The challenge identified:
During review of December 2017 statistics at our ACS verified Level 1 Trauma Center, we noticed that our under-triage rate per the Cribari method was on the rise nearing 10 percent. The issue of undertriage has long been a priority due to the potential preventable mortality and morbidity associated with delays in activation of trauma teams and definitive care provided to trauma patients (American College of Surgeons, 2014). We congratulate discovered several trauma patients that were not properly activated based on our internal activation criteria. The patients ultimately were reviewed via our PIM process and it was identified that improper activation and lack of communication between pre-hospital, nursing staff and providers led to some of the improper levels of activation for these patients.

Objectives:
A tool was developed for nurses to use for proper activation based on pre-hospital information. The time-frame of implementation of this tool has a direct correlation with our under-triage rates decreasing. After initial implementation of the tool in January 2018, our under-triage rate decreased from 9.4% in December 2017 to 3.6 by August 2018.

Project Design:
An internal activation criteria tool was developed to mirror our activation criteria. This tool was included in the trauma flowsheets packets. Check boxes indicated the mechanism, vital signs, and other criteria that meet our internal activation levels. The focus of the tool is for nurses receiving the notification of impending arrival of injured patient to ask clarifying questions and be able to appropriately activate based on the information obtained. The trauma nurses in the Emergency Department (ED) were instructed on the tool and recent patient scenarios of improper activation levels were discussed during the monthly trauma nurse meeting as well as at shift changes. The purpose and importance of the tool was also described to the nurses who would predominantly be completing the tool. The Trauma Program Manager (TPM) also educated the charge nurses who would potentially be getting notification of injured patient arrival via pre-hospital communication.

Sustaining the change:
Sustaining the change was done by focusing on the use of the tool with every potential trauma activation. The tool was continually addressed during the first quarter of 2018 and periodically through the second quarter at both the monthly trauma nurse meetings as well as the monthly trauma team leader meetings. The completion of the tool was also included as part of the trauma nurses’ monthly flowsheet audits performed by the PI nurses. The discrepancy of incorrect activation or omission of tool was directly communicated to the nurses as well as TPM and ED Director to ensure compliance of use. Implications of the findings suggest that familiarity of trauma activation criteria and empowerment of nurses that are directly involved in trauma care will improve undertriage rates of trauma activation. Although there have been two outlier months with higher under-triage percentages, the data show a gradual decreasing trend. Future steps would be to use the trauma tool to review activation criteria with the addition of other morbidity and mortality inducing risk factors (Jammula, et al., 2018) to ensure judicious use of our resources for our highest level of activation.

References:


Abstract ID: 511122