The Data You Want Versus The Data You Can Get: Challenges evaluating clinical practice data in an emergency department.

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Problem: How do we evaluate the effect of the Rapid Medical Evaluation (RME) area and the Provider in Triage (PIT)?

Goal: Reduce number of patient who left without being seen (LWOBS) and initiate care earlier for Emergency Severity Index 3 patients to attempt to impact overall length of stay in the emergency department.

Objective 1: Discuss barriers in evaluating clinical practice data using multiple electronic record platforms and opportunities to bridge the gaps for future evaluations.

Objective 2: Explore opportunities to use qualitative feedback to improve processes when validated tools are not available.

Background:

- Novice CNS assisting rural civilian emergency department in an academic medical center to evaluate a newly implemented triage intervention: Rapid Medical Evaluation and a Provider in Triage. ED had increased LWBS rate and crowding.
- Literature review demonstrated Provider in Triage and Rapid Medical Evaluation were effective in majority of studies on reducing LWOBS rate and mixed results related to ED length of stay.
- Unable to evaluate previous pilot study related to inconsistent staffing, variations in volume by day, and non-standard process.

What do we want to evaluate?

PICOT: Does a Rapid Medical Evaluation Area with and without a PIT Reduce Left without Being seen rates and ED crowding metrics?

What additional questions did we want to ask?

What measures do we want to collect and analyze?			
Measure	**Feasible data**	**Nice to have data**	**Did this answer PICOT?**
Age, Sex, Ethnicity			
Chief Complaint			
Private, Government, Medicare, Medicaid, No insurance			
Emergency Severity Index (ESI) level			
Chief complaint			
Diagnosis			
Door-to-room (hh:mm)			
Room-to-disposition decision (hh:mm)			
ED LOS Door until left ED after disposition decision			
Number of patients registered per day			
Number of patients who LWBS			
Length of time spent in RME			
Orders placed in RME			
Whether or not additional diagnostic orders were placed once patient was roomed			
Time from when patient had diagnostic orders completed to when patient was placed in a ED room			
Focus group questions			

Challenges:	**Ways to mitigate/ Bridge the gap**
Nursing and Physician communication	
Boarded patients	
CNS new to this civilian ED	
Knowledge gap:	
How do we obtain data?	
IRB process and data security	
Data was segregated	
Aggregate data did not have a door to disposition time variable	
Time constraints:	
12 week evaluation reduced to 8	
Staffing shortage	
Insurance data time consuming and did not reflect pay assumptions	
How do we get feedback about process?	
Validated tool vs. focus group questions	
IRB- would not allow focus group audio tape	

Highlighted quantitative results:

Highlighted focus group results:

How can we do better next time?

Implications:

- Novice Clinical Nurse Specialists should be informed of challenges to consider when constructing new quality improvement projects or evaluation of evidence based practice implementation projects. They should learn the difference between ideal data set and what is feasible, and work to close the gap within the electronic medical record.
- Clinician and clinical informatics staff should strive to make the electronic medical record reflect current processes, support research endeavors, and continuous quality improvement projects

NOTES: