

“Who’s Next?” Triage Challenges and Best Practices in Ontario’s Hospitals

Hospital emergency departments (EDs) treat people with injuries and unexpected illness as well as those with chronic conditions. They provide care for patients that ranges from advice for self-care to complex medical and surgical interventions. As EDs tend to be very busy, health professionals must determine, through a process known as triage, which patients require immediate care and how long others can safely wait for care.

Triage is complex. It needs an appropriate physical environment with adequate staffing. The triage nurse needs special training and considerable experience in order to be able to make timely decisions about the patient’s needs. To assess, maintain and improve the quality of care, triage activities require equipment, supporting documentation, quality assurance and the identification of best practices.

The Canadian Triage and Acuity Scale (CTAS) was introduced in 1997 to provide health professionals with a five-level triage scale that specifies presenting complaints and gives detailed descriptions of conditions at each level. In 1999, the Ontario Ministry of Health and Long-Term Care mandated the CTAS for EDs across Ontario.

The Ontario Hospital Association’s Triage Project aims to ensure that all of Ontario’s emergency patients are consistently and accurately assessed using CTAS. This study was commissioned by the Triage Project and is one of the first studies to examine both the triage environment and process in hospitals of different sizes and missions.

The study included a survey of hospital ED administrators. As part of the survey, administrators were asked to add comments to structured questions and to reply to open-ended questions. They were asked to describe problems experienced in triage in the following six areas:

- ▶ Physical layout
- ▶ Crowding
- ▶ Documentation
- ▶ Attitudes
- ▶ Staffing and training
- ▶ Quality assurance

They were also asked to identify other triage-related problems, and to describe solutions that had worked well in their EDs. This Research in FOCUS on Research looks at their responses.

This issue of Research in FOCUS on Research is based on the report *Triage Practices and Procedures in Ontario’s Emergency Departments* (2005) by Cater Sloan and Raymond W. Pong of the Centre for Rural and Northern Health Research, Laurentian University; Vic Sahai, Robert Barnett and Mary Ward, formerly of the Northern Health Information Partnership; and Jack Williams, formerly of the Institute for Clinical Evaluative Sciences. This research project was commissioned by the Triage Project Steering Committee of the Ontario Hospital Association.

This study was funded by a grant from the Ontario Ministry of Health and Long-Term Care to the Ontario Hospital Association.

The interpretations, views and conclusions expressed here are those of the authors, and no endorsement by Laurentian University, the Ontario Hospital Association, or the funding agency should be inferred.

Physical Layout

According to respondents, poorly designed physical layout can make it difficult to monitor arriving and waiting patients, disrupt patient flow, contribute to crowding, cause a lack of privacy, cause communication difficulties, and lead to interruptions.

Several EDs reported satisfaction with their physical layouts, while many others were planning improvements, especially to increase privacy.

- ▶ *“Insufficient glass versus wall to allow clear sight lines, the walls are too high.”*
- ▶ *“Patients arriving interrupt triage assessment and slow the process.”*
- ▶ *“Unable to do an in-depth exam at triage due to lack of privacy.”*
- ▶ *“[We plan] the addition of a sink, door into department locked, access button in triage and nursing station, and a closed-circuit camera.”*

Crowding

Crowding in the triage area often results from EDs that are too small for the volume of patients. This can delay triage and reassessments, affect privacy, and may cause patients to leave without being seen. Staff may respond to crowding by assigning lower or higher CTAS scores than are appropriate.

Increased staffing was mentioned as an effective way to handle crowding, including the suggestion of hiring a nurse practitioner for the ED or increasing staffing at peak times. The most often mentioned solution was ED renovation. Specific planned improvements include a “larger waiting area with a children’s area, a dedicated triage waiting area, more privacy, electronic tracking, more treatment rooms,” and “plans to separate emergency and ambulatory care.” Some EDs successfully use alert systems, video cameras, two-way radios, or a patient liaison or volunteer in the waiting room. Crowding is also eased by the use of walk-in clinics and after-hours clinics.

