Abstract 27

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Title: Developing New Workflows after Emergency Department Expansion

Background:
Ocean Medical Center (OMC) is a 337 bed community hospital in Ocean County, New Jersey. In March of 2014, OMC’s new Emergency Department (ED) opened tripling the square footage of their previous ED. In 2014, the ED had >58,000 visits with a 10% increase over the 2013 volume An Accredited Chest Pain Center with PCI by the Society of Cardiovascular Patient Care since 2006, the Acute Coronary Syndrome (ACS) Committee monitors and reviews multiple processes and metrics involving the care of the Chest Pain patient. Performing and having an EKG interpreted within 10 minutes had been the standard to identify or rule out STEMI patients. Within the first months of moving into the new ED, the door to EKG (D2EKG) time went from an average of 5 or less minutes to 12 to 13 minutes. Immediately, a task force was formed with key stakeholders in the D2EKG process with the objective to explore the causes of EKG delays and develop strategies to decrease times.

Methods:
The multidisciplinary team members included: Physician champions from the ED and Cardiac Cath Lab Cardiovascular Acute Myocardial Infarction Care Nurse Practitioner Department Managers from: • ED • Cardiac Cath Lab • Access Services • Security • Quality and Outcomes Department Staff members representing: • ED nursing and technical staff • Registrars • ED Greeters • Cardiac Cath Lab Utilizing the Plan, Do, Check, Act (PDCA) improvement cycle as the model to enact changes, the team set out to identify the barriers to success. Brainstorming, Fishbone diagramming and process review of actual outlier cases were performed.

Results:
Barriers identified from process analysis: 1. Environmental Factors a. Ambulatory Entrance/Reception area utilized for various purposes. Emergency patients comingled with other activities at reception desk. b. Access Services Registrar distracted by competing activities c. Reception is isolated from actual triage area d. Triage nurse has no line of sight to reception area/patients arriving (camera surveillance only) 2. Reception Desk Staffing a. Access Services/Greeter/Registrar could be the same person b. Volunteer (part time) c. Triage Nurse rarely able to be at reception desk due to volume 3. Arriving ambulatory patient complaint reported to non-clinical staff during quick registration a. Complaint of “Chest Pain” prompts registrar to overhead page “STAT EKG” to alert a Patient Care Associate(PCA) b. Symptoms that could indicate a cardiac issue are not recognized as AMI presentation by
greeter and do NOT trigger STAT EKG. These patients are quick reg’d, have ID band placed on wrist and directed to have a seat in the waiting room. c. When incoming volume increases, the volunteer moves through the line of patients waiting and asks patients what they are here for. 4. PCA has multiple roles/responsibilities; not dedicated to triage area. 5. Communication issues a. Dead zones for overhead paging b. Pocket phones not always carried by staff or ED physicians c. “Shout out” communication hand off from PCA when leaving floor to transfer patients/ specimen delivery/ errands, and triage EKGs unattended to d. Difficulty locating ED physician to read STAT EKG. 6. Lack of Security presence at Ambulatory ED entrance / Reception Area a. Registrar isolated from ED staff with no clear line of communication b. Registrar responsible for managing hospital visitors after hours.

Conclusion:
Reviewing the barriers, some quick fixes were implemented: • Roping and signage at the reception desk to separate the walk in ED patients from hospital visitors. • Reminders and stated expectations that staff keep their pocket phones on them at all times was communicated. • Re-education to all reception desk staff and volunteers of “head to belly” ACS symptoms The task force presented the problems and barriers to administration. Support was provided through: • The addition of a dedicated triage EKG PCA and an additional 12 hours 7 days a week Triage RN added into the 2015 budget. Also approved were budgeted hours to staff triage PCA 9a-9p to be responsible for stat EKGs for walk ins • A salary variance was allowed immediately for additional reception desk staffing especially during predicted high volume hours. • Moving a triage RN to the reception desk • Additional volunteers were also assigned to assist at the reception desk. • Additional Security support to assist in directing visitors to the main hospital front desk and assist with high volume times. Administrative leadership and clinical engagement were key factors in making the workflow changes required to bring D2EKG times back in line with the guidelines and OMC’s previous results. Door to EKG times in the subsequent months were between 3 and 6 minutes. The ACS Committee continues to explore ways to reduce time waste including implementation of ED pause and single call activation via the Physiocontrol LifeNet system.