nurse and then checked the flow chart. Staff stated they were influenced by the flow charts with unfamiliar presentations whereas ATS 1 and 2 patients were clear and needed no referencing.

Responses of 'before' and 'during' also related to confidence. Flow charts tended to guide them earlier with triage category allocation.

Triage experience range across categories

Before	During	After	Combination
8 months – 4 years	6 months-8 years	7 months-17 years	5 months- 20 years

How often do you override a category?

Not often	13 responses
20- 30% of the time	3 responses
Often	9 responses
Other	2 responses

Overriding a triage category appeared to link with triage knowledge and experience. 11 of the 13 staff who nominated 'not often' had 5 or less years of triage experience. Reasons given included:
(i) Flow charts being mostly accurate
(ii) Limited triage experience therefore unwilling to override, instead advice sought from senior triage nurse
(iii) Ability to find a discriminator matching the patient's condition
(iv) Where a patient's condition improved or worsened
(v) Where pain score and activities were not in line

Considering the 'often' response, 6 out of 9 staff had 6 or more years of triage experience.
Reasons given for overriding often included:
(i) Pain score being imprecise particularly when analgesia administered at triage
(ii) Physiological changes not matching the patient's description
(iii) Where "I don't deem a discriminator fits with current state after physical and verbal assessment".
(iv) "Based on clinical assessment and experience it is acceptable. Do not want to put patients above others who have been waiting longer than necessary".

There were a number of comments regarding the accuracy of pain scores on the flow charts and lack of additional supportive information such as physiological changes and 'reasonable' interventions.

If you override categories, does this involve up triaging or down triaging?

Up	2 responses
Down	17 responses

Both	8 responses

The trend was towards down triaging a flow chart and category but the limited explanations from staff did not show a trend. One respondent stated the flow charts triage on the side of caution hence override was necessary. Another staff member felt triage nurses give higher triage categories and references a flow chart to possibly lower the category. (It was not recorded if the previous triages giving the higher categories had used a flow chart also). One other reason for down triaging related to pain as a discriminator.

This survey does not intend to demonstrate override as being correct or incorrect, rather how staff utilise the override option, the frequency and reasons.

Do you feel confident in your triage category allocation when you find an appropriate discriminator within a flow chart?

Yes	20 responses
No effect	5 responses
Other	2 responses

The majority of staff felt confident when an appropriate discriminator was found. Triage nurses across all levels of experience felt justified, validated and supported in their decision making and assessment skills. For those who had no effect on confidence cited triage experience, the need for judgement to be exercised despite a discriminator being appropriate and category 3 being 'too generous' as reasons.

How do you feel when you do not find an adequate discriminator on the flow chart?

Approximately half of the triage nurses replied that they relied on clinical judgement and were unaffected when they could not find an adequate discriminator. A number of staff with less than 2 years triage experience stated they consulted the senior triage nurse and allocated a triage category after discussion.

Two nurses felt less confident, while others felt frustrated but acknowledged no triage tool was perfect.

How does it affect your confidence in allocating a triage category when you have to write a discriminator on the flow chart and support your decision with written comments?

There was no effect on confidence for 23 of the staff surveyed when asked to write discriminators and support triage decisions. This was underpinned by confidence in assessment skills, consultation and rationale.

A comment generated from this question and later repeated by others was that flow charts have provided backup when a doctor questioned a triage category. Staff found this helpful.

How do the flow charts affect your confidence in allocating a triage category 1?

Patients requiring a triage category 1 were considered straightforward as they fail the primary survey. Flow charts did not affect confidence in this category.

How do the flow charts affect your confidence in allocating a triage category 2?

Flow charts had no effect on confidence when allocating a category 2 for 17 of the 27 staff. Six staff felt they were helpful guiding questions to ask with reference to the cardiac guidelines and BP parameters being clear.

Triage category 2's were generally considered straightforward. Nurses did feel supported by flow charts in this category when some presentations were 'borderline'. They stated decisions were validated and flow charts helped them to be confident when a doctor questioned a T2.

There was no correlation between effect on confidence and triage experience in this category.

How do flow charts affect your confidence in allocating a triage category 3?

No effect	11 responses
Helpful	12 responses
Other	4 responses

There was an interesting mix of answers to this question with a correlation between effect on confidence and triage experience. Where staff answered there was no effect on confidence, they did still believe flow charts validated a decision and on occasion influenced difficult decisions when it was not clear if a patient was a category 3 or 4. One respondent ventured that flow charts have the ability to reduce a triage's level of confidence.

Two thirds of the staff who felt flow charts were helpful in allocating a triage category 3 had less than 5 years triage experience. They acknowledged them beneficial at this stage in their career, assisting with interviewing patients through guiding questions, providing support particularly when attending to children, differentiating between categories 2 and 3, and generally confirming decisions.

One staff member with significant triage experience felt more category threes were allocated than any other category and flow charts support the triage decisions.

How do the flow charts affect your confidence in allocating a triage category 4?

Out of the 27 triage nurses surveyed 13 said the flow charts were supportive and helped with confidence when making a decision to allocate a category 4. Similar reasons to triage category 3 were provided. Flow charts prompted questions to ask, helped to differentiate between categories 4 and 5, validates decisions after patient assessment and was supportive when challenged by relatives confronting triage over a category given.

From the 11 who responded with no effect on confidence, they were confident despite the charts, allocated independently or worked the charts to their decision, based their triage decisions on time to treatment, patient stability and whether an LMO was more appropriate for dealing with the condition. One comment was that flow charts 'help rule things out' but still do not affect confidence. Staff experience in this category ranged from 7 months to 15 years.

How do the flow charts affect your confidence in allocating a triage category 5?

No effect	16 responses
Helpful	9 responses
Other	2 responses

A number of explanations were provided for flow charts having no effect on confidence within this category. Triage category 5 patients were considered straightforward and confidence was therefore not tested. Staff of varying experience also stated that few presentations were captured in this category particularly by the flow charts.

Those who felt flow charts were helpful, supporting confidence, agreed that category 5 patients were straightforward. Decisions were confirmed hence these respondents felt more confident about allocating a category 5.

Pain: a High Acuity Discriminator

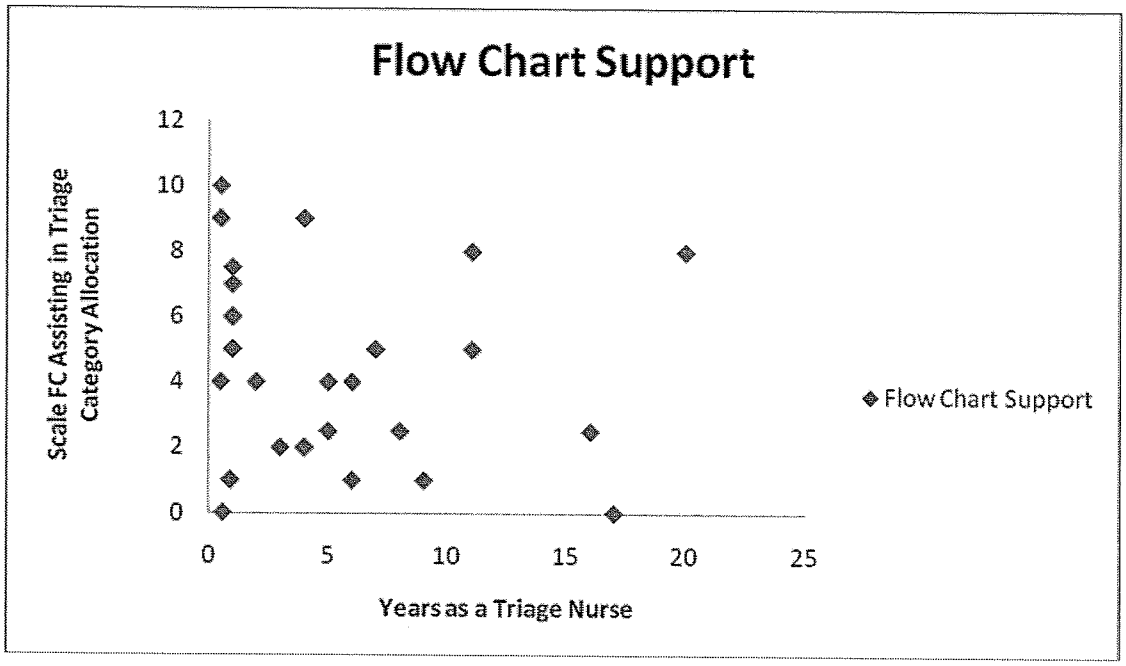
Is the T2 discriminator 'pain' sufficient to warrant immediate attention in acute or resuscitation?

A consensus of opinion was found among 23 of the 27 staff. It was considered that a patient complaining of severe pain with no clinical signs or symptoms did not warrant a triage category 2. The group felt category 2 patients with pain as a discriminator commonly needed IV analgesia to alleviate pain. This cannot be attended at triage.

Staff answering 'yes' of which there were 3 expanded little on their answers. One comment given was there is 'nothing worse than seeing a patient suffering and distressed'.

Deciding an Urgency Code

On a scale of 1-10 please indicate how well flow charts help you with deciding a triage category.



The above graph demonstrates nurses with less than 3 years triage experience have found the flow charts to be moderately to very helpful when determining patient's triage categories. Staff with 5 to 10 years triage experience found the charts marginally to moderately helpful.

General Comments from Triage Nurses

An opportunity to express comments about the flow charts otherwise not captured by the survey was provided. These have been grouped according to triage experience.

Less than 5 years triage experience

The majority of responses were in favour of continuing flow chart use at triage. Charts were considered relevant and supportive, though their application was debated. Triage nurses in this category found the flow charts to be "helpful", "supportive and should continue", a "great tool", justifying decisions made, "teach good assessment skills", a "good reference" and generally "heading in the right direction". Respondents often commented that compliance and usage were reduced in times of high workload at

triage. Some suggested computerising the charts to make the process faster and thereby reducing the triage workload.

One triage nurse suggested the flow charts be laminated as a reference tool rather than used individually for each patient. The delay between discriminator selection and patient identification label availability was cited as a delay in the triage process also.

Variation in flow chart application caused concern. It was considered by one respondent that if all triage nurses used flow charts, consistency in triage practices could be achieved.

A limited number of staff said they would rather not fill out flow charts and did not use them when the department was busy. It was felt that at times of increased activity flow charts became obstructive in the delivery of timely, thorough management. Flow charts had the potential to place more stress on the senior triage nurse as the less experienced triage tried to fit a patient to a discriminator. Incorporated with other diagnostic tools, the flow charts could provide solid triage information though.

5 years or greater triage experience

Time constraints and retrospective application featured prominently in this category. As previously stated, the triage category was often known hence the retrospective application. Experienced triage nurses did not feel they needed flow charts to assist in decision making and in their current form charts slowed the triage process.

These staff also provided interesting observations and suggestions for future flow chart use. They were generally considered a good teaching tool, validating thinking and providing prompts for new and less experienced triage nurses.

Concern was expressed when it was believed that less experienced staff relied on the flow charts rather than assessment skills to triage patients. While being a useful guide, flow charts should not replace "thinking or assessment". It was suggested that some staff were triggered by a word or description and promptly assigned the corresponding triage category. A cursory assessment at best was done. By concentrating on "a piece of paper with suggestions" critical thinking was potentially disempowered.

Loss of context, variables within the defined presenting symptoms and lack of confidence to override were possible drawbacks associated with flow chart use. One respondent believed that introducing the flow charts before a hospital based triage training package created an imbalance which confused staff and discouraged assessment skills. "The form triages instead of them triaging and assessing the patient".

Knowledge, assessment skills and education were considered cornerstones for successful and safe triage practices. Alternate triage strategies such as considering how long a patient could safely wait to see a doctor were offered. The role of triage was felt to be one of the most difficult and demanding in the department requiring seniority and competence. Flow charts were an adjunct to triage education and assessment, possibly helpful in standardising triage category allocation and should be offered in a computerised mode but not compulsory.

General Discussion

Numerous studies have been published examining the Manchester triage flow chart validity and reliability. Our aim was not to assess these but rather examine the effect modified flow charts had on triage nurses' confidence when working in a busy Emergency Department. Confidence can be related to experience and knowledge, hence flow charts may impact by providing a framework for reference and learning. Of interest also was perceived support for more experienced triage nurses and their methods of utilising the charts in daily practice.

An opportunity to trial flow charts to assist triage decision making was provided in late 2007. At this time there were approximately 20 staff with less than 5 years triage experience. Many had less than 3 years. An ATS based triage flow chart system had potential to assist and consolidate triage practices. At the time of the evaluation and factoring in staff changes, there remained a significant span of triage experience. It was therefore reasonable to provide and trial this tool.

The data identified a number of themes.

1. Flow chart inclusion in triage practices
   The majority of nurses across all levels of experience found the flow charts to be supportive and validated triage decisions. Novice triage nurses particularly benefited from the flow chart guidance when developing interview techniques, assessing patients and allocating triage codes. Expert triages benefited when triage categories was challenged particularly category 4 patients.

   These findings are in line with the Patricia Benner theory of Novice to Expert. Skill acquisition and clinical judgement is 'built heavily upon the experiences at lower levels' (Benner, 1984). Education and guidelines are relied on early in a nurse's career. By the time a nurse is considered an expert he/ she is able to 'utilize substantial analytical and critical thinking effort in order to assess multiple relevant elements in a patient's condition and arrive at plans that possess both short- and long-term goals.'

   In keeping with Benner's theory expert triage nurses applied the charts predominantly after the triage process having a broad knowledge base and confidence in their skills. This group emphasised the need for greater education to be provided to those starting at triage.

2. Education
   Education of novice triage nurses was considered a priority by respondents. At the time of the survey, triage nurses learnt their skills and role primarily through a preceptor and on-the-job training.
   Several forums for triage education have since been organised.
   (i)February 12, 2009 Canberra Hospital is sponsoring ten triage nurses to attend the Department of Health and Aging Triage Workshop in Canberra.
   (ii)Commencing in March a hospital based triage course will be provided for new and existing triage staff. A two day workshop followed by two days supernumerary at triage with mentoring is planned.

(iii)The triage workbook has recently been updated by the Clinical Support Nurse and members from the Triage Working Party with current departmental practices and policies.

Staff deemed competent in acute and resuscitation will be provided the above opportunities. The hospital based triage course may also be offered to staff from other hospitals.

3. Computerisation and Application

Survey respondents suggested the flow charts should be computerised to reduce the workload.
This presents several issues.

Software ought to allow the Nurse Coordinator (NC) to easily access the presenting problem, triage category and nursing history. Providing a drop down presenting problem menu is time efficient but should have the capacity to allow the triage nurse to free text when needed. This would then allow the NC to have a broader understanding of waiting patients' acuities.

Should flow charts be completed for all patients, used intermittently on the basis of triage experience or difficult presentations, or should they be as a reference tool only? There were a number of comments referring to the dangers of dual triaging processes; that of the flow charts competing with ATS practices. The flow charts have incorporated the ATS hence one should compliment the other. Were all staff to reference the guidelines provided by the flow charts during the triage process, a more staff inclusive process could be achieved. Novice to expert in theory would be supported.

4. Flow chart currency and review process

To date, changes to the flow charts have been made following recommendations from the Director of the Emergency Department and the Clinical Review Committee. GESHAN and other specialty guidelines have also been included. A more formal, transparent approach to maintaining flow chart currency needs to be established.

The Triage Working Party along with medical representation could assume this role. Then responsibility for currency, evidence based practices and consensus of opinion would be regularly shared. Differences of opinion over presenting problems and discriminator inclusion could be considered in an open forum and general agreement reached. This would be beneficial for all staff.

Limited Comparative Review

As an alternate means of evaluating the flow charts, an experienced ATS trained triage nurse and an Emergency nurse with no triage experience were asked to triage the same patients. Both staff were on light duties and willing to participate. Neither had used the flow charts prior to this evaluation.

The nurses were given the same patient's triage paperwork covering a three day period. They were then asked to separately triage the patients according to their level of experience and use a flow chart to show what discriminator and urgency code they would use.

The results showed approximately 50% agreement in triage category and discriminator selection. This result could be explained by a number of comments written by the nurses when separately triaging. As they had access to only the original ED Record and flow chart in some instances not enough information was written in the triage nursing assessment area. In two of these instances the patients were taken directly to a treatment area, one assigned a T2 and the other a T3 (T3 ATS 30 minutes).

Other differences were related to the interpretation of pain. Pain was described as "under control but due for more pain relief" on one presentation. A T4 was given by the ED nurse with no triage experience while a T5 was allocated by the experienced triage nurse with a reference to lack of limb deformity.

There was also a different flow chart selected by both nurses in one instance. The experienced triage nurse accepted the original flow chart but the other chose a broader capture flow chart. This second chart had the most appropriate discriminator for the presentation. It also agreed with the original triage category.

Interestingly there was a much higher level of concordance (71%) between the original triage discriminators/ urgency codes and the inexperienced triage nurse's discriminators/ urgency codes. Pain as a discriminator was often selected. Where differences did occur the original triage nurse (i)overrode triage categories, (ii) identified a different discriminator and (iii) chose a different flow chart in limited cases. This may in part be explained by the original nurse interacting directly with the patient and informed through more than subjective and objective means.

The above results cannot be interpreted broadly. The participating nurses were only available for a short time. Additionally, the patient's randomly selected came from one week of activity. Factors such as better documentation and personal interpretation could be explored further. In this instance an ED nurse with no triage experience used the flow charts to achieve 71% concordance with decisions made by currently practicing triage nurses. This same nurse's concordance with an experienced triage nurse inexperienced in flow charts use was much less.

Recommendations

- Integration of ATS strategies for triaging with flow chart inclusion thereby supporting all levels of experience. Combined, the system should be complimentary and provide consistency in triage decisions.

- Education to be fully established, supported and available to those new to the role. A significant improvement in workload and level of responsibility will also benefit senior triage nurses.

- Computerise flow charts to provide efficiencies with software capacity to meet the NC and medical needs.

- Flow chart currency and the review process to be formalised. Where possible guidelines should be established to clearly identify urgency of treatment for defined conditions. This will also improve consistency.

Acknowledgements

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Survey compiled and written by Michele Evans, Project Officer, ED CH. January 2009.

Triage Flow Charts

2009 Evaluation Report

Trial overview

- Introduced 26.11.2007
- 45 flow charts – hardcopy
- Minor changes only: ACEM CP guidelines
  CRC recommendations
  Ca Institute
  Stroke NH&MRC
- Compliance varied: experience, time constraints, learning triage/ assessing/referencing charts.

Demographics

- Yrs as an RN: broad range 2-36yrs (> 30 yrs 3-8 yrs triage exp)
- Yrs in ED: 10/12 – 25 yrs
- Yrs as triage RN: 7/12 – 20 yrs (*mean 5 ½)
- 6 out of 29 triages had a triage qualification
- Total of approx 40 triage nurses

-1/2 of the staff with ≥ 15 yrs nursing experience had spent 1/3 of their time in ED

-9 Staff < 5 yrs nursing experience were triaging within approx 2 ½ yrs. Of these, 1 had spent all their post grad experience in ED. (often introduced to the role within 2 yrs of ED nursing)

Locating a flow chart quickly

- Mostly able to physically locate FC.
- Issue with presenting problem not matching triage expectations therefore slowing selection process.
- 3 staff commenced at triage after introduction of flow charts and were familiar with pp, discriminators and locations.
- Workload impacted practices.

Referencing FC & allocating triage category

- 58% after (range of experience 7/12- 17yrs)
- Process across all responses similar
- (i) Assess pt
  (ii) Decided or idea of triage category
  (iii) Referred to FC with +/- adjustment based on discriminator
  (iv) Later circled discriminator
  -*Flow charts were used as a guide*
- Other answers to this question:
  T1/2 straightforward; know from ATS what triage cat.; look for a discriminator; never used them before – use to check if category correct; have to use a FC; helps between categories.

Overriding Triage Category

- Not often: 13

Reasons: accuracy of FC, limited experience, discriminator capture sufficient, condition change and pain score related.*

- Often: 9

Pain score inaccurate, physiological changes not in line with pt description*; discriminator not fitting; based on clinical assessment and experience it is acceptable*

Overriding up or down?

Up 2 responses
Down 17
Both 8

- Comments generated:

Up triage traumas, up-triage when comorbidities and unwell children; stoic patients with vitals worse than they look; down triage where condition not acute; usually go down due to pain as a discriminator; FC err on the side of caution*; down- according to gut feeling*.*

Appropriate discriminator

- Yes – 20 responses.

Comments generated:

Mostly a back up for triage category esp when physiological assessment matches FC; reassuring; backs me up; mostly (pain stands out); justifies/ validates a decision*; relieved though don't need a FC to say made correct decision;*

- No

Still have to make a judgement; already know; no effect due to triage background; because they may fit a discriminator but there is still 'something'.

No adequate discriminator

- The more triage experience, the more triages relied on clinical judgement.
- Less experienced triage nurse comments:

Look at other discriminators, d/w other triage*, use other strategies (how long can the pt wt?); put them in T3 just in case; if difficult presentation really problematic; if by self feel less confident; frustrating; annoying.*

Writing a discriminator

- No effect on confidence.

If confident in assessment- no problem; consult with other triage*; most of time have enough knowledge- spend a bit longer, ask a few questions; valid reason for choosing triage category; helps when doctor questions category (FC backup); experience makes you confident*.*

Confidence T1

- No effect on confidence.
- General comments additional to influence on confidence:

FC supportive, this category straightforward, primary survey, haven't had a T1, GCS 9 supported; chemical burns to eyes T1 ?; not used for T1s*; intubated pts?*

Confidence T2

- Mostly no effect on confidence.
- General comments:

Helpful with cardiac guidelines; T1/2's straightforward; supports B/P; helps with doctors questioning; only a few times go to FC to check; if I want to give a T2 I will; validates decisions, legally good idea, provides backup for trickier presentations; pain as T2 must be within clinical picture; use FC after assessment and disposition; traige based on obs, assessment and instinct.*

Confidence T3

- No effect 11; helpful 12; other 4
- No effect on confidence comments:

  Only helpful when difficulty deciding between T3 &4; no big difference; if need a T3 will allocate; should a dislocation be a T2 or 3?; no problem- confident; potential to decrease triage's level of confidence; validates decisions but does not affect confidence;*

- Positive effect on confidence:

  Very helpful at this stage- makes me think about questions to ask; help with paeds, override pain, defines T2/3/4/5; supports and helps confidence; validates decisions; makes you feel better; good learning tool.*

Confidence T4

- No effect 11; helpful 13
- No effect comments:

  No effect on confidence but do help to rule things out; if need to allocate T4 will do; confident; no effect on confidence but does validate decisions; decisions based on time to treatment, stability of pt, LMO appropriateness

- Helpful:

  Helps with confidence; validates decisions; this category a bit more hazy therefore helps; helps with stopping up triaging which other staff want you to do; confirms decisions; helps when relatives confront triage; helps with differentiating between T3&4; decides between acute and FT.

