Triage of Patients in NSW Emergency Departments

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POLICY STATEMENT

TRIAGE OF PATIENTS IN NSW EMERGENCY DEPARTMENTS

PURPOSE

The purpose of this policy is to outline the key components of triage of patients presenting to Emergency Departments in NSW hospitals including the role, key responsibilities and the processes that support efficient and safe triage.

This policy does not seek to outline the clinical components of this process; clinical information related to triage is as indicated by the Australasian College for Emergency Medicine's (ACEM) policy[1] and guideline[2] on triage and the College of Emergency Nursing Australasia (CENA) Position Statements on Triage.[3,4]

This policy should be read in conjunction with NSW Health Policy PD2010_075 *Emergency Department Patients Awaiting Care*

MANDATORY REQUIREMENTS

- Triage is an essential function of an Emergency Department (ED). Triage (or an alternative local 'sorting' process by a senior ED clinician) should be the first interaction a patient has in the ED.
- ED and hospital processes must support the ability of triage to be carried out within five minutes or less so as not to delay other patients awaiting triage. This includes limiting the responsibilities and additional tasks required of the Triage Nurse, where appropriate, so that focus can remain on timely triage of patients as they enter the ED
- The triage process encompasses a brief clinical assessment of the patient on arrival to the ED to determine the priority for clinical care. Assignment of triage category reflects the clinical urgency of the patient's condition.
- The patient's level of urgency is indicated using the Australasian Triage Scale (ATS) and the Triage Nurse determines (in consultation with relevant ED and Ambulance staff if required) the most appropriate place for the patient to commence or wait for further treatment.
- It is recognised that triage is a dynamic process and may require that the patient be re-triaged if their condition changes or deteriorates prior to being seen by a treating clinician.
- The physical location and environment of triage must ensure the safety of staff and patients and accommodate privacy for the assessment of patients.
- The process of Triage involves the application of high-level patient assessment skills and knowledge to determine the patient's degree of urgency to see a treating clinician – it is for this reason that triage in NSW EDs should be carried out by Registered

[1] ACEM Policy on the Australasian Triage Scale
http://www.acem.org.au/media/policies_and_guidelines/P06_Aust_Triage_Scale_-_Nov_2000.pdf
[2] ACEM Guidelines on the implementation of the Australasian Triage Scale in Emergency Departments
http://www.acem.org.au/media/policies_and_guidelines/G24_Implementation__ATS.pdf
[3] CENA Position Statement: Triage Nurse http://cena.org.au/CENA/Documents/CENATriageNursePSJuly2009.pdf
[4] CENA Position Statement: Triage and the Australasian Triage Scale
http://cena.org.au/CENA/Documents/2012_06_14_CENA_-_Position_Statement_Triage_FinalD2-1.pdf

Nurses. It is not appropriate for clerical/administrative staff to undertake triage. In Hospitals with ED role delineation level 1 & 2, there may be occasional circumstances where an Enrolled Nurse is the first point of contact for a patient arriving in the ED. Contingencies for this occurring are described in section 2.5 -Triage Education.

- Registered Nurses undertaking the triage role must demonstrate and maintain clinical expertise in emergency nursing and have appropriate training in the triage role; the requirements of which will be determined locally. Please see section 2.5 Triage Education for further information on 'expertise in emergency nursing.

IMPLEMENTATION

Local Health District and Specialty Health Networks are responsible for:

i. Assigning responsibility, personnel and resources to implement this policy

ii. Establishing mechanisms to ensure that the essential criteria are applied, achieved and sustained as usual processes for triage; this should include nomination of an executive sponsor

iii. Ensuring that any local policy reflects the requirements of this policy and is written in consultation with responsible executive, Clinical Governance unit, ED senior management, and senior clinical staff.

iv. Providing opportunity for Registered Nurses to complete local triage education programs; ensure adequate supervision for Registered Nurses learning the triage role and demonstrate local processes for the ongoing evaluation of triage practice.