- ▶ *“The ER area is too small for the numbers of patients, therefore we are unable to meet CTAS guidelines.”*
- ▶ *“A sudden influx of patients tends to overcrowd and extend the wait time at triage.”*

Documentation

Various types of information were reported missing from triage records, with reassessment mentioned most frequently. Different reasons for this were suggested, from lack of time to not enough space on the form. Also singled out was inadequate documentation of the pain scale, reportedly because of “on-going issues with accurate documentation of objective-subjective data.”

In some cases, the code recorded by the ambulance paramedic is transcribed as the triage code, or there is discrepancy between the two codes. Both of these practices can lead to confusion.

The problem at some hospitals of duplicating charting on the triage record and the ED chart has been solved by using a duplicate triage form, by electronic charting, or by combining the triage and ED forms into one tool.

- ▶ *“A dedicated triage nurse would enhance better and/or full documentation.”*
- ▶ *“Physicians do not document times or what is done.”*
- ▶ *“[We need to] convince all staff of the importance and value of good documentation.”*

Attitudes

Patients can become upset and even aggressive when they mistakenly expect to be seen on a first-come, first-served basis. Several respondents suggested increased signage and pamphlets about triage, and for staff to take the time to explain triage to patients. One ED has a policy that all triage nurses have excellent public relations skills.

Staff, too, experienced frustrations with triage, arising from the extra work and stress that triage and reassessment timelines create, from occasional disagreement between nurses and physicians about the triage level, and from inconsistent triaging by staff. More training and education can help overcome these problems. On the other hand, many respondents reported that their staff appreciate the consistency and organization of the CTAS system.

Quality Assurance

Quality improvement is a cyclical process of setting goals for improvement, measuring progress towards these goals, recognizing what works best, and providing feedback to further enhance performance.

Of the 40% of EDs with no quality assurance (QA) mechanism for triage activities, just over half have plans to develop one. The most frequently mentioned barriers to having a QA program were lack of human resources and time. A formal QA process, an automated process, a standard audit tool, resources, and education were all mentioned as desirable for setting up a QA program.

The remaining 60% of administrators reported their EDs have a QA mechanism. About 9% of their ED triage charts are reviewed for QA purposes. Just over half of these EDs have a designated person (clinical manager, nurse manager, charge nurse, staff nurse, program director, etc.) or team (quality council, triage team, audit committee, etc.) to monitor triage QA. Usually this same individual or group conducts the QA as well. Some respondents also used external reviewers from other hospitals or from District Health Councils.

Medical records and charts are reviewed for triage code, time to triage, physician assessment, reassessment, completion of triage documentation, and outcome of the visit. Some have daily or weekly review, others review only every two years. Some do occasional audits or spot checks, some limit audits to charts with more serious CTAS scores.

Various audits have revealed problems that can be addressed, for example, that “pain scales, vital signs and acuity levels are not always documented,” that “physicians are not meeting response times,” or that patients are being under- or over-triaged. It is important that those responsible for QA have the opportunity to discuss cases at regular meetings. Sharing audit results with staff and creating forums for discussion lead to the identification of best practices.

- ▶ *“Nurses often feel overwhelmed at triage, [because there are] too many patients. Nurses feel stressed when standards cannot be met.”*
- ▶ *“Physicians and nurses feel frustrated by the lack of funding for sufficient staff to meet triage requirements and response times.”*
- ▶ *“MDs don’t buy into CTAS levels, and do not want to follow CTAS levels for seeing patients.”*

Staffing and Training

Administrators reported that staffing difficulties arise from lack of funding for dedicated triage staff, lack of qualified and experienced workers, difficulties in recruiting and keeping staff, difficulties filling particular shifts with trained personnel, and the need for extra staff to substitute for those undergoing training.

The need for education and training for new and existing triage nurses was often mentioned. There is an apparent lack of access to formal CTAS programs for some areas, especially paediatric CTAS. There were many comments about the lack of funding to support training (e.g. tuition, materials, replacement staff).