Confidence T5

- 16 staff felt FC's had no effect on confidence:

  Straightforward; not many captured here therefore doesn't affect confidence; no issue; no change; no problem- confident; do give them based on triage experience; doesn't worry me; usually an easy decision.*

- 9 staff felt FC's helps confidence:

  Helps; criteria guide to give choice about where to access health care; very clear; little more confident; more confident with giving T5.*

Pain as a T2

- 23 of the 29 nurses felt patients reporting severe pain without physiological signs did not warrant a T2.
- Where analgesia had not been administered pre-hospital a T2 was also deemed less appropriate esp if control of pain could be achieved at triage.
- 'T2 only if pt appears in pain'.
- 'Pts don't need a T2 on pain alone'.

Rating flow chart assisting with triage category allocation

- From the graph staff with less than 3 yrs experience found the flow charts moderately to very helpful.
- Staff with 5-10 yrs triage experience found the flow charts to be marginally to moderately helpful.

General Comments

- If inundated with pts- more work to do. If by self then ask a senior triage. Should computerise to make it easier and help environment.
- FC really helpful as only started at triage. When questioned about triage category, FC's justify my decision.
- Don't take them away- they are a great tool.
- Some pts don't fit- when busy FC get missed.

- Painful to fill out
- Really a good idea, supportive, should continue
- Computerise but should be able to override and add prn. Rather not do FC but teach good assessment skills.
- Usually a good reference for respiratory conditions in children.
- Do we need 1 per pt? Should there be laminated FC for reference purposes? Sticker delay an issue.

- Jr staff- potential to be useful however loss of context. The act of triage is instinctive. Some discriminators not discreet. A guide to allow staff to triage safely.
- Heading in the right direction. Possibly computerise. Needs to be a quicker process.
- Often know the triage category before look at FC.
- We have lots of T3's- the FC have a lot to do with that. If new to triage, they would be fabulous.

- When busy compliance would be inaccurate. Easy when quiet. Don't use them when busy.
- Jr staff rely on FC- done retrospectively. not supported by data
- Time constraints using FC's. Good for knowledge and skills.
- At times of increased activity FC can be obstructive. Potential to place more stress on senior triage when jr staff trying to fit pt to FC. FC may be incorporated with other diagnostic tools to provide solid triage information.

- Introducing FC before triage education package created an imbalance and 2nd guessing. Education is needed. FC can confuse triages rather than looking at the pt in front of them.
- Good as a guide. Not to be compulsory. Don't disempower triages thinking, by concentrating on a piece of paper with suggestions. An adjunct to triage. Drawbacks: variables of pp which may not be fully assessed, lack of confidence to override (data), trigger words without assessment.

- It would be good if everyone used the FC consistently to address variation issues. Some triages do T3 and not many 4's or 5's.
- Triage is a L3 job; far more difficult than an NC.
- Computerising would be good. Waiting for labels an issue. 2 triages good.
- Possibly useful in helping to standardise. But there is so much more that sits behind in terms of assessment.
- Always access FC. Valuable tool for training.

Summary

- Flow chart inclusion in triage practices.

Enough evidence to suggest that FC aid in the triage process.

One of the hallmarks of the theory is that each level is built heavily upon the experiences at lower levels (Benner 1984). For instance, the only usable experiences novices can rely on are textbook knowledge and black-or-white rules laid out prior to clinical exposure. Without the benefit of real life scenarios that are often perplexing to the novice and any given situation's tendency to veer towards grey areas, a novice will be very limited to routine task performance with little analysis. A step up from novice, an advanced beginner may be able to perform simple ED tasks such of triaging a simple, straightforward cases and recognising normal variability in vital signs in common clinical scenarios, although atypical settings may be misleading. Competent nurses utilise substantial analytical and critical thinking effort in order to assess multiple relevant elements in a pts condition and arrive at plans that possess both short and long term goals.

- Education

12.2.2009 Dept Health & Aging Triage Education Package

March hospital base triage course

Triage workbook complete

- Review process

Triage working party and medical staff could assume this role.

Currency, evidence base, consensus of opinion

Will all pts in pain be symptomatic?

NICS for pain

- Computerisation

Must be applicable to our needs

NC should be able to appraise the acuity of the waiting room quickly

Reduces inefficiencies

Completed for all staff or a reference tool?

Dual triaging processes need to be avoided.

Danger of senior triage nurses not supporting use and influencing jr staff- should work together. Processes should be complimentary rather than competitive. FC are considered a useful triage tool..

EMERGENCY DEPARTMENT MINUTES
TRIAGE WORKING PARTY

Date:	10.2.2009
Time:	1100 - 1220hrs
Venue:	ED tutorial room
Present:	Felicity Dalzell, Courtney Hayes, Jenny Northey, Megan Wotton, Kelly Johnston, Kate McCallum Michele Evans (minutes & chair)
Apologies:	Sharon Lewis

Item	Description	Detail	Date & Action
1.	Previous minutes	PCN role definition near completion. General discussion regarding responsibilities. It was felt the NC managing a shift should be able to direct the PCN with regard to ambulance offloads. No other role in the department is independent of the NC; this maintains fluidity of human resources. The NC also has 'the big picture' hence all staff should be under their direction. The PCN should report directly to triage. Confidence of the PCN's was discussed. Triage nurses felt the patient record should remain at triage and not be taken by the PCN. This maintains order and priority and triages are able to review paperwork etc freely. A PCN instead could use a nursing sheet. SOP's: Update on SOP's provided. Modified to include changes to legislation covering nurse initiated medications. Discussion re: IN Fentanyl as an appropriate drug at triage. Should S8's be given at triage? National Emergency Care Pain Management Initiative is looking at recommending the most appropriate drugs to be administered at triage.	Courtney to take information to Sharon and Amy

		Randwick and Westmead Children's give IN Fentanyl.	
2.	Triage Workshop	Courtney presented the Triage 2 day workshop schedule. 6 staff will participate with 2 days in the clinical skills room and 2 days supernumery at triage with support. TWP members were encouraged to participate in the teaching program particularly in their area of expertise or interest. Staff nominated sessions they will run. Resources will be forwarded to them covering the requirements. Aim to set up powerpoints, educational resources etc which all experienced triage nurses can use to teach. Triage nurse Manual updated and available. For the working party to review and submit any additions/ changes promptly to Courtney. (Previously reviewed Nov 2008).	Courtney to forward information to individual members Courtney to forward Triage Nurse Manual to all triage working party members.
3.	Deaf phone	Limited number of calls to this phone. Is it the appropriate technology; compatible with current systems? Should these calls go to Health First as part of the medical advice service?	Michele and Megan to action.
4.	Disaster Plan	Out of date. TWP would like to reread the triage responsibilites.	Courtney
5.	Flow charts	Presentation of report for next meeting. Meeting running overtime.	Michele
6.	Next Meeting	TBA	

Minutes approved: date ..... Motion ..... &
Seconded .....

Emergency Department

ACT Health

PRELIMINARY CARE NURSE (PCN) ROLE

Standard Operating Procedure 4.1

Objective: To provide basic nursing care for patient's triaged to the waiting room, who are waiting for further medical treatment/care in the Acute area.

Protocol:

- At the start of the shift, receive handover of patients currently in the waiting room either from T1/T2 or the PCN you are taking over from.
- The PCN is not to look after ambulance patients offloaded into the corridor.
  - This was confirmed by the CEO of The Canberra Hospital on 15th October 2008
  - If the corridor begins to fill with ambulance patients, T1 and/or T2 become involved in the care of these patients. This is in consultation with the N/C.
  - If there is a float nurse or a CQN available (and he/she is not taking the MET nurse/Resus 3 patient load), they too become involved in the care of the ambulance patients. This is also in consultation with the Nurse Coordinator (N/C).
  - If patient numbers in the corridor increase; this becomes part of the Emergency Department Escalation Plan. (i.e DON, ADON, CNC etc become involved and put into place a workable plan).
- PCN is not to initiate the first set of observations. This is, and always has been a triage role.
- PCN is not to triage patients. (NOTE; if you have been accredited in the triage role and you are rostered to work a PCN role, you may cover T1/T2 during breaks only).
- PCN is not to attend to FAST TRACK patients. If any questions regarding FAST TRACK patients, refer back to T1/T2/Fast track nurse.
- PCN is not to attend to Registrar Review patients. If any questions regarding Registrar Review patients, refer back to T1/T2.
- PCN is not to provide care that is initiated in the Acute area i.e. ECG's, IVC's, IVF, Bloods/Blood Cultures, 02, Swabs etc.
- As PCN provides basic nursing care for patients in the waiting room, this involves simple 'first aid'- basic dressings, MSU dipsticks etc

Modified:		Review Date:
[illegible]		30-1-09.

Emergency Department

ACT Health

Standard Operating Procedure 4.1

- PCN is to perform the second & subsequent visual observations of the patient and/or vital signs as required.

  -Triage Category 3 patients' vital signs must be observed 30 mins after initial, then hourly until they go into the Acute area. There is no need to do a full set of vital signs every hour-Simple visual observation may suffice on some patients. e.g. "Pt visualised, nil distress noted", "Spoke with patient, pain level has not changed", or "Pt outside smoking, eating chips and gravy".

  -Triage Category 4 and 5 patients need visual observations and/or vital signs hourly, until they go into the Acute area.

- PCN is to report all variants of observations, change of pain level & the giving of analgesia to T1 or T2-whoever did the initial triage.

- PCN can transfer patients from the waiting room to Acute with consultation with T1/T2.

- All medications initiated to patient's in the waiting room needs to be put on a medication chart-not on the back of the triage sheet.

Levels of Nursing: Endorsed Enrolled Nurses are now being introduced to role of PCN. All levels of Registered Nurses will be involved in the role including; Pink, Pink/Green, Green, Green/Blue, Blue. People who do 12 hour shifts will also be involved- but will only be in the role for a standard 8 hour shift. It is a shared role.

Shift Times: All shift times will be involved in the role. The N/C allocates this role.

New Staff Members: New staff members shall not be placed in the PCN role in the first 4 weeks of commencement. This will help in familiarising themselves with the departmental routines and in gaining of confidence.

Professional Conduct: In the Emergency Department, we all work as a team and we each strive for the same patient outcome. Be kind and courteous to your fellow colleagues. We all have to work together so we should give others the courtesy we demand for ourselves.

-ACT Health and The Canberra Hospital Emergency Department has a No Bullying Policy. It will not be tolerated. If you wish to seek further information on the policy-please speak with Sharon Lewis (ADON) or Megan Wall (NUM).

General Information: The PCN Working Group has regular meetings-all welcome. The PCN is now represented at the Triage Working Group which are held every month.

Modified:		Review Date:	

Emergency Department

ACT Health

PRELIMINARY CARE NURSE (PCN) ROLE

Standard Operating Procedure 4.1

- Triage Category **3** patients' vital signs must be observed **30 mins after initial** presentation and then **hourly** until they go into Acute. There is no need to do a full set of vital signs every hour. Simple visual observations may suffice on some patients. E.g. "Pt visualised eating and drinking, nil distress noted", "Spoke with pt, nil change" or "pt visualised-nil distress noted."

- Triage Category **4** and **5** patients need visual observations and/or vital signs hourly until they go into the acute area.

- PCN is to report all variants of observations, change of pain level & the giving of analgesia to T1 or T2.

- PCN can transfer patients from the waiting room to acute with consultation with T1/T2.

- All medications initiated to patient's in the waiting room needs to be put on a **medication chart** -not on the back of the triage sheet.

- All visual observations, vital signs and interventions **must** be documented.

Levels of Nursing: Endorsed Enrolled Nurses are now being introduced to the role of PCN. All levels of Registered Nurses will be involved in the role including;

- Pink - Pink/Green - Green - Green/Blue - Blue.
- People who do 12 hour shifts will also be involved.
- Any shift may be allocated the role of PCN.

New Staff Members: New staff members shall not be placed in the PCN role in the first 4 weeks of commencement. This will help in familiarising themselves with departmental routines and in gaining of confidence.

Professional Conduct: In the Emergency Department, we all work as a team and we each strive for the same patient outcome. Be kind and courteous to your fellow colleagues. We all have to work together so we should give others the courtesy we demand for ourselves.

ACT Health and The Canberra Hospital Emergency Department has a
No Bullying Policy. It will not be tolerated.
If you wish to seek further information on the policy-please speak with Sharon Lewis (ADON) or Megan Wall (NUM)

Modified: Amy Hicks		**Review Date:** 2012	

Emergency Department

ACT Health

PRELIMINARY CARE NURSE (PCN) ROLE

Standard Operating Procedure 4.1

The PCN is responsible for the reassessment and/or re-triage of patients', who are waiting for initial medical treatment/care in the acute waiting room area.

- At the start of the shift, receive handover of patients currently in the waiting room either from T1/T2 or the PCN you are taking over from.
- The PCN's scope of practice is to reassess patients in the waiting room. The PCN is not expected to look after ambulance patients offloaded into the corridor.
  - This was confirmed by the CEO of The Canberra Hospital on 15th October 2008
  - If the corridor begins to fill with ambulance patients, T1 and/or T2 become involved in the care of these patients in consultation with the N/C.
  - If patient numbers in the corridor increase; this becomes part of the Emergency Department Escalation Plan. The N/C will evaluate the situation and reallocate staff where appropriate.
- The PCN is not expected to initiate the first set of observations. This is the responsibility of triage.
- The PCN is not expected to triage patients. (NOTE: if you have been accredited in the triage role and you are rostered to work a PCN role, you may cover T1/T2 during tea/lunch breaks).
- The PCN is not expected to attend to FAST TRACK patients. If there are any questions regarding FAST TRACK patients, refer them back to T1/T2/Fast track nurse.
- The PCN is not expected to attend to Registrar Review patients. If there are any questions regarding Registrar Review patients, refer them back to T1/T2.
- No Triage nurse or PCN is to provide care that is initiated in Acute:
  (Eg - ECG's, IVC's, IVF, Bloods/Blood Cultures, 02, Swabs etc).
- As PCN provides basic nursing care for patients in the waiting room, this involves simple 'first aid' e.g. basic dressings, MSU dipsticks etc
- PCN is to perform the second and subsequent visual observations of the patient and/or vital signs, as required.

Modified: Amy Hicks		Review Date: 2012	

EMERGENCY DEPARTMENT

ACT Health

Triage Nurse #1.

Standard Operating Procedure

This SOP defines the role and responsibilities of a Triage Nurse as the senior clinician within the front-of-house team.

Objectives: To promote and maintain high quality nursing assessment and care for all patients presenting for treatment in the Emergency.

Protocol:

1. At the commencement of each shift the Triage #1 will accept handover from both triage nurses and the Preliminary Care Nurse (PCN). He/she will reassess any waiting patients where a history or condition is unclear.

2. Triage #1 is the most senior nurse at triage. He/she will endeavour to be:
   - Informed or familiar with all patients waiting who have been triaged.
   - Aware of the general state of the waiting room.
   - Alert to patient expects and those queued.
   - Cognisant of departmental capacity.

3. As an experienced triage, he/she should provide leadership and direction. All bed requests for acute will be coordinated by Triage #1. This will ensure the next most appropriate patient will be taken in for assessment.

4. Triage #1 shall remain at the desk. Tasks requiring a triage nurse to move from the desk/waiting area will be attended by Triage #2.

5. Where the workload permits, he/she will educate and preceptor less experienced triage nurses who may be working in the role of Triage #2.

Modified: [signature] (CNC) **Review Date:** 30 June 09

EMERGENCY DEPARTMENT

ACT Health

Triage Nurse #2.

Standard Operating Procedure

This SOP defines the role and responsibilities of a Triage Nurse within the front-of-house team.

Objectives: To promote and maintain high quality nursing assessment and care for all patients presenting for treatment in the Emergency.

Protocol:

1. At the commencement of each shift the Triage #2 will accept handover from both triage nurses and the Preliminary Care Nurse (PCN). He/she will reassess under the direction of Triage #1 any waiting patients where a history or condition is unclear.

2. Triage #2 may be a less experienced nurse at triage. He/she will:
   - Assess patients and regularly update Triage#1.
   - Respond to ambulance attendances.
   - Liaise with T1 when requesting an acute bed.
   - Be guided by Triage #1 in clinical and policy matters.

3. Responsibility for answering the telephones and radios is shared. Triage #2 will communicate instructions, inbounds and other appropriate information to Triage #1.

4. Tasks requiring a triage nurse to move from the desk/waiting area should be attended by Triage #2.

5. Where the workload permits, education and preceptoring will be provided to the nurse working in the role of Triage #2.

Modified: Lewis **Review Date:** 30.6.09.

Agenda item next meeting

Greater Eastern & Southern
Child Health Network
NSW HEALTH

SYDNEY CHILDREN'S HOSPITAL RANDWICK

Clinical Nurse Initiative and Triage Education (Paediatric Skills Acquisition) Project

Sydney Children's Hospital Emergency Department as part of the GESCHN projects will be running two 2 day courses to eligible registered nurses working in mixed emergency departments. RN's will be educated in skills required for paediatric triage as well as initiatives and skills that can be utilised to provide care to the waiting child and family. It is expected that RN's will already be at the level of triage and fulfil some of the extended skills of a Clinical Initiative Nurse.

Aims of the Project:

- To provide a targeted paediatric triage/ CIN education program for RNs working in mixed EDs
- Upskill ED nurses in the unique aspects of paediatric triage and paediatric CIN guidelines.
- Increase the level of triage and CIN confidence in ED RN's from mixed EDs.
- Increase the utilisation of paediatric specific triage tools and CIN guidelines in mixed emergency dept waiting rooms or paediatric specific areas.
- Increase the use of child friendly practices in mixed emergency departments.

Over 80% of children treated in emergency departments across the state last year were seen and treated in mixed departments.

This course is designed to increase the level of confidence, competency and skills of those nurses working in mixed departments in the role of paediatric CIN and triage.

The education model provided in the course will focus on paediatric triage, and in particular early care to the waiting child and family. The earlier that management and care of the sick child is commenced in the waiting room and the more involved the family is, staff are better able to be aware of and manage any changes or sudden deterioration of the child in the child's condition.

Participants will be asked to identify two achievable change processes that they can implement and report back to SCH within 3 months of completion of the course. Participants will also be encouraged to adapt existing Paediatric tools to local needs and SCH will provide support in this process.

Funding has already been allocated to support study leave for this course. It is anticipated that two nursing staff per GESCHN site will be allocated to attend the course.

We are currently looking at running the course on the following dates:

- 24TH-25TH August 2009
- 26TH-27TH October 2009

Both courses will be held at Sydney Children's Hospital, Randwick.

For further information please contact

Cath Sumsky
Nurse Educator Emergency
Sydney Children's Hospital
Tel: (02) 9382 0257
Email:
Catherine.sumsky@sesiahs.health.nsw.gov.au

Course Co ordinators:

Cath Sumsky
Nurse Educator - Emergency
Sydney Children's Hospital

Paul Hunstead
Clinical Coordinator
Emergency Department
Sydney Children's Hospital

Greater Eastern & Southern Child Health Network
NSW HEALTH

SYDNEY CHILDREN'S HOSPITAL RANDWICK

Clinical Nurse Initiative and Triage (Paediatric Skills) Course

Expression of Interest Application Form

Nurses within the Greater Eastern and Southern Child Health Network (GESCHN) working with children in emergency departments, are invited to apply for this two day course to be held at the Sydney Children's Hospital, Randwick. Two course dates are available. Interested staff should complete this application and return it by email, fax or post to the address/ number indicated below.

Course Dates	Preference Given
24th -25th August at SCH	
26th -27th October at SCH	

Title:_____ First Name:_____ Surname:_____

Hospital:_____

Department:_____ Position:_____

Ph:_____ Mobile:_____

Fax:_____ Email:_____

Postal Address:_____

Enquiries and Contact

For further information and to submit this application please contact

Cath Sumsky, Nurse Educator

Address:
Emergency Department.
Sydney Children's Hospital.
High St. Randwick. NSW 2031
Tel: (02) 9382 0257
Fax: (02) 9382 1978
Email:
catherine.sumsky@sesiahs.health.nsw.gov.au

Project Proposal

Title
Flowing In The Right Direction: Exploring Triage Confidence Within a Flow Chart Setting.

Identified Topic
Do triage flow charts support clinical decisions and engender greater confidence in triage nurses when assessing common presentations to Emergency?

Triage nurses operate within significant constraints including overcrowding, bed block and heightened aggression in the workplace. They must 'trawl through information, recognise and discriminate between patterns of clinical urgency, develop a working diagnosis, predict patient care needs and evaluate collected information.' Clinical urgency must be determined in a timely and consistent manner.

Evidence suggests triage flow charts can provide clinical consistency and are safe, but do they expand professional confidence within a labile setting? What difference do the flow charts make to experienced triage nurses' confidence as compared to less experienced triages?

Evidence Base to the Problem
Do staff feel more confident triaging where flow charts are in place? It is known that the:
(i) 'Selection of the correct triage code will avoid incidences of over or under triaging and provide for safer patient outcomes.' (Victorian Dept. Health. Consistency of Triage in Victoria's ED's. Melbourne Monash Institute 2001)
(ii) Emergency Departments are busy and experiencing greater aggression from patients and family members. 'To decrease the potential influence of an emotionally charged triage response to a particular situation or event, triage must learn emotions can hold sway over gate-keeping, timekeeping and decision making.'
(Emergency and Trauma Nursing, Kate Curtis, Clair Ramsden, Julie Friendship. Page 21).
(iii) Triage flow charts based on the Manchester system:
- Support clinically consistent
- Form a baseline for audit
- Enhance recruitment and retention
- Enhance patient safety.