REVISION HISTORY

Version	Approved by	Amendment notes
December 2013 (PD2013_047)	Deputy Director General, System Purchasing and Performance	New Policy Replaces PD2008_009

ATTACHMENTS

1. Triage of Patients in NSW Emergency Departments: Procedures

Triage of Patients in NSW Emergency Departments

NSW GOVERNMENT Health

PROCEDURES

Issue date: December-2013

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CONTENTS

1 BACKGROUND

1.1 About this document

Triage is an essential function of an Emergency Department (ED) and must be the first interaction a patient has in the ED. This Procedure Document supports and further explains the mandatory requirements of the *Triage in NSW Emergency Departments Policy* through the following components:

- The purpose and role of Triage
- Use of the Australasian Triage Scale
- Re-triage of patients with deteriorating conditions
- Triage location and safety requirements
- Triage education
- Triage of Ambulance patients
- Telephone advice
- Mass Casualty Disaster and Triage.

1.2 Key definitions

For the purpose of the Policy Statement and this Procedures Document, the following definitions apply:

Acuity:

Acuity is a synonym for urgency, and they can be used interchangeably. An acuity-based description should answer the question: “This patient should wait for assessment and treatment by a treating clinician no longer than….”

Australasian Triage Scale (ATS):

The Australasian Triage Scale (ATS) is a 5-point scale that is designed for use in hospital-based emergency services throughout Australia and New Zealand. It is used to help sort patients by clinical urgency.

Competency:

Competency refers to the consistent application of knowledge and skill to the standard of performance required in the workplace. It is also the ability to consistently perform work activities; applying skills and knowledge; to agreed standards over a range of contexts and conditions.[1]

Complexity:

Complexity relates to the difficulty of the presenting problem and the resources involved in finding a solution to the problem. A low ATS category with a highly complex problem may consume more resources and workload than a high urgency but low complexity presentation.

[1] http://www.hwa.gov.au/sites/uploads/national-competency-report-final-20120410.pdf.

Emergency Triage Education Kit (ETEK):

The Emergency Triage Education Kit (ETEK) is a teaching resource that aims to provide a consistent approach to the educational preparation of Australian emergency clinicians for the triage role. In particular the ETEK has been designed to promote the correct use of the ATS. The ETEK can be accessed via:

http://www.health.gov.au/internet/main/publishing.nsf/Content/casemix-ED-Triage+Review+Fact+Sheet+Documents

Re-triage:

The process of re-triage involves an assessment of the waiting patient who has not been assessed by a clinician responsible for care within the time frame allocated by the initial triage category. The purpose of re-triage is to identify and escalate the care of a patient whose condition is deteriorating, reassign an appropriate triage category and prioritise clinical resources to manage the patient.

Streaming:

Streaming is a predetermined method of allocating patients to a particular treatment cohort during the triage process based on specific criteria. Such criteria may include urgency or complexity, age or presenting problem. Streaming may include allocation to a specific area within the ED, a specific set of resources (eg. medical and nursing teams) or to a patient service external to the ED (eg. specialty clinic). The practice of streaming patient presentations from the point of triage into appropriate care areas is shown to result in improvements in waiting times and ED length of stay.

Transfer of Care:

Transfer of Care in this policy refers to the NSW Health key performance indicator of the percentage of patients arriving by ambulance whose care is transferred from paramedics to ED staff within 30 minutes of arrival. Transfer of Care is defined as the transfer of accountability and responsibility for a patient from an ambulance paramedic to a hospital clinician.

Triage:

Triage is the process of assessment of a patient on arrival to the ED to determine the priority for medical care based on the clinical urgency of the patient's presenting condition. triage enables prioritisation of limited resources to obtain the maximum clinical utility for all patients presenting to the ED. The triage nurse applies an Australasian Triage Scale category in response to the question: "This patient should wait for assessment and treatment by a treating clinician no longer than…."

1.3 Legal and legislative framework

Duty of Care

By engaging with a patient as they present to the ED, the Triage Nurse enters into a health professional–patient relationship. The Triage Nurse shares the responsibility of the hospital to ensure that patients who present to the ED are offered an appropriate assessment of their urgency of treatment requirements.

