in the acute obstetric setting

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Background
Women’s Assessment Unit (WAU) is a 9 bed acute obstetric assessment unit of Waikato Hospital, New Zealand. WAU has approximately 5,500 presentations a year of women from 20 weeks gestation to 6 weeks postnatal who require secondary/tertiary assessment of a pregnancy related condition.

It was identified by observational data collection of waiting times to be seen, that increasing numbers of obstetric patients with increasing complex conditions presenting for acute care had long wait times to be seen and to have an initial assessment by a midwife.

During these times of high acuity, it was also identified that women were at risk of unidentified deteriorating condition with no process in place to rapidly and consistently assess the urgency of need to be seen. A triage tool was adapted from the Australasian Triage Scale (ATS) for adults currently used by Waikato Hospital emergency department to triage acute presentations to the emergency department. Additional work was done to reallocate room usage.

The implementation of a triage model of care to WAU has reduced the clinical risk of non-recognized potential of deterioration in acutely presenting women. >90% of women are now seen and triaged by a midwife within 5 minutes of arrival at the unit.

The problem
By working on the process we expect:

The woman seen in order of acuity

We aim to improve the prioritisation of acute women in WAU for care. GLOBAL MISSION STATEMENT: acutely presenting to WAU for care"

A triage tool was adapted from the Australasian Triage Scale (ATS) as it could be relatively easily adapted for the obstetric patient in an acute obstetric setting. After approaching the other acute assessment area in our hospital, the emergency department, we settled on the Australasian triage scale (ATS) as it may be relatively easily adapted for the obstetric patient in an acute obstetric setting, and allowed the midwifery team to communicate the newly implemented triage scores to indicate urgency to the medical staff in a "language" that they already understood.

The adaptation was undertaken by a multidisciplinary senior obstetric team to reflect best practice.

The 5 tier triage system, was also able to demonstrate high validity and reliability for categorising acutely presenting adults.

We adopted the ATS performance indicators and performance measures and worked towards the aim of meeting these.

Training of midwifery staff was initially on an intensive one on one basis with the charge midwife manager and a series of updates and education/discussion boards. These focused on "what triage is", "how triage scoring works" and "how we will triage". This intensive training was chosen to address the challenge of being solely staffed by midwives who work on a rotational basis within women’s health and usually have no nursing training.

The patient pathway under the old model of care was also mapped to decide if current room use would enable triaged patients to be seen in the most appropriate space. Under the old model it was observed that women could wait for hours in a room awaiting medical review, after completion of midwifery assessment was complete. Room allocation was based on "what room is free". This led to delays for incoming women waiting for a room to be seen in and acutely unwell women being placed into safest assessment room while a woman with a minor condition could be waiting to be seen in a larger acute room.

A new pathway was designed and communicated that allowed for high and low acuity movement of women to different rooms based on “most appropriate space.”

As part of the new pathway, room allocation/first choice use was assigned.

Communication to referring was undertaken by a series of attendance at midwifery collaborative meetings with external self-employed midwives who access the service for women in the community and newsletter and low acuity movement of women to different rooms based on “most appropriate space.”

Method: PDSA

WORKSHEET: PDSA Cycle Progress Sheet

What is our aim?

• To increase clinical safety by improving the prioritisation of acutely presenting women in WAU with the aim of having all acutely presenting women seen by a midwife within 10 minutes of arrival, with a consistently applied method, which reflects the urgency of need to be seen.

How will we achieve our aim?

• Audit triage tool with multi disciplinary team to ensure ongoing shortened wait times to be seen.

• Ongoing training of all midwives to upskill to increase triage tool reliability for categorising acutely presenting adults.

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• Further audits are planned to identify if triage is reducing overall time to see a midwife.

• Care needs to be taken with noting influences on abnormal observations (Women walk up a hill to the unit – Now they are being seen within 10 minutes of arrival prior to first observation)

• Our audit tool and the triage category allocation is planned to monitor reliability of the tool parameters and consistency and correct allocation of triage categories.

The triage tool


Discussion

• Initial review into triage tools that could be used within the obstetric setting by midwives, showed that there was not a tool that had been developed for obstetrics in the obstetric setting. After approaching the other acute triage scale in our hospital, the emergency department, we settled on the Australasian triage scale (ATS) as it could be relatively easily adapted for the obstetric patient in an acute obstetric setting. After approaching the other acute triage scale in our hospital, the emergency department, we settled on the Australasian triage scale (ATS) as it could be relatively easily adapted for the obstetric patient in an acute obstetric setting, and allowed the midwifery team to communicate the newly implemented triage scores to indicate urgency to the medical staff in a “language” that they already understood.

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• This intensive training was chosen to address the challenge of being solely staffed by midwives who work on a rotational basis within women’s health and usually have no nursing training.

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Results

ORIGINAL AUDIT

From the incomplete data collected (Data collection stopped when WAU was busy).

Times waiting to be seen by a midwife varied between 0 and 115 minutes (average wait time = 19 minutes: mean wait time = 29 minutes)

32 out of 72 women in the initial audit waited greater than 10 minutes to be seen by a midwife, and of these 8 waited longer than an hour.

RE AUDIT POST Triage

Using the triage tool and new room allocation times waiting to be seen reduced. 22 out of 23 women were seen within the expected triage time of 10 minutes (86.6%)

QUALITATIVE OBSERVATIONS

• Communication with medical and midwifery teams is improving with “shared language”

• Communication with women about anticipated wait times is improving (Increasing satisfaction). Patient satisfaction surveys are planned.

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