Letters To The Editor

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Impact of ED Triage Symptom- and Travel-Screening Strategy

Dear Editor:

Thank you for publishing the article entitled "Can you catch it? Lessons learned and modification of ED triage symptom- and travel-screening strategy" by Schwedhelm et al.[1] The authors' subsequent discussion on a recent Emergency Nurses Association podcast episode provided some additional helpful information ("Behind the Research in November *Journal of Emergency Nursing*," 2020).[2] The successful efforts to identify, isolate, and inform on patients with potentially communicable exposure, thereby reducing staff exposures, certainly warrant applause. However, certain additional pieces of information may be helpful for organizations discerning whether or not to apply this approach. These include, but are not limited to, clarification of the staffing model, further details regarding the 75% compliance rate, and the observed pre- and postimplementation metrics for (1) door-to-triage times, (2) door-to-provider times, and (3) left without being seen (LWBS) rates, at a minimum.

The article mentioned the use of a 24/7 "greeter nurse." Was the greeter nurse a distinctly separate person from the nurse performing triage duties? If yes, was a cost analysis done to evaluate the return on investment of this additional role, which is approximately 4.2 full-time equivalents, against the total cost of exposure, which would include time off and potential turnover?

For more than a decade, there has been ongoing discourse regarding what questions belong in an arrival/triage process and what questions should occur later in a visit.[3,4] More recently, the 2020 Emergency Nurses Association General Assembly adopted a resolution to further opine on screening questions during triage.[5,6] Identifying and isolating patients with potentially communicable diseases are certainly crucial. Although the authors discussed potential delays for the patients who had been positively screened, it is also important to note what impact, if any, occurred on preprovider evaluation times for all patients. Specifically, did the creation of this process lengthen the door-to-provider interval for all patients or have a negative impact on the LWBS rates?

Finally, can the authors further detail the "approximate 75% compliance rate"? Are there separate compliance rates for outpatient clinics compared with the emergency department? Were there any trends observed among the ED patients who did not have the screening completed?

In summary, it would be beneficial if future articles discussing the use of screening questions before provider evaluation also identify the impact of the process, if any, on ED throughput metrics, including, but not limited to, the door-to-provider interval and LWBS rate.—*Nicholas Alen Chmielewski, DNP, RN, CEN, CENP, NEA-BC, FAEN, Senior Managing Consultant, Berkeley Research Group, LLC, Emeryville, CA; E-mail: nchmielewski@thinkbrg.com.* ***ORCID identifier:*** *https://orcid.org/0000-0002-6543-9669.*

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