All nurses should have an understanding of basic legal principles, which include consent, the elements of negligence, definition and sources of the standards of care, and how policies and guidelines can influence practice to maximise patient safety. There is an expectation that the Nurse performing the role of triage will have adequate experience, training and supervision to perform the role. The employing institution also has a responsibility to ensure that triage staff are adequately prepared to perform the role.

Patients who 'Did Not Wait' for treatment following Triage

Patients may choose to leave the hospital without being seen by the treating clinician in the ED; if the patient is competent, the Triage Nurse cannot prevent them from leaving. However, the Triage Nurse has a responsibility to advise the patient of the consequences of such a decision, and appropriate documentation recording this event should be completed (see 'Documentation' section below). Issues must be escalated to the appropriate senior ED clinician in charge of the department as required.

Patients who have a cognitive impairment (e.g. from drug use, alcohol use, a head injury, mental illness, delirium or patients at risk of suicide or with self-harm ideation) are at risk from adverse events in such situations. The Triage Nurse must therefore consider their duty of care in such cases. The Triage Nurse must be aware of and fulfil his or her responsibilities with these patients and abide by any local policies or protocols. For the purposes of triage, a rapid re-triage and/or escalation to senior ED staff may be indicated.

Documentation

Medical records are a method of communication for health care team members and are a contemporaneous record of events. They must be accurate, clear and succinct. It is also expected that the records will be easily accessible and able to be understood[2].

Minimum information that is required to be recorded for any triage episode include the following:

- Date and time of triage assessment
- Name of the Triage Nurse
- Presenting problem
- Relevant clinical assessment findings and limited relevant history
- Initial triage category allocated
- Area the patient is allocated or streamed to within the ED
- Diagnostic, first aid or treatment initiated at triage

[2] NSW Health Policy 2012_069 Health Care Records – Documentation and Management available http://www0.health.nsw.gov.au/policies/pd/2012/PD2012_069.html

- Type of visit code.

Any change in the patient's condition prior to being seen by the treating clinician must be documented clearly. If re-triage is required; documentation should include

- The time of re-triage
- Reason for the re-triage
- Information about escalation of the patient's change in condition to relevant senior ED staff.

Documentation regarding patients that choose to leave the ED without treatment should detail as much information as is available, including the following:

- information given to the patient or carer regarding the need to stay for treatment
- advice given regarding alternative or ongoing care
- the name and position of the clinician that concerns were escalated to
- the patient's condition on departure
- the time that the patient left
- any action that was taken subsequent to the patient leaving
- any other relevant information.

2 COMPONENTS OF THE TRIAGE PROCESS

2.1 The Purpose and role of Triage

Triage is a critical component in the delivery of emergency care, and is the first point of contact and assessment in the patient's ED journey.[3] The purpose and role of triage is to first identify patients with life-threatening or emergency conditions and initiate appropriate interventions (eg. emergency first aid as per local protocols), then second, allocate the patient to an appropriate area or stream within the ED.

ED and Hospital processes must support the ability of triage to be carried out within five minutes so as not to delay other patients awaiting triage. This includes limiting the responsibilities and additional tasks required of the Triage Nurse, where appropriate, so that focus can remain on timely triage of patients as they enter the ED.

Triage is used to determine the patient's clinical urgency; it is not an indicator of complexity of the patient's condition and should not be used as a substitute for this.

Triage involves rapid patient assessment, interpretation of the clinical history and physiological assessment, while objectively discriminating between the ATS categories of urgency. Triage decision-making is inherently complex, made under conditions of uncertainty and with limited or obscure information.

[3] Hodge, A., et al., *A review of the quality assurance processes for the Australasian Triage Scale (ATS) and implications for future practice.* Australasian Emergency Nursing Journal, 2013. **16**(1): p. 21-29.