What are the Project Aims and Objectives?
A. To investigate the impact of flow charts on triage confidence when assessing **five** common presentations to the Emergency Department:
(i) Adult abdominal pain (ii) Adult chest pain (iii) Adult psychiatric presentations (iv) Paediatric diarrhoea/vomiting (v) Paediatric asthma.

B. To determine if flow charts assist in decision making, providing a framework for consistent allocation of triage codes.

C. To identify if experience in emergency nursing impacts on confidence in performing in the triage role.

Key steps to achieving an understanding of triage confidence includes the introduction of flow charts to Emergency, auditing triage codes of patients in the above five categories, identifying triage staff and recording their experiences and overall confidence when using the flow charts.

Project Outline:

Patient population and setting:

The project will be undertaken in the Emergency Department of The Canberra Hospital. The target group will include all Emergency nursing staff who perform in the role of triage during the course of the project.

Key Actions and Interventions

1.A retrospective audit recording patient's presenting complaint/s with allocated triage code based on current ATS guidelines will be collected. This will include the five identified most common presentations. The audit will be conducted over a week of Emergency Department presentations.

2.Triage flow charts will be developed and tailored to include TCH policies and procedures and then introduced at triage. Five flow charts will be introduced every week from the 26th November 2007. The process will be completed by 29th February 2008.

3.An education program will be provided. Information and education sessions will be conducted weekly in the ED tutorial room.

4.A staff self-evaluation survey will be developed and given to all triage nurses in May 2008. Methodology will be determined in consultation with RCNMP.

5.A final audit of the five identified presentations will also be completed. Evaluation will be finalised by 30th June 2008.

Outcome Measures

The following performance indicators will be used to evaluate the project:

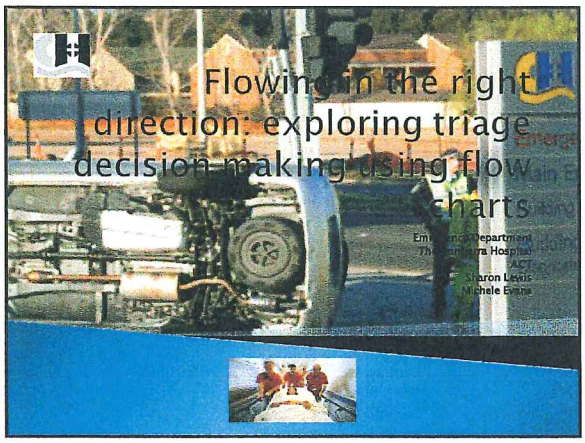
(i) Self reported increased confidence of triage nurses
(ii) Accuracy and consistency of triage score allocated
(iii) Compliance with triage protocols

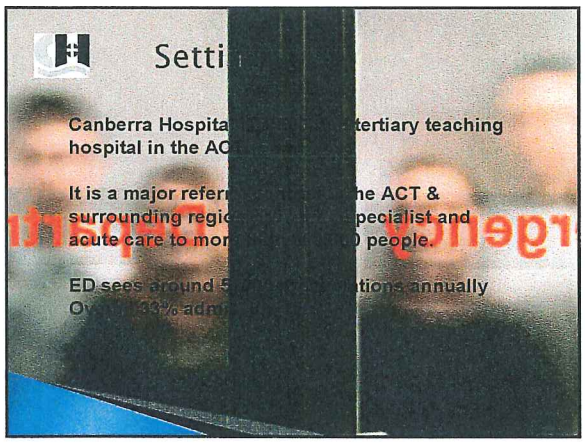
Integration

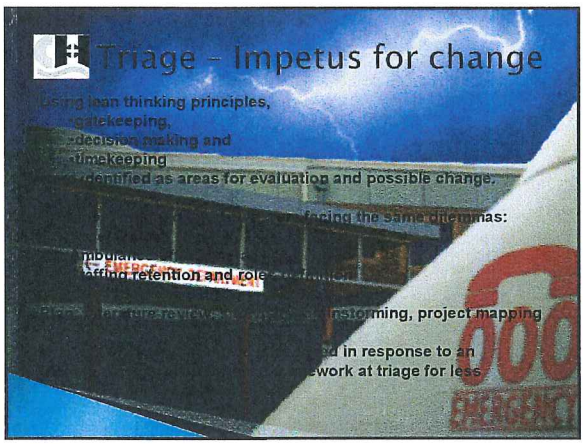
This project will build on 'Improving the Patient's Journey' and is consistent with and complements other work redesign projects in the department. This is particularly relevant in light of a decrease in staff confidence following an adverse event in the waiting room.

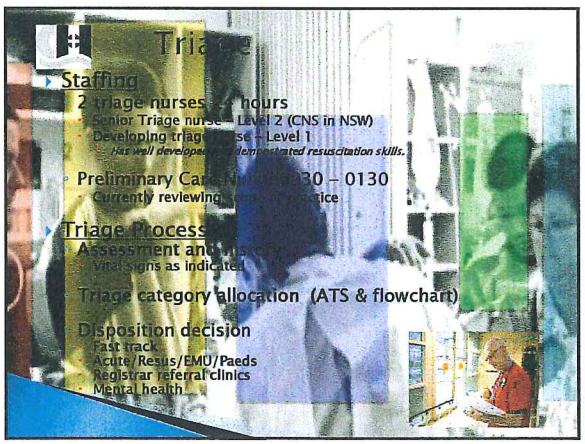
This is also consistent with ACT Health's commitment to provide safe and quality care to the residents of the ACT.

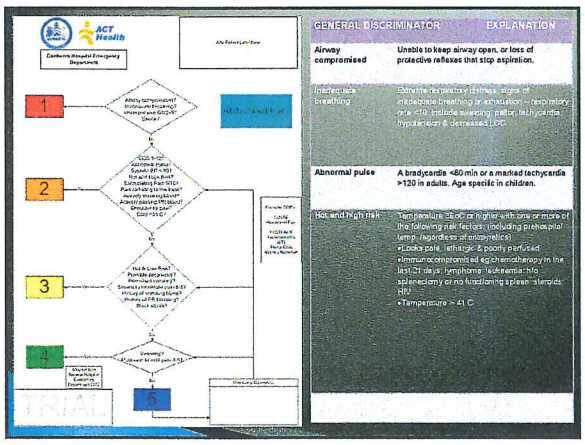
TCH performance at triage was recently ranked poorly in a National Benchmark Study. This project will empower triage nurses to allocate the appropriate triage category consistent with ATS and Manchester guidelines.

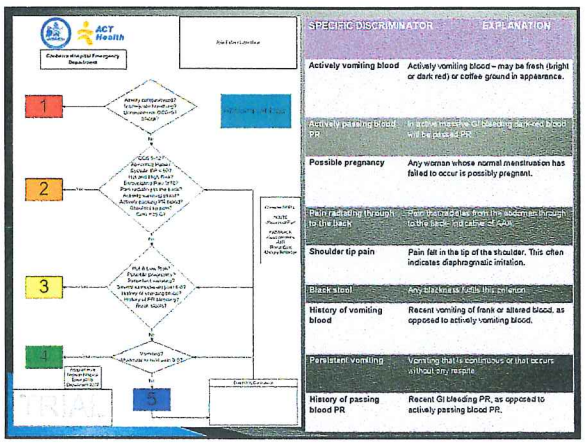

Flowing in the right direction: exploring triage decision making using flow charts
Sharon Lewis
Michele Evans


Setti
Canberra Hospita
hospital in the AC
It is a major refer
surrounding regi
acute care to mor
ED sees around 5
Ov


Triage - Impetus for change
Using lean thinking principles,
gatekeeping,
decision making and
timekeeping
identified as areas for evaluation and possible change.
facing the same dilemmas:
EMERGENCY
staffing, retention and role
storming, project mapping
d in response to an
work at triage for less
EMERGENCY


Triage
Staffing
2 triage nurses
Senior Triage nurse – Level 2 (CNS in NSW)
Developing triage
Has well developed
Preliminary Care
Currently reviewing
Triage Process
Assessment and
Vital signs as indicated
Triage category allocation (ATS & flowchart)
Disposition decision
Fast track
Acute/Resus/EMU/Paeds
Registrar referral clinics
Mental health

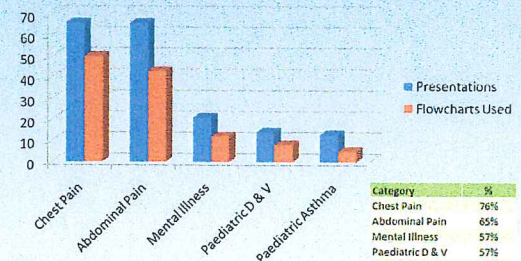

ACT Health
GENERAL DISCRIMINATOR
EXPLANATION
Airway compromised
Unable to keep airway open, or loss of protective reflexes that stop aspiration.
Inadequate breathing
Abnormal pulse
A bradycardia <60 min or a marked tachycardia >120 in adults. Age specific in children.
Hot and high risk
Temperature 39.0C or higher with one or more of the following risk factors (including pre-hospital temp, regardless of antipyretics)
•Looks pale, lethargic & poorly perfused
•Immunocompromised eg chemotherapy in the last 21 days, lymphoma, leukaemia, no splenectomy or no functioning spleen, steroids, HIV
•Temperature > 41 C
1
2
3
4
5
TRIAL


ACT Health
SPECIFIC DISCRIMINATOR
EXPLANATION
Actively vomiting blood
Actively vomiting blood – may be fresh (bright or dark red) or coffee ground in appearance.
Actively passing Blood PR
Possible pregnancy
Any woman whose normal menstruation has failed to occur is possibly pregnant.
Pain radiating through to the back
Shoulder tip pain
Pain felt in the tip of the shoulder. This often indicates diaphragmatic irritation.
Black stool
Any blackness outside this criterion
History of vomiting blood
Recent vomiting of frank or altered blood, as opposed to actively vomiting blood.
Persistent vomiting
Vomiting that is continuous or that occurs without any respite
History of passing blood PR
Recent GI bleeding PR, as opposed to actively passing blood PR.
1
2
3
4
5
TRIAL

Evaluation of Triage Flowcharts

- Do they provide a framework for consistent allocation of triage categories?
- Determine whether flowcharts support triage decision making
- Examine the impact of flowcharts on a triage nurse's confidence when allocating a triage category
  - TARGET PRESENTATIONS:
  - adult abdominal pain,
  - adult chest pain,
  - adult psychiatric presentations,
  - paediatric diarrhoea and vomiting, and
  - [illegible]asthma

Results – Compliance



Category	%
Chest Pain	76%
Abdominal Pain	65%
Mental Illness	57%
Paediatric D & V	57%
Paediatric Asthma	38%

Data collection – Interview

- [illegible]wed 16 tri[illegible]staff
- Dete[illegible]ne whether the flowcharts assisted in decision making when allocating a triage category
- Determine whether the flowcharts had an effect on confidence when allocating a triage category

Results – Interview questionaire

- Out of 16 triage nurses 5 had qualifications in ED Triage – 31%
- Most triage nurses (81%) used the flowcharts *after* deciding on a triage category

Confidence

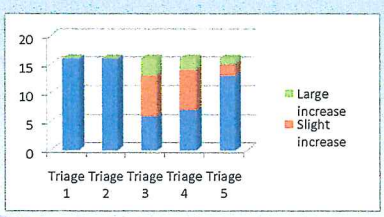
- *"Do you feel confident in your triage allocation when you find an appropriate discriminator within a flow chart"?*
  - No effect; already made a decision on clinical assessment
  - 5 staff with 1 year or less experience identified they felt relieved, reassured, validated, & more confident if discriminator [illegible] the flowchart. These staff also used flowcharts as a reference

Confidence

- *"How does it affect your confidence in allocating a triage category when you write a discriminator on the flow chart to support your decision with written comments"?*
  - [illegible]affect on confidence
  - 5 staff [illegible]ar or less experience identified feelings [illegible]ration, were unsure & sought advice then from a senior triage nurse

Results – interview

- How do flowcharts affect your confidence in allocating a triage category?



