

Response to Chmielewski Letter



Dear Editor:

We would like to thank Dr Chmielewski for his comments on our article “Can you catch it? Lessons learned and modification of ED triage symptom- and travel-screening.”¹ Dr Chmielewski raises some important clarifying points that we hope will be addressed below.

The first set of questions posed by Dr Chmielewski is related to the use of a greeter nurse, available 24-7, who screens each patient as they present to the emergency department. The greeter nurse role was implemented at our hospital several years ago to optimize a quick clinical visual scan and collection of chief complaints to identify those needing immediate care (eg, chest pain and stroke symptoms) as well as to enhance overall patient and family experience. The greeter nurse also handles incoming phone calls from clinics or private offices wanting to move individuals who need a higher level of care to the emergency department, thereby reducing the burden on the charge nurse in the emergency department and enabling them to focus on ambulance traffic and overall clinical care. The greeter nurse performs triage duties only when the ED volume is low (between 3 AM and 7 AM); at all other times, 1 to 2 other triage nurses perform triage functions. With the ongoing coronavirus disease pandemic, the greeter nurse (donned in an N95 respirator and face shield) now also serves the role of relaying expectations related to the visitors of those seeking emergency care. As Dr. Chmielewski notes, the position requires additional full time equivalents. Anytime additional full time equivalents are considered, a cost benefit analysis should be performed. However, the role of greeter nurse can and has absorbed additional routine tasks and is multifactorial, from screening patients on arrival to reducing burden on the ED charge nurse by coordinating incoming calls to optimizing overall patient and family experience. Smaller hospitals with less ED volume and demand looking to replicate this model can be creative in adapting front end spaces to include the greeter nurse. This creative flexibility might translate into the triage nurse being out front and serving as both the greeter and triage nurse. Having a registered nurse in the role of a greeter nurse act as the first contact of any patient presenting to the emergency department improves patient safety and serves as a structured risk mitigation strategy for the registration staff.

The implementation of the detailed screening process did not lengthen the door-to-provider interval for all patients or otherwise have a negative impact on the left-without-being-seen (LWBS) rates; in fact, the creation and implementation of this process improved most ED

metrics. Adverse safety events in the ED waiting room were reduced to near zero owing to the immediate visual assessment, chief-complaint analysis, and appropriate triage. Immediate masking on arrival and symptom assessment mitigated exposures for other patients and families as well as health care workers. Metrics such as LWBS and door-to-provider rates improved. Several strategies contributed to having a less than 1.58% LWBS rate and 16.8-minute median door-to-provider rate during the current fiscal year; the greeter nurse not only had a significant impact on the timed ED metrics, but also on overall patient satisfaction scores.

The final clarifying point to make is in regard to the stated 75% compliance rate. Screening compliance is a report defined in the electronic medical record. A spot check or routine screening can be automated and monitored over time, and the electronic medical record can analyze data from any location where screening is expected (eg, clinics, immediate care sites, and diagnostics locations). A 75% compliance rate in the emergency department may be best explained in moving some individuals quickly to the emergency department for care or for those unable to be screened who are clinically compromised and arrive by ambulance. No other trends were noted.

We hope we have satisfactorily responded to Dr Chmielewski's letter to the editor. We agree with the author that it is important to assess and understand the impacts of symptom- and travel-screening processes on ED throughput metrics; however, as detailed here, the development and implementation of the described screening process at our hospital improved most ED metrics as well as overall patient satisfaction scores. Moreover, the coronavirus disease pandemic further reinforces the critical importance of rapidly identifying and isolating patients with potential highly hazardous communicable diseases to mitigate hospital-based exposure events.—Michelle M. Schwedhelm, MSN, RN, Executive Director, Emergency Management & Clinical Operations, Co-Executive Director, Global Center for Health Security, Nebraska Medicine, Omaha, NE; Jocelyn J. Herstein, PhD, MPH, Research Assistant Professor, Global Center for Health Security, Department of Environmental, Agricultural, and Occupational Health, College of Public Health, University of Nebraska Medical Center, Omaha, NE, E-mail: jocelyn.herstein@unmc.edu; Suzanne M. Watson, RN, Nurse Manager, Emergency Services, Nebraska Medicine, Omaha, NE; Amy L. Mead, RN, Associate Nurse Manager, Emergency Services, Nebraska Medicine, Omaha, NE; Leo Maddalena, MS, Applications Sr Analyst, Enterprise Clinic, Nebraska Medicine, Omaha, NE; Devon D. Liston, MPH, Applications Sr Analyst, Enterprise Clinic, Nebraska Medicine, Omaha, NE; and Angela L. Hewlett, MD, Associate Professor,

Internal Medicine Infectious Diseases, University of Nebraska Medical Center, and Medical Director, Nebraska Biocontainment Unit, Nebraska Medicine, Omaha, NE.

<https://doi.org/10.1016/j.jen.2020.12.002>

REFERENCES

1. Schwedhelm MM, Herstein JJ, Watson SM, et al. Can you catch it? Lessons learned and modification of ED triage symptom- and travel-screening strategy. *J Emerg Nurs.* 2020;46(6):932-940. <https://doi.org/10.1016/j.jen.2020.03.006>