Assessment of clinical urgency is achieved by observation of general appearance, collection of a focused history to identify presenting problem and clinical risk and collections and interpretation of physiological data using a primary survey approach

It is the responsibility of the Triage Nurse to escalate and engage further assistance from senior ED clinical staff where appropriate.

It is recognised that the triage process relates to managing the queue of patients who present for treatment. Currently this is done consistently by Triage Nurses, however EDs may choose to implement strategies to manage the queue according to local needs (for example, decision making clinicians seeing patients immediately on arrival to the ED).

It is important that the Triage Nurse is competent in identifying and promoting cultural safety for patients that are triaged including access to interpreter services, notification of Aboriginal Liaison Officers where appropriate and is able to access culturally appropriate information regarding triage and the waiting room for patients.

2.2 Use of the Australasian Triage Scale

In all NSW EDs, emergency nurses perform the triage role using the ATS. The ATS is a five-point scale used to prioritise patients. An ATS category from one to five is allocated according to the maximum time the Triage Nurse determines the patient can wait for emergency care.

The Triage Nurse applies an ATS category in response to the question *"this patient should wait for assessment and treatment by a treating clinician no longer than..."*

ATS Category	Treatment Acuity (maximum waiting time)	Performance Indicator Threshold*
ATS 1	**Immediate**	**100%**
ATS 2	**10 minutes**	**80%**
ATS 3	**30 minutes**	**75%**
ATS 4	**60 minutes**	**70%**
ATS 5	**120 minutes**	**70%**

** Performance Indicator Threshold represents the percentage of patients assigned ATS Category 1 through to 5 who commence clinical assessment and treatment within the relevant waiting time from their time of arrival.*[4]

2.3 Re-triage of patients with deteriorating conditions

It is recognised that triage is a dynamic process and may require that the patient be re-triaged if their condition changes, deteriorates or additional relevant information is received prior to being seen by a treating clinician"

[4] ACEM Policy on the Australasian Triage Scale
http://www.acem.org.au/media/policies_and_guidelines/P06_Aust_Triage_Scale_-_Nov_2000.pdf

Such relevant information may be received via a source such as: interpreters, Drs letter, family members, past medical records etc.

The process of re-triage involves an assessment of the waiting patient who has not been reviewed by a clinician responsible for care. The purpose of re-triage is to acknowledge any change in clinical condition of a patient and assign a relevant triage category. A patient may be assessed as requiring a higher acuity triage category (due to deterioration).

Documentation is to occur detailing the assessment, application of a new triage category, and necessary discussions or escalation of the patient's condition to a senior ED clinician (Registered Nurse, Medical Officer, Team Leader).

Patients and/or carers should be informed at the time of triage what to do if their condition changes or they become concerned while waiting for care and how the triage system works to prioritise care.

All waiting patients should be regularly assessed by either the Triage Nurse or Clinical Initiatives Nurse (CIN) if available; particularly if the waiting time exceeds the allotted triage category maximum waiting time.

2.4 Triage location and safety requirements

The triage environment must provide safety for the public, the Triage Nurse, staff and patients of the ED. The triage environment must take into account the potential risk of aggressive behaviour of patients or their relatives.

The environment:

- Must be immediately visible and well sign posted
- Must allow for clear visibility of the waiting room by the Triage Nurse
- Must have access to an area for patient examination and provision of first aid
- Must be designed to maximize the safety of the Triage Nurse, staff and patients (eg. duress alarms, egress routes for staff exiting the triage room and access to security personnel)
- Should enable and facilitate patient privacy (a private consultation room is recommended for patient examination).

2.5 Triage education

It is recognised that triage should be completed by *specifically trained and experienced RNs*[5] as:

> *… clinical decisions made by triage nurses require complex cognitive process. The Triage Nurse must demonstrate the capacity for critical thinking in environments where available data is limited, incomplete or ambiguous.*[6]

The Registered Nurse must demonstrate clinical expertise in emergency nursing prior to commencing triage education and training.