Results – interview

- *the Triage Category 2 discriminator 'R*
  sufficient to warrant immediate attention
  acute or resus"?
  - *tion fr pati*
  - *ge ass ment i*
  - *eyon whi*

Discussion

- *rts: Provide a framework for allocation of triage categories?*
  - *Diff sess due to compliance being variab in c gories*
  - Computerising the flowcharts should improve compliance and also simplify auditing
  - *with flowcharts is dependent on staff p flowcharts which takes time*
  - *on & usage of flowcharts consistency: CP as an eg*

Discussion

- Flowcharts: Determine whether flowcharts support triage in decision making?
  - Senior staff felt they didn't require support from the flowcharts where as the junior staff reference the flowcharts for unfamiliar presentations and in deciding a triage category for T3 T4.
  - Senior staff [illegible] support from the flowcharts [illegible] making process [illegible] decisions by referring [illegible] the decision making [illegible]

1.Triage Assessment Subj/obj/obs/ VAS	2.Category Allocation	3.Expected Wait

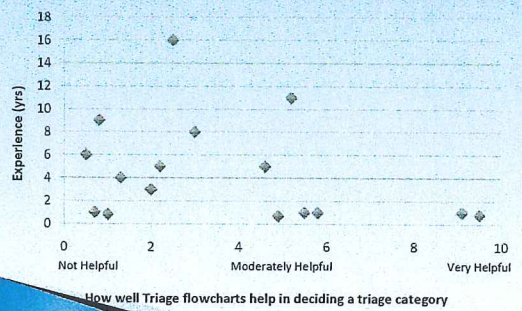
Discussion

- Flowcharts: Examine the impact of flowcharts on triage nurse's confidence when allocating a triage category
  - Staff are confident when allocating a T1 or T2 – these are based on a primary survey (clear evidence base into many education programs)
  - T3 patients we see 35% on time, risk factors nurse is aware of when making these decisions
  - T4 patients we see 35% on time, risk factors nurse is aware of when making these decisions
  - Specific discriminators within a presentation confidence T3 & T4 triage categories will flow charts help to make triage nurses confident they have made the right decision

Discussion

- *[illegible] increase in the number of p[illegible] ions given a triage category 2 s[illegible] the ction of the flowcharts*
  - *ct/Nov 2007 11% of presentations to ED were* category 2
  - In July/August 2008 13% of presentations to ED were category 2
    - See average 80% of category 2 presentations within 30 minutes
    - See average 35% of category 3 presentations within 30 minutes

Triage decision making



How well Triage flowcharts help in deciding a triage category

General Interview Comments:

- From the [illegible]ws general comments where:
- Fl[illegible] a standard, consistent triage
- H[illegible]ent skills are still needed
- W[illegible]n flowchar[illegible]eases
- [illegible]la gnostic tools the flowcharts can pro[illegible]ormation
- [illegible]ould be used [illegible] a r[illegible]ool rathe[illegible] for all triage decisions

- Increase in T3 categories
- Provides a safe triage guide
- Good as a guide when [illegible]re unfamiliar with certain presentations
- Less experienced triage staff use the flowcharts and need to also develop assessment skills for balance
- Current manual documentation does add to triage assessment time which is significant during times of peak demand

Acknowledgments

Thank you to:
Leonie Johnson
[illegible]ren King
Kath Clayton
Lexi Bryne
Ian Miller

Contacts:
Michele Evans
michele.evans@act.gov.au
Sharon Lewis
sharon.lewis@act.gov.au

GO WITH THE FLOW...

A LITTLE DITTY...

- It was the start of the new academic year at the nursing school. The hospital was teeming with young enthusiastic student nurses eager to learn all about patient care. The ED was particularly challenging for them as decisions there had to be made promptly...

- One of the nurses was working alongside the triage nurse, who was explaining how important it is to triage a patient appropriately so that the patients who need medical attention first get it before lower priority cases. She described how patients often present to the ED with minor medical problems instead of going to their LMO.

'It is important to recognise patients with serious medical problems among the sea of patients in the waiting room,' she said.

- 'This applies to patients with chest pain too,' she continued. Not all patients presenting with chest pain have a cardiac problem. In fact, statistics in America have shown that, of the 5-6 million patients presenting to ED's with chest pain every year, almost ½ have non-cardiac chest pain. Using the Manchester triage system can help in identifying patients with suspected cardiac chest pain and filtering out those with non-cardiac pain.'

- It was time to see the next patient, who happened to have chest pain. The triage nurse said, ' **Now *watch* how I apply the Manchester triage system to this patient.**'

- She asked the patient to describe the pain in his chest. He looked at her and said, 'Well, the pain I have now is quite similar to the one I had last summer, and they had to 'jump start' me then.'

- The patient was seen by the doctor immediately....

BMJ 2004. Diagnosing cardiac chest pain. Ajay L Mahajan

MANCHESTER SYSTEM: A HISTORY

The Manchester Triage Group was set up in November 1994 with the express aim of establishing a consensus amongst senior ED physicans and nurses regarding the standard for triaging.

It soon became apparent that the groups aim could be set out under 5 headings:

1. Development of a common nomenclature.
2. Development of a common definition.
3. Development of a robust triage methodology.
4. Development of a training package.
5. Development of an audit guide to triage.

A review of a triage nomenclature and definition that were in use revealed considerable variation. It was apparent that there were a number of common themes running through these systems.

Once the common themes of triage were highlighted, the group was quickly able to agree on a common nomenclature and definition system.

Each of the new categories had a number, colour and name. Design was in terms of target time to first contact with treating clinician.

These are very similar to Canadian and Australian systems.

Codes and values:

00 Not triaged

01 Immediate resuscitation

Patients in need of immediate treatment for preservation of life

02 Very urgent

Seriously ill or injured patients whose lives are not in immediate danger

03 Urgent

Patients with serious problems, but apparently stable condition

04 Standard

Standard ED cases without immediate danger or distress

05 Non-urgent

Patients whose conditions are not true accidents or emergencies

Manchester Triage Scale:

Number	Colour	Category
1	red	Immediate
2	orange	Very urgent
3	yellow	Urgent
4	green	Standard
5	blue	Non-urgent

WHAT IS IT?

- A reliable five-level triage system that has become the standard in the UK and Canada.
- The system uses a flow-chart based format.
- Triage identify the patient's chief complaint, then choose one of 52 flow charts to conduct a structured interview and then assign a triage category.

INCORPORATING FLOW CHARTS INTO OUR PRACTICES

- Nepean Hospital adopted the Manchester System for their Emergency Department in 2000. They identified a need to modify the flow charts to incorporate ATS guidelines and adapt to Australian presentations.
  (eg. No bites/stings)
- These modified and tested flow charts will be introduced to our department on 26.11.07.

BENEFITS

- Flow charts provide a framework to guide less experienced triage nurses in the questions to ask and the allocation of a triage category.
- Experienced nurses often have interview techniques that complement the flow charts.

- The flow charts provide clinical consistency and safety.

  Steps:
  - 1st - An initial assessment - primary survey
  - 2nd- Focus on the patient's primary complaint (assuming patient stable) using **discriminators.**
    Pattern recognition
    Physiological data.

  Research supports the use of physiological criteria as a basis for clinical decisions
  - 3rd- Appropriate urgency code.

The flow charts are a sensitive tool for detecting those who subsequently need critical care.

They may up triage.

SCENARIOS

53 y.o. male BIBA with sudden onset of crushing central chest pain 3 hours ago. He developed pain whilst he was chopping down a tree in his garden. On arrival he is in a semi-recumbent position on the ambulance trolley.

- RR 18 with no use of accessory muscles
- SaO2 99%
- HR 68 regular, skin- pale, cool and moist
- BP 135/75
- GCS 15
- C/- crushing central chest pain 9/10 with no radiation
- Temp 36.6
- No relevant PHx

Using a flow charts what discriminator would you use hence triage category?

26 y.o. male presents with his wife complaining of sudden onset of abdominal pain. He is able to walk slowly to the triage desk but requires assistance from his wife. He has had pain for 12 hours but it has become much worse in the last 2 hours. He has vomited once and had 2 episodes of diarrhoea. He has not eaten today.

- RR 14 with no accessory muscle use
- SaO2 99%
- HR 98 regular and skin pale, cool and dry
- BP 100/75
- He is c/- R sided abdo pain 6/10 with no radiation
- Temp 37.8 C
- No relevant PHx

Using the flow charts what flow chart and discriminator would you use? What triage category would you allocate?

82 y.o. female presents with her daughter following a collapse at home. She is unable to walk and requires assistance to get out of the car. She is brought to the triage desk in a wheelchair. The patient's daughter tells you that her mother has been feeling unwell for 2 days and was nauseated and vomiting today. She collapsed in the lounge room as she got up from a chair and was unconscious for 1-2 minutes.

- RR 20 with no accessory muscle use
- SaO2 97%
- HR 148 irregular, and her skin is pale, cool and moist
- Her BP is 90/55
- Her GCS is 13 (open to speech, confused place & time)
- She has no complaints of pain but states she feels dizzy
- Temperature 37.4C
- Glucometer broken

She has a history of ischaemic heart disease, non-insulin diabetes and CCF. Her daughter has brought her medications with her and she takes Daonil, Digoxin, Warfarin, Frusemide and Slow K. She has had all of her usual medications today.

Using the flow charts what flow chart and discriminator would you use? What triage category would you allocate?

31 y.o. female presents with a 1 day history of vomiting, diarrhoea and crampy abdominal pain. She is able to walk to the triage desk unassisted and she states that her symptoms were of sudden onset.

- RR 16 with no accessory muscle use
- SaO2 98%
- HR 88 and her skin is pale, warm and dry
- GCS 15
- She is complaining of generalised pain 4/10

She states that she has not vomited for 4 hours but continues to have diarrhoea. She has a PHx of asthma for which she uses a Ventolin puffer.

Using the flow charts what flow chart and discriminator would you use? What triage category would you allocate?

Does she need acute or FT?

28 y.o. female presents with her daughter who reports a 3 day history of PR bleeding. The patient is able to walk to the desk unassisted. The patient is verbally aggressive and will not disclose exact losses.

RR appear normal

Not obviously pale or diaphoretic

She will not disclose any pain but wants to be see NOW

She has a PHx of MRSA and VRE and last week admitted to another hospital post 'collapse'.

You have only one BP machine at triage and others are not available.