The “train the trainer” approach was suggested as a way to let more nurses receive triage training. Other suggestions were to have annual refresher courses for all triage staff, ongoing mentoring, physician involvement in CTAS training, and posters and resource manuals for paediatric CTAS.

- ▶ *“[We arranged] to have nurses within the hospital who are in need of a modified work program to assist triage... (i.e. to see to patient needs in the waiting rooms, re-evaluate vital signs, answer their inquiries, but not to triage). This is very successful.”*
- ▶ *“The use of medical directives in triage helps with patient flow and satisfaction.”*
- ▶ *“Development of a professional practice model for ED nurses that includes triage [would be beneficial].”*

- ▶ *“No money to support QA.”*
- ▶ *“The medical records department was a big help [with QA].”*
- ▶ *“[With QA we have an] increased awareness of triage requirements for documentation.”*
- ▶ *“The results of the audits were shared with everyone and everyone appears more accepting.”*

Other Problems with Triage

As well, administrators identified a broad range of other system-level difficulties with triage:

- ▶ In addition to the lack of access to training programs for staff (as discussed above), administrators reported problems obtaining outside support and supplies like posters and training manuals.
- ▶ Some felt that smaller hospitals and inner-city hospitals face more challenges when it comes to triage.
- ▶ Problems arise from having the CTAS tied to the funding formula, whether or not physicians bill on a fee-for-service basis.
- ▶ The general lack of physicians means there are more patients without a family physician who use the ED as a “walk-in clinic.” It was suggested that nurse practitioners could help ease the overload caused by these “orphaned” patients.

- ▶ *“We were not aware of the changes made to CTAS, nor do we have a contact person to refer to as needs arise.”*
- ▶ *“It is much more difficult for a small hospital to initiate this type of program due to limited staff and lack of training money.”*
- ▶ *“CTAS is a middle class tool. It does not focus on homelessness or other population-based issues.”*

The triage process itself gives rise to some problems. Some administrators are still sorting out whether to register patients before or after triage. But many have worked out their own strategies.

- ▶ *“Vital signs are done at the time of registering patient and for CTAS 4 and 5. Anything lower is brought in immediately and assessed.”*
- ▶ *“The patient is triaged and registered in the same location. Patients do not move. Staff move from station to station.”*
- ▶ *“Since CTAS was implemented, we continued to register patients first, as long as we were able to triage patients within 15 minutes of arrival. Now we have a wait time of 19 minutes, and we are in the process of changing to triage first.”*

Conclusion

The introduction of CTAS into Ontario’s EDs has not been easy for many hospitals. Resources – whether physical, human, or training – are often in short supply and budgets are limited. The timeline standards for triage and reassessment add stress to an already stressful workplace. Some patients and some staff are having trouble accepting triage. In many cases, record-keeping for triage needs improvement.

Despite these problems, positive comments were made with respect to all six areas under consideration in this survey. Through the increasing use of quality assurance mechanisms, Ontario’s EDs are clearly making efforts to review and strengthen the triage process with the goal of enhancing efficiency and improving patient outcomes in EDs.

- ▶ *“Patients are more accurately triaged now, according to presentation, not according to staffing, availability of spots in the department, or wait times.”*
- ▶ *“Staff are receptive to triage training and appreciate the value of triage.”*

06-A2

Research in **FOCUS** on Research is published by the Centre for Rural and Northern Health Research (CRaNHR), Laurentian University. Each issue is a summary of a study conducted by CRaNHR researchers. As a form of knowledge dissemination and transfer, it is intended to make research accessible to a wider audience.

For further information, please contact:
Centre for Rural and Northern Health Research
Laurentian University
Ramsey Lake Road
Sudbury, Ontario, Canada P3E 2C6

phone: 705-675-1151 ext. 4357
fax: 705-675-4855
e-mail: cranhr@laurentian.ca
URL: www.cranhr.ca