[5] Australasian College for Emergency Medicine (2006) *Policy on the Australasian Triage Scale*
[6] College of Emergency Nursing Australasia (2009) *Position Statement Triage Nurse*

The LHD will determine the baseline level of clinical expertise expected of a prospective Triage Nurse; however, new graduate (transitional) nurses should not be eligible to undertake a triage education program. The following is recommended as baseline clinical expertise[7]

- One-two years full time ED nursing experience (this does not include the New Graduate year)
- Successful completion of the NSW Health '*Transition to Practice, Emergency Nursing Program'* or equivalent transitional program
- Completion of the Clinical Excellence Commission (CEC)[8]
    - Between the Flags program
    - D.E.T.E.C.T.
    - D.E.T.E.C.T. junior
- Advanced Life Support accreditation
- NSW Health Paediatric Clinical Practice Guidelines e-learning package[9].

Local decision making should be applied by ED Nursing Managers, Clinical Nurse Consultants and Nurse Educators on readiness of nurses to undertake the triage role where appropriate. Local systems should be in place for Recognition of Prior Learning to ascertain an equivalent level of the development of clinical expertise.

It is the responsibility of the LHD Executive, the Medical Director of the ED (or equivalent), the Nurse Manager of the ED (or equivalent) and LHD Nursing Education service to ensure an adequately resourced, locally relevant, comprehensive triage training and assessment program. It is recommended that the program should encompass the following elements:

- It should be based on the *Emergency Triage Education Kit*[10] (ETEK)
- It should not teach ETEK in isolation, but use it as part of a training and competency based triage program
- It should include information about local procedures, processes and nuances.
- It should provide supernumerary support during practical triage training
- It should ensure that novice triage nurses have access to senior medical and nursing staff for support as they learn the triage role (either in person or via appropriate telecommunications)

At the completion of a triage training program, the Triage Nurse must be able to demonstrate knowledge and/or competence as follows:[11]

- Recall the science and practice of triage
- Outline the Australian health care system

[7] Health Policy Priorities Principle Committee (2011) *Australian Triage Process Review*
[8] Clinical Excellence Commission (2013) *Between the Flags*
[9] NSW Ministry of Health (2010) Paediatric Clinical Practice Guidelines e-learning package
[10] Australian Department of Health and Aging (2009) *Emergency Triage Education Training Kit*
[11] Adapted from College of Emergency Nursing Australasia (2009) *Position Statement Triage Nurse*

- Describe the role of the Triage Nurse
- Apply the ATS
- Relate the legislative requirements and considerations
- Discuss epidemiology and population health
- Demonstrate effective communication skills including use of electronic medical record systems where appropriate.
- Application of the primary and secondary surveys
- Apply and synthesize an assessment and triage decision making process by the following presentation types:
    - Trauma
    - Medical and surgical emergencies
    - Older persons emergencies and delirium identification
    - Paediatric emergencies
    - Obstetric and gynaecological emergencies
    - Mental health emergencies and the Mental Health Act 2007
    - Rural and isolated triage practice
    - Environmental emergencies
- Discuss quality and safety in health care and apply it to triage decision making.
- Discuss cultural safety issues and ensure cultural competence of triage staff

It is recognised that in hospitals with ED role delineation level 1 & 2, there may be occasional circumstances when an Enrolled Nurse is the first point of contact for a patient arriving in the ED.

For these contingencies, hospitals must:

1. Have clear processes established in order to rapidly notify a registered nurse of the patient's arrival.
2. Note that Registered Nurses are responsible for formal triaging in all circumstances.
3. Establish training for those Enrolled Nurses likely to encounter these circumstances so that they are equipped to identify high acuity patients.

Ongoing evaluation of performance, updates of clinical practice and professional development must be in place to ensure currency of knowledge and practice for the role of Triage Nurse.

2.6 Triage of Ambulance patients

Patients arriving to the ED via ambulance will be assessed and triaged as per normal ED triage procedures.

Some LHDs may have local protocols in place for rapid triage/triage bypass of specific clinical groups (e.g. ST Elevation Myocardial Infarction, Trauma, Sepsis and Stroke). LHDs are required to ensure that all triage staff are aware of local protocol agreements relating to the triage of specific clinical groups within their ED.