What flow chart would you use and what discriminator?

What triage category would you allocate? How would you deal with the infectious component? Obs? Bed allocation? Current infective state?

23 y.o. female presents with one day history of PV bleeding. She is able to walk to the desk unassisted. She states she is 8/40 and has had 'spotting' since this a.m. She described her PV loss as a few bright spots.

- RR 16 with no accessory muscle use
- SaO2 98%
- HR 78 and skin pink, warm and dry
- BP 120/80
- GCS 15
- She does not complain of pain

She has no relevant PHx.

What triage flow chart would you use? What triage category would you allocate? How would you manage further care of this patient?

As of Monday the 26th November 5 flow chart will be introduced at triage per week until all 46 are available. All staff are to use these please. (later computerised)

Triage need to **circle the discriminator** on charts provided. The charts are to then stay at triage for later collection.

Triage Flow Chart Audit Tool

Presentation Date:
Patient UR:
Triage:

Indicator	Yes	No	N/A	Comment
1. Flow chart used	*			
2. Correct chart used	*			
3. Discriminator identified	*			
4. Presenting problem not present on chart and other identified				
5. Triage category linked to discriminator	*			
6. Override of category with explanation	*			
7. *Further explanation for above points 1-7?* *Only where necessary*				
8. Triage vitals attended (see reference table) These should be done at the time of triage (within 10 minutes)				
9. Pain score recorded if present	*			
10. Analgesia +/or other intervention Pain ≥ 5 should have analgesia or other intervention (eg RICE). Patient refusal or pre-hospital analgesia to be documented	*			
11. Paediatric assessment Pink, warm, moist, alert, urine output				
12. Limb assessment Movement, warmth, colour, sensation, pulse, cap refill				
13. Subjective assessment Pt description of complaint				
14. Objective triage assessment Physical assessment as permits	*			
15. Re-triage (where necessary)	*			
16. Appropriate disposition Waiting room, acute, resus etc				
17. Alert identified on triage screen (prn) Trauma code, Trauma alert, Fast Track, Helicopter				

Audited by:_____ Date:_____

REFERENCE TABLE: MINIMUM TRIAGE REQUIREMENTS FOR VITALS

	Category 1 & 2	Category 3 & 4	Category 5	
Chest Pain-adult	No obs. Discriminator only	-Hot/low risk= temp -pleuritic pain= P, BP, Temp, SaO2. -New irreg pulse= P, BP -Persistent vomit=P, BP -Major trauma criteria= P, BP, R (Pain score where pain a symptom)	Pain score should be recorded for any chest pain.	Where a T2 is overridden to a lower category a minimum requirement of BP, P , R and pain score should be recorded by triage. Ambulance offload pts exempt from vitals by triage. (PCN at 30/60)
Abdo pain- adult	No obs. Discriminator only	Hot/low risk= temp Possible preg= P, BP Black stool= P, BP Hx vomit blood=P, BP Persistent vomiting=P, BP Hx of passing blood PR= P, BP (Pain score where pain a symptom)	Pain score should be recorded for any chest pain.	Where a T2 is overridden to a lower category a minimum requirement of BP, P and pain score should be recorded by triage. [Cold <35.0C a Temp shoud be done] Ambulance offload pts exempt from vitals by triage. (PCN at 30/60)
D & V- paed	No obs. Discriminator only	Hot/low risk= temp Unable to feed=P, R, Temp, SaO2 & hydration status [skin tone, m. membranes, cap refill, LOC] Black stool=P, R, hydration status Hx vomiting blood=P, R and hydration status. Signs of dehydration= P, R, hydration status. Persistent vomiting= P, R , Hydration status. Hx passing PR blood= P, R, hydration status. (Pain score should be recorded where apparent.)	Pain score should be recorded where apparent.	Where a T2 is overridden to a lower category a minimum requirement of P, R and hydration status should be recorded by triage. Ambulance offload pts exempt from vitals by triage. (PCN at 30/60)
Asthma- paed	No obs. Discriminator only	Mod increased WOB= P, R, SaO2, Mildly increased WOB= P, R, SaO2, Low PEFR= P, R, SaO2 Low SaO2= P, R, SaO2.		Where a T2 is overridden to a lower category a minimum requirement of P, R and SaO2 should be recorded by triage. [Cold <35.0C a Temp shoud be done] Ambulance offload pts exempt from vitals by triage. (PCN at 30/60)
+Mental illness +Deliberate Self Harm +Behavioural Disturbance ADULT	Discriminator and mental health chart.	Discriminator and mental health chart.	Discriminator and mental health chart.	

TRIAGE CONSIDERATIONS & AUDITING (taken from Consistency of triage in Victoria's ED's)

Triage decisions and triage category allocation should be based on the pts individual need for care. The triage category should be allocated according to the pts ***objective clinical urgency.***

Primary triage decisions should be based on both objective and subjective data as follows:

Objective data:

- 1st : Primary survey - should form the basis of all primary triage decisions. Any breach necessitates immediate intervention.
- 2nd :Physiological data- research supports the use of physiological criteria as a basis for clinical decisions. (Many studies report that the majority of pts exhibit physiological abnormalities in the hours preceding cardiac arrest and that pt outcomes can be related to physiological criteria. Research demonstrates that triage nurses frequently use normal clinical indicators when making triage decisions).

  The aim of physiological discriminators is not to replace the clinical judgement of the triage nurse but to provide a consistent, research based approach to triage education.
  Additionally, each discriminator should be considered as part of a larger clinical picture and not considered in isolation.

- AIRWAY: any adult with an obstructed or partially obstructed airway should be allocated T1. 75% occlusion for adults to exhibit stridor. Children much lower obstruction to cause stridor.
- BREATHING: respiratory dysfunction is known to be a clinical antecedent to adverse events. New onset dyspnoea and tachypnoea are well documented to be significant indicators of impending adverse events. Admission to hospital with pulmonary problems has been demonstrated to have a higher than average incidence of mortality and morbidity and inadequate oxygenation has been identified as one of the recurrent factors in preventable deaths.

  Given that respiratory dysfunction is a predictor of poor outcome, it is important that respiratory dysfunction is identified during the triage assessment.
- CIRCULATION: haemodynamic compromise esp. hypotension has been documented as an indicator of poor outcome. If present, it must be detected during the triage assessment. May include BP or peripheral pulses, skin status, conscious state, alterations in heart rate.
- DISABILITY: CONSCIOUS STATE: alteration in conscious state (confusion, agitation, restlessness, lethargy) has been documented to be a clinical indicator of poor outcome and adverse event. Level of activity in children was one of the most common factors cited by triage nurses as influential in paediatric triage.
  - A GCS of <9 is considered a severe head injury; mortality rate of up to 40% with most deaths occurring in the first 48 hrs. A GCS of 9-13 is considered moderate, mortality <20%, long term disability may be as high as 50%. A GCS of 14-15 is considered mild with most head injuries in this bracket; estimated 38% will have findings on CT and 8% require neurosurgical intervention.
- DISABILITY: PAIN: assessment should take into account subjective and objective data. Pts do not need to justify their pain to health care providers. The purpose of triage assessment is to ascertain how long that pt can wait with that degree of pain. It is also the role of the triage to

initiate simple interventions that will relieve pain such as application of an ice pack, or splinting or elevation of a limb.

- DISABILITY: NEUROVASCULAR STATUS

- Opthalmic emergencies: threat to the function of the affected eye/s. Chemical esp alkalis rapidly penetrate the corneal tissue and as they continue to penetrate may ultimately result in damage to the iris, ciliary body and lens. Important to ascertain first aid measures also.
- Age >65 has been associated with increased incidence of adverse events and increased morbidity and mortality following an adverse event. Extremes of age (>80 and neonates) have physiological differences that place them at increased risk of serious illness or injury. They have decreased physiological reserve, altered physiological responses to illness or injury and may present to ED with non-specific signs and symptoms.
- Risk factors: in both adult and paeds that place them at greater risk of serious illness or injury. A patient may be at significant risk of illness or injury and can be physiologically normal at triage. The presence of multiple risk factors, particularly if directly related to the presenting complaint should be considered seriously and the presence of one or more risk factors may result in allocation of a higher triage category.
  +Mechanism of injury : specific mechanisms that place a pt at risk of life threatening injury.
  +Comorbidities: systemic disease increases the risk of serious illness or injury.
  +Historical variables: pts may present with completely normal physiology at triage but the history of events prior to presentation increases the index of suspicion of serious illness or injury. Eg apnoeic episode at home with babe normal at triage- but the story may warrant a triage catefory of higher acuity than is indicated by the pts physiological status.
  +Other: actual and potential effects of drugs and ETOH. Pts may present following ingestion of drugs or ETOH and have a normal primary survey however the type and amount may make it reasonable to predict physiological deterioration and allocate at triage a higher acuity than is indicated by the pts physiological status on arrival.
  +Body temperature: <35.5 or >38.5C and hypothermia in trauma pts 35C are cited to be a predictor of increased mortality.+Rash: anaphylaxis or meningococcal disease (usually have concurrent primary survey abnormalities).

Subjective data: Chief complaint

Precipitating event / onset of symptoms

Mechanism of injury

Time of onset of symptoms / event

Relevant past history

Objectives for triage :

Perform an accurate triage assessment and allocate a triage category based on that assessment and primary discriminator.

Accountability and responsibility with documentation

What needs to be documented?

Complete, accurate and timely documentation is a critical professional and legal requirement of working at Triage.

A rather obvious revelation! However, the trick is to sort the wood from the trees by observing the patient (TIP: Don't just look at the computer!), asking the right questions and then distilling the relevant "facts" – all this while faced with the additional challenges of juggling and multi-tasking.

The purpose of the triage assessment is to complete a primary assessment and to quickly decide patient disposition. This may sometimes require polite interjection, when interviewing the patient, to prevent going off-track and getting into a secondary and quite detailed history. The gathered triage information then needs to be succinctly documented. NB. For emergent presentations time is critical. Action triage response immediately and document retrospectively.

> **Remember:**
> In the eyes of the law, *NOT DOCUMENTED = NOT DONE*

Sometimes it is just as important to document the negative findings as well as the positive findings for example:
Gradual onset of headache over last 8 hours. Pain 5/10. No neck stiffness/photophobia/rash. Alert and orientated. Pupils 3 ERTL. Hx of flu-like illness last week. Analgesia given as charted.

> Where indicated chart vital signs including respirations , GCS and/or neurovascular observations where they are relevant to the clinical assessment.

Observations form part of the objective patient assessment and provide a baseline should the patient's condition change .

> Document any clinical interventions initiated as a result of the initial, or subsequent assessments of the patient while they are waiting AND the effect of the interventions.

For example:
Exacerbation of asthma following URTI. Not responding to 4/24 salbutamol puffer. O/A speaking in short sentences, tachypnoeic, using accessory muscles of respiration. Wide spread inspiratory wheeze on auscultation. O2 Sat 91% RA
ADD: Access block –no bed available. Given Salbutamol 8 puffs as charted. Commenced on O2 6LPM via HM. Signature
* Record baseline observations*
2120hrs. O2 Sat 96% with O2 6LPM via HM. On auscultation decreased AE :R>L. Inspiratory wheeze @ bases. RR decreased to 20. Signature

OR

Fell onto outstretched hand 1/24 ago. O/A Deformed swollen left wrist. NV intact. Cap refill <3secs. Pain 4/10. ADD: Rings removed. Sling, ice and elevation. Declined analgesia.
1700hrs. Pain increased 7/10. NV obs recorded– unchanged. Panadeine Forte as charted. Signature
1730hrs. Pain improved 4/10. Signature

Other tips for documentation:

- Don't forget to record drug allergies and relevant medical history in EDIS alert fields
- Record and sign for all nursing interventions
- Chart medications given
- Keep it objective - document only what you observe, hear, feel, smell or count rather than what you think, conclude or assume.

