Getting it right with triage – no easy matter

Shortcomings in a rural hospital Emergency Department

Over the holiday break, the media highlighted a case involving the death of a 69-year-old man who died after a nurse at the Emergency Department, where he had been treated and discharged earlier in the day, referred him to an after-hours doctor, rather than recommending his readmission to hospital (*Dominion Post* 26/12/05). The investigation revealed shortcomings in the assessment carried out by the Emergency Department doctor, and identified that, in view of his history and symptoms, the patient had been discharged prematurely. In addition, a key issue was whether the emergency nurse, when later contacted by telephone by ambulance officers who had been called back a third time to the patient's home, made an adequate assessment of the man's condition before deciding that it did not warrant his return to the Emergency Department.

The hospital telephone triage policy assessment procedure required the nurse to ask specific questions of the caller. Although all the information needed to make a decision regarding a referral was available to the nurse at the time of the telephone conversation, the patient's cardiac and respiratory history carried significant morbidity that was not recognised in assessments made of his condition. Furthermore, as the policy contained no criteria or decision-making protocols for referral of cases to either the after-hours doctor or the Emergency Department, referral decisions were left up to the individual staff member making them. Shortcomings in both the written triage policy, and the actions of the staff implementing it, resulted in this patient not receiving appropriate care. The nurse was found in breach of the Code for failing to respond appropriately to the telephone call and failing to document her telephone conversation as required by the telephone triage policy. (The doctor who had prematurely discharged the patient was also found to have breached the Code). The hospital has revised its triage policies as a result of this incident (04HDC00658).

Accident and medical centres

Triage procedures have also caused concern in clinical settings other than hospitals. A recent complaint to my office concerned the priority for treatment provided to a six-year-old girl who attended an after-hours medical centre with her father. She was sensitive to sound, had not been moving freely, was hot, had vomited, and had a sore head and diarrhoea. The doctor who saw the girl after an hour's wait recorded that in addition to her other symptoms, she had full neck flexion, raised red papules on her arms and legs, and an annular lesion on her left shoulder (for which she was treated with cream). He diagnosed a viral illness, prescribed paracetamol, and gave clear instructions in the event that the child deteriorated or failed to improve. The doctor advised that he checked the child's entire skin surface and she did not have a suspicious rash or a stiff neck (he considered that the raised papules were "clearly" insect bites).

During the night the child complained that she could not move her body and her bones ached. She vomited at least three times. The following morning her mother noticed a rash that was similar to bruising. She thought her daughter had meningitis. She took her daughter back to the centre, where again they waited for an hour before being seen by the doctor. The child was diagnosed with meningococcal septicaemia,

prescribed oxygen and intramuscular penicillin, and referred urgently to the hospital Emergency Department, where she made a good recovery.

The child's father complained that (among other things) the clinic appeared to have no system in place that ensured that his daughter's priority for assessment was adequately determined in view of her symptoms and previous presentation.

Medical centre's response
The clinic did not have a formal triage process because only one nurse was on duty each shift. An unwritten triage procedure required that the receptionist liaise with the nurse if a patient appeared very unwell or said he or she felt very unwell. The nurse would scan the waiting room at regular intervals as often as possible, ideally every 15 minutes and, on the basis of this assessment, ensure that the receptionist and doctor prioritised their consultations. However, regular and frequent scanning did not occur when the centre was very busy, as it was on both occasions in this case.

The centre acknowledged that it was not acceptable to have a gravely ill child waiting for an hour to be assessed. Although the child's consultation form was marked "2nd visit", the receptionist did not refer her to the nurse immediately because the earlier diagnosis was recorded as a viral illness, and such re-presentations are not unusual. The child looked pale, but not distressed, so was not prioritised.

Following this incident, the centre implemented a policy that all second visits within 24 hours should go to the front of the queue, and the need for conscientious scanning of the waiting room for patients of concern has been emphasised. All staff are now required to attend triage courses as part of their induction (03HDC16186).

General practices
Robust policies for triage are no less important in general practice surgeries. When injury or infection strikes holidaymakers and visitors, the local GP surgery is most likely to be the place they seek help. Practices need a system in place for dealing with visitors in need of medical attention who arrive without an appointment. The system should ensure that decisions taken regarding the urgency of care — or even whether or not care is provided at all — are made by staff trained to make appropriate and safe decisions.

The recent experience of one of my staff reveals the potential for harm when inappropriate triage decisions are made. When travelling away from her home town, she developed an abscess and became systemically very unwell. She visited the nearest GP surgery as she knew that a dose of antibiotics would be required to stem the infection. The receptionist informed her that the doctor was fully booked and would not be able to see her. Mrs E insisted that she needed to see a doctor. The receptionist reluctantly agreed that a nurse would see Mrs E. Some time later, the practice nurse examined Mrs E and agreed that yes, she certainly did need to see the doctor. Several hours later, after all booked patients had been seen, the doctor saw Mrs E, gave her an initial dose of antibiotics in the surgery, and issued a prescription for the course she needed.

Mrs E received treatment because she knew the nature of her complaint, and that urgent treatment was required, and, despite feeling extremely unwell, emphasised her

need to see the doctor when dismissed by the receptionist. A less-informed and assertive person may have returned home to bed, with the risk that the infection, untreated, may have developed into septicaemia. It is unlikely that, having been sent away by the receptionist, and debilitated by the infection, she would have pursued medical treatment elsewhere. The crucial decision in this case — whether the patient needed to see a doctor — had been made by a receptionist without consideration of the clinical facts. An effective triage process, conducted by staff with appropriate clinical training, was needed.

The standards for general practice (*Aiming for Excellence* Indicator A.2.2 RNZCGP, 2002) state that practices must use a system that assists staff to identify and provide an appropriate response to urgent medical conditions, and that all members of the practice team (including receptionists) must be trained accordingly. Failure to comply with these standards may breach the Code (see www.hdc.org.nz; 00HDC07870).

Expert's views on the complexities of triage

Dr Steven Searle, one of my independent advisors, commented that there is not adequate research data to provide evidence for what, if any, triage should occur at different health facilities in primary care settings. The more important issue is: how to overcome potential limitations of whatever procedure is possible in a given environment so that patient care is improved. For example, more frequent checking of the waiting room in the above scenario would divert the nurse from other tasks and potentially increase the overall wait for all patients. It is not reasonable or appropriate in many health-care facilities to triage everyone. Dr Searle commented: "It may be that the best approach is to only triage walk-in patients who state their problem is urgent." Some facilities have large signs at reception and in the waiting area advising patients to tell the staff if they have an urgent problem such as chest pain, or they are very unwell. However, all facilities need a method of dealing with urgent cases. The policy, however low level, should be documented, so that staff know the reasons behind it, and patients have a realistic expectation of the procedure at the facility.

Dr Searle's view was that triage issues may become clearer as a result of the report from the After Hours Primary Health Care Working Party. Further clarity in this complex matter would help improve the care of patients who need urgent medical attention.

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Acting Health and Disability Commissioner

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