Obstetric Triage Improvement Process

**Description**
In recent years, there has been an increase in patient census and acuity at The Johns Hopkins Hospital's labor and delivery (L&D) unit. The traditional approach to triage is on the basis of a first-come, first-served process. This process results in filling all available triage rooms with less acute patients when more acute patients present for care, resulting in nontriaged high-acuity patients waiting in the lobby. There are six triage rooms with one assigned nurse. One nurse could be responsible for up to six roomed triage patients while nontriaged patients wait.

**Objectives**
(a) To analyze how nurse-managed, acuity-based obstetric triage facilitates patient leveling and decreases time from presentation to nurse assessment. (b) To understand how to assess current workload and staffing to support implementation of AWHONN's recommended triage nurse:patient ratios.

**Evidence**
The team referenced AWHONN-recommended staffing guidelines and triage literature.

**Methods**
In 2015, expert L&D nurses developed and tested an acuity-based triage tool and patient rooming process. The goal was to decrease time from patient presentation to nurse assessment and improve care coordination on the basis of patient acuity. Outcome data were shared with staff and administration who conceptually supported the process. In 2017, current unit workload and staffing was evaluated to identify staffing to support an acuity-based triage process. There were two data-measurement tools created to track unit workload and staffing. The charge nurse recorded, in 2-hr increments, number of roomed triage patients, number of patients waiting to be triaged, overall unit census, and available staff. AWHONN's recommended staffing guidelines were used to identify the indicated number of triage nurses needed on the basis of the number of triage patients.

**Outcomes**
The process increased global awareness of triage census and acuity. Time from presentation to nurse assessment decreased by more than 50%. This result demonstrated that, with the current triage census, two triage nurses were needed to implement an acuity-based triage process and meet AWHONN's staffing recommendations.

**Evaluation**
The project supported a change to acuity-based obstetric triage to improve patient safety. Administration approved a workflow redesign and an increase in staffing to support the acuity-based triage process.

Impact of a Sepsis Screening Tool on the Assessment of Maternal Sepsis

**Description**
Maternal sepsis screening tool in the labor and delivery unit.

**Objectives**
To study how a sepsis screening tool will impact nurses on the labor and delivery unit and their awareness and recognition regarding sepsis.

**Evidence**
Sepsis accounts for up to 28% of all maternal deaths and 15% of maternal admissions to the intensive care unit. Although some sepsis screening tools exist, sepsis in pregnant women has not been researched extensively and can resemble the normal pathophysiology of pregnancy. The evidence shows that early recognition and treatment of maternal sepsis increase the chance of survival.

**Methods**
To measure our outcome, we surveyed labor and delivery unit nurses before implementation to assess their current knowledge of the sepsis screening tool and their comfort level caring for a patient who has sepsis. After 3 months of implementation, we reassessed nurses' knowledge regarding sepsis.

**Outcomes**
According to our preimplementation data, 47% of nurses (14/30) stated that they were comfortable caring for a patient with sepsis and 57% of nurses (17/30) stated that they currently assessed for sepsis every shift. However, when asked to select the symptoms of sepsis, only 3% of nurses (1/30) were able to correctly select all of the symptoms. Ninety-three percent (28/30) of the nurses agreed that a sepsis screening tool would be helpful to them in their role as a nurse. According to our postimplementation data, 48% of nurses (10/21) were able to correctly identify all of the symptoms of sepsis and 76% of nurses (16/21) reported that their knowledge had improved.
Implementation and Sustenance of Best Practices in the Treatment of Maternal Hypertension

Description
Maternal hypertension continues to be one of the leading causes of morbidity and mortality in the obstetric population. Timely identification and treatment of maternal hypertensive crisis in the hospital setting are critical to patient outcomes.

Objectives
Describe the importance of timely identification and treatment of maternal hypertensive crisis. Demonstrate how a nurse-driven protocol can reduce time to treatment for patients presenting with a hypertensive crisis during pregnancy.

Evidence
Evidence-based practice recommendations from the American College of Obstetricians and Gynecologists, California Maternal Quality Care Collaborative, and Illinois Perinatal Quality Collaborative helped identify key strategies to educate team members, identify appropriate parameters, and implement care on the basis of current recommendations.

Methods
This initiative focused on implementation of evidence-based practice using the advancing research and clinical practice through close collaboration (ARCC) model for patients experiencing a hypertensive crisis in the obstetric emergency room and inpatient maternity care setting. The ARCC(c) model provided a framework to engage the multidisciplinary team, including obstetrics and gynecology providers, family medicine providers, midwives, nurses, and leadership. This initiative identified the need for new equipment, improvements in medication availability, education about best practices, and protocol formation. The key intervention was a universally endorsed, nurse-driven protocol to initiate interventions during a maternal hypertensive crisis.

Outcomes
Timely treatment of hypertensive crises has improved since we started this initiative. In 2017, our initial goal was to treat 80% of patients within 60 min. Within the 1st year, we attained a compliance rate of 88% of patients being treated with 60 min. We have sustained this performance and adjusted this goal metric: Our current goal is to initiate treatment in 80% of patients within 30 min to improve outcomes. In the past year, we have sustained and exceeded our goal of treating patients within 30 min, with a compliance rate of 91%.

Evaluation
Engagement of the care team throughout the process helped identify barriers and develop the collaboration to achieve our goals of timely treatment. The ARCC(c) model guided the process of stakeholder engagement and development of interdisciplinary champions who consistently supported the practice change at bedside. We continue to monitor performance, evaluate outcomes, educate staff, and engage stakeholders in this initiative.

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