  For example:
  "Patient smells of ETOH, has slurred speech and is unsteady on feet" .

  rather than

  "Patient appears drunk".

- Document time and sign any entries that you make in notes
- Use only approved abbreviations.

Always check : Right Person, Right Notes

Police requests for a copy of patients notes

There is a formal administrative process to allow a patient's medical records to be subpoenaed by the Courts. However occasionally a member of the Australian Federal Police will ask Triage for a copy of the patient's medical records. This is in breach of the privacy legislation and is NOT permitted.

Under no circumstances is a copy of the patient's medical record to be handed to the police. If required the notes can be subpoenaed through the appropriate process

Agenda Items

Evans, Michele

From: Hollis, Gregory
Sent: Tuesday, 12 May 2009 12:49 PM
To: ED-OIC; Evans, Michele; Lewis, Sharon; Wall, Megan; Gras, Roy; Lewis, Sharon; Hayes, Courtney; Dwyer, Toni; Grace, Roseanne
Cc: Hall, Michael (TCH); Reid, Barbara; Jackson, Kate; Maccullagh, Jeanett
Subject: RE: Daily Excess Wait Report for Cat 1 and Cat 2 after Audit for 11 May 2009

Toni/Rosie/Roy etc,

After discussion between Kate/Sharon/me/Mike Hall etc it has been agreed that another appropriate time for triage category "seen by" time is in relation to psych presentations.

Can you please add (slightly) to your workload, that:

Time seen for TC2 includes:
- Time "Psychiatric Triage checklist" is completed by ED nursing staff (triage) IF all ticked "No".

Rationale - those cases are then reviewed by CATT & legitimately don't require specific ED medical input unless requested.

Let me know of any problems in implementation.

Sharon/Michele/Courtney/Megan etc - can you please reinforce with triage staff the importance of fully completing the psych checklist.

Thanks

Greg

Greg Hollis
Director
Emergency Department
The Canberra Hospital

From: ED-OIC
Sent: Tuesday, 12 May 2009 12:29 PM
To: Evans, Michele; Hall, Michael (TCH); Hollis, Gregory; Jackson, Kate; Lewis, Sharon; Maccullagh, Jeanett; Reid, Barbara; Wall, Megan
Subject: Daily Excess Wait Report for Cat 1 and Cat 2 after Audit for 11 May 2009

Agenda Items

Toni Dwyer

EDIS Administrator/Audit Manager
Emergency Department
Canberra Hospital
PH: 0262442426
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ED-OIC@act.gov.au

E-mail Message

From:	Cormack, Mark [EX:/O=ACTGOV/OU=CALLAM/CN=RECIPIENTS/CN=MARK_CORMACK]
To:	Elsey, Jennifer [EX:/O=ACTGOV/OU=CALLAM/CN=COMMUNITY CARE/CN=JENNIFER_ELSEY]
Cc:	
Sent:	29/05/2009 at 3:40 PM
Received:	29/05/2009 at 3:40 PM
Subject:	FW: Strategies to improve triage category performance times
Attachments:	Canberra Hospital ED TC performance V2.doc

TRIM and resub

> _____
> From: Hollis, Gregory
> Sent: Friday, 29 May 2009 2:57 PM
> To: Cormack, Mark; Thompson, Ian (ACT Health); Stone, Bill; Reid, Barbara; Burnand, Jo
> Cc: Ainsworth, Brenda; Monaghan, Martin
> Subject: Strategies to improve triage category performance times
>
> Mark/Ian/Bill/Barb/Jo,
>
> The attached plan outlines the strategies currently in place, planned, and under consideration for continued improvement in Triage Category performance times at Canberra Hospital.
>
> We would also like to acknowledge the support provided by Canberra Hospital executive team in recent months in regard to ED patient flow.
>
> We would be grateful for your feedback.
>
> Greg, Mike, Kate & Sharon.
>
>

ACT Health

Canberra Hospital Emergency Department

Strategic Plan: Triage Category Performance times

Approved by: Director, Deputy Director, DON, ADON (May, 2009)

Introduction:

This document describes current and future strategies, maintenance and implementation plans. It has been developed following the 2010 Summit final report in December, 2008, and in line with:
a) the described Canberra Hospital ED vision of becoming national leaders in excellence in Emergency care
b) developing a plan to reach the Commonwealth goal of 80% of all ED patients being seen within the ACEM recommended triage times by 2012.

This plan will be a living document, that is reviewed and updated regularly as new strategies are considered, and the efficacy of current and future strategies are reviewed.

The 80% target is believed to be the first time that an Australian government has articulated a performance goal. The current ACEM KPI's are: TC1-100%, TC2-80%, TC3-75%, TC4-70%, TC5-70%.

Current Canberra Hospital overall performance figures vary, but average 55-60%.

Strategies must focus on TC3 and TC4, as these are by far the largest groups and the most problematic performance. Performance in other categories must be maintained.

Current strategies, and those planned over the next 12 months are largely within existing resources. Beyond mid-2010, a number of the strategies will require the provision of additional resources and support to facilitate implementation.

Strategies currently in place

1. Triage category 2 Interventions.
   In place for several years. Successful.
   Maintenance of TC performance consistently at or above 80%.
   eg Immediate transfer to bed space or resuscitation bay. Overhead announcement of all TC2. Senior Doctor review policy.

2. EDIS daily Data review
   In place since 2004. Time corrected daily for a number of set & approved criteria
   eg time of commencement of medically approved and supervised protocol, Chest pain pathway – ECG review, earliest Dr seen time in notes or on EDIS, etc.
   Continue to ensure capture of earliest legitimate time seen.
3. MHAU checklist
   introduced early May, 2009. Approved screening tool for likelihood of medical issues in mental health patients.
4. Fast track
   Minimal improvement, predominantly TC5.
   Future review of criteria, review of medical staffing may provide improvement.
5. Physio primary clinician
   specific patient groups, fast track. Some impact.
6. Paediatric registrar in ED on evening shift
   Introduced 2008
   Analysis has been unable to demonstrate any impact on TC performance times. Intervention likely to be maintained for other reasons.
   More detailed audit of intervention is under consideration.
7. Alternate pathways
   a. GAU (Gynae assessment unit) – continue. Effective for a group of patients
   b. Registrar review clinic. Some impact; maintain. Consider expansion to specialties in addition to current orthopaedic/plastic surgery service.

Strategies planned now, or in the immediate future

1. Rapid assessment Doctor (RAD)
   Launch 30th May, 2009.
   Target group predominantly TC3 & TC4.
   Unable to implement 24 hours due to current deficiencies in consultant and registrar staffing.
   Scope may be extended in future when shortfalls are addressed.
2. SOP's – ACT-wide
   Not yet introduced at either Calvary or Canberra Hospital.
   Impact expected to be limited at TCH.
   Education occurring at both Hospitals, expected introduction in June, 2009
3. 3-2-1
   Partially in place. Various issues to address to improve impact:
   a) Not supported by ACT Health policy (policy finalised; yet to progress through final stages of ACT Health policy approval framework).
   b) 3 – early "decision-maker" assessment of patient. Two strategies to further improve: 1. RAD + future extension, 2.Recruitment and retention of senior medical staff
   c) 2 – Three issues here: 1. shortfall of decision-makers. Require recruitment/retention/future funding. 2. Inpatient team compliance – requires ongoing support & intervention TCH-wide. 3. Reluctance of

ED senior staff to implement – requires policy support + reinforcement by ED Director

d) 1- Remains the most significant factor affecting availability of ED bed space. Almost completely beyond ED control. Requires TCH-wide intervention

4. QA processes
   Maintain focus on TC performance in ED QA process.
5. Daily (weekday) patient flow meetings – senior Dr/Nurse with CH exec.

Future strategies and implementation plans/considerations

1. Access Block
   Remains the single largest cause of poor ED performance. Requires ongoing intervention outside the ED.
   Continue to build on the recent strong TCH executive support.
   Brief periods of 1-2 weeks of reduced access block are problematic, as they do not allow for systematic process change. Longer periods of sustained improvement in access to inpatient beds are critical.
2. Staffing. Key issues here are:
   a. Consultants – expected to recruit to current funded FTE by mid-2010. Require increased funding from mid-2010 to support sufficient clinical cover to support rapid decision making
   b. Registrars – Current recruitment almost adequate. Requires ongoing attention to retention strategies, and will require increase in the medium-term.
   c. RMO/CMO – Significant deficiencies in recruitment currently, with regular shifts below establishment. Requires immediate attention. Night shift requires immediate increase to 3 RMO (currently 2).
3. Expansion of RAD, rapid assessment team
   Potential for significant impact on TC3/TC4
   Requires funding and recruitment of senior staff
   May include a Dr/Nurse team model
4. Streaming
   Current physical layout does not support streaming. Significant decision to be made in upcoming future model of care work – admit/discharge streaming, or not. As this will impact significantly on Capital work plans over the coming 5-7 years.
5. I.T. support for ED flow policy/practice
   It is understood that the Alcidion Second screen proposal has been rejected, despite ED support.
   Current data/administrative staff are working on tools that may assist, using revisions of "Crystal" reports.
   I.T. solutions to support real time reinforcement/alerts regarding patient flow/3-2-1 decisions are required
6. Nurse Practitioner
   Role of ED nurse practitioner, and Paed Nurse Practitioner is supported and under development.

7. Aged Care
   Current discussion with RADAR, Aged Care, and discharge liaison nurses regarding early intervention in ED. Interventions likely to be recommended as a result.
8. Review of criteria for "seen by" time
9. Legislation/Government Policy/funding initiatives
   Models based on the UK 4 hour rule may be considered, eg an ACT 8 hour rule.
10. Walk in clinics
    Not expected to produce any improvement in performance, based on publications, and experience world-wide. Will also not target the majority of the TC3&4 patients that are the clear group requiring intervention. Individual and ED Network submissions in response to the discussion paper have occurred. It is expected Walk-in clinics are likely to be introduced in the ACT, and it is anticipated they may be promoted as an appropriate intervention. They should not be regarded as a strategy that will contribute to ED performance. May play an appropriate role as a nurse-led model, with expansion of options for ambulatory health care, and are likely to create demand.
11. Education/training
    Requires ongoing attention as a key part of the articulated TCH ED vision statement.
    Scenarios/simulation/training to promote rapid assessment, decision making, and team approaches will facilitate performance
12. Triage review
    Future National & local reviews of triage processes & systems are likely.
    Maintain awareness of direction of these, and impact on local performance initiatives.

Version Control

DATE	VERSION NUMBER	DISTRIBUTION	ACTION
May 2009	1	GH, MH, KJ, SL	First Draft
May 2009	2	TCH & ACT Health Executive	Final draft for comment