Following triage assessment, the Triage Nurse will determine the most appropriate location within the ED to facilitate transfer of care of patients presenting by ambulance and release of paramedics from care of the patient. This will include allocation of patients to defined clinical areas within the ED or transfer to the waiting room where appropriate, particularly low acuity and low complexity patients for whom staying on the ambulance stretcher is not necessary.

To facilitate Transfer of Care, a clinical handover using a structured approach such as 'IMIST AMBO', must occur between the treating Paramedic and accepting ED clinician. Transfer of Care is deemed complete only when this clinical handover has occurred and the patient has been offloaded from the ambulance stretcher and/or the care of the ambulance paramedics is no longer required.

In the event, that the patient is unable to be offloaded from the ambulance stretcher to an appropriate location within the ED, joint care and monitoring of the patient by ED staff and paramedics will continue until the patient can be offloaded. Transfer of Care should occur as soon as possible.

2.7 Telephone advice

It is not the role or responsibility of the Triage Nurse to provide clinical telephone advice to the public, carers and non-health professionals who may telephone the ED in an attempt to seek emergency and other medical advice.

If the Triage Nurse identifies that a caller is requiring general medical advice they should direct the caller to phone the National Triage Telephone Advice Line (*healthdirect Australia*) on 1800 022 222. If the Triage Nurse identifies that the call may be of an emergency nature, the Triage Nurse should direct the caller to hang up and phone 000 for assistance. If the Triage Nurse identifies that a caller is ringing about a mental health problem, they should direct the caller to phone the NSW Mental Health Line on 1800 011 511.

2.8 Mass Casualty Disaster and Triage

This procedure document outlines the process for ED triage under 'usual' circumstances.

Mass casualty triage, while similar, is distinct from the triage process that has been described in this document. During mass casualty incidents, or 'disasters' the triage process may change. This decision will be made by a hospital disaster controller, or their delegate.[12]

[12] http://www0.health.nsw.gov.au/policies/gl/2010/GL2010_011.html

LIST OF RELATED DOCUMENTS

1. Australasian College for Emergency Medicine policy on the Australasian Triage Scale available: http://www.acem.org.au/media/policies_and_guidelines/P06_Aust_Triage_Scale_-_Nov_2000.pdf
2. Australasian College for Emergency Medicine guidelines on the implementation of the Australasian Triage Scale in Emergency Departments available: http://www.acem.org.au/media/policies_and_guidelines/G24_Implementation__ATS.pdf
3. College of Emergency Nursing Australasia position statement: Triage Nurse available: http://cena.org.au/CENA/Documents/CENATriageNursePSJuly2009.pdf
4. College of Emergency Nursing Australasia Position Statement: Triage and the Australasian Triage Scale http://cena.org.au/CENA/Documents/2012_06_14_CENA_-_Position_Statement_Triage_FinalD2-1.pdf
5. Australian Triage Process Review report available: http://www.ecinsw.com.au/sites/default/files/field/file/Australian%20Triage%20Process%20Review.pdf
6. Emergency Triage Education Kit available: http://www.health.gov.au/internet/main/publishing.nsf/Content/casemix-ED-Triage+Review+Fact+Sheet+Documents
7. Emergency Department Triage Method available: http://www.ecinsw.com.au/sites/default/files/field/file/Triage%20Method-Oct%202010-2.pdf
8. NSW Health Emergency Department Models of Care July 2012 available: http://www0.health.nsw.gov.au/pubs/2012/pdf/ed_model_of_care_2012.pdf
9. NSW Health Policy PD2005_315 Zero Tolerance Response to Violence in the NSW Health Workplace available: http://www0.health.nsw.gov.au/policies/PD/2005/PD2005_315.html
10. NSW Health Policy PD2007_036 Infection Control Policy available: http://www0.health.nsw.gov.au/policies/pd/2007/PD2007_036.html