**COMMON CLAIM THEMES**

- Non-compliance with triage guidelines including inadequate assessments, vital signs monitoring and documentation.
- Inappropriate assignment of triage level (e.g., urgent vs. emergent).
- Failure to recognize gravity of patient’s condition and/or presenting symptoms.
- Delay in practitioner seeing the patient post-triage.
- Failure to reassess patient frequently enough and as per triage guidelines.
- Circumstances of accident and mechanism of injury do not prompt full assessment and/or assignment of higher and/or lower acuity level.
- Inordinate focus on one issue leading to inadequate assessment of another.
- Change in patient status not acknowledged/communicated/documentated.
- Delay in triaging.
- Failure to communicate appropriate information to receiving healthcare providers.
- Inadequate staffing issues (e.g., only one triage nurse available) leading to delayed assessment and or excessive patient volumes.
- Miscommunication from patient or family about presenting problem(s)/condition(s).

**CASE STUDY 1**

A patient arrived at the ED on a very busy night with acute cellulitis of the finger which deteriorated at a rate that was eventually determined to be quite unusual. Although medical opinion deemed a prolonged wait to see a physician did not contribute to the subsequent loss of the finger several days later, upon investigation, the triage assessment and documentation of the patient assessment and the injury fell significantly below the standard based on the National Emergency Nurses’ Affiliation Standards, the Canadian Triage and Acuity Scale (CTAS) and the hospital’s own policies.

**CASE STUDY 2**

An elderly patient arrived at a busy ED with a chief complaint of abdominal pain. Assessed as being in moderate pain and triaged as urgent, the patient remained on a stretcher in the hallway. The patient died within two hours of arrival time. Upon review of the case, a number of omissions were noted including a lack of recognition of the seriousness of the patient’s presentation, non-compliance with the organization’s reassessment expectations and an incomplete triage assessment lacking in documentation of vital signs, pain scale and oxygen saturation.

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REFERENCES

• HIROC claims files.


Inadequate Triage Assessment/Reassessment

**Reliable Care Processes**
- Ensure immediate assessment and prioritization of patients’ conditions as they arrive at the ED; sending more urgent patients directly to the triage nurse.
- Adopt a formal triage acuity scale (e.g., CTAS) to assist in prioritizing patient needs.
- Obtain and document a full set of vital signs (heart rate, respiratory rate, blood pressure, temperature), plus or minus oximetry, Glasgow Coma Scale [GCS], and pain scale for assignment of triage level.
- Adopt standardized (easy to use) triage forms or flow sheets.
- Set guidelines/protocols for and ensure rapid transfer to the treatment area for patients who require immediate care and/or interventions.
- Ensure patients are instructed on when and how to inform staff of condition changes while waiting; post multi-language signage regarding this.
- Ensure regular re-assessment, documentation, and treatment (if indicated) of triaged patients in waiting areas (the extent of the re-assessment depends on the presenting complaint, the initial triage level and any changes identified by the patient).
- Ensure follow-up of any registered patients and investigations for patients who leave without being seen for treatment and/or by a physician/nurse practitioner.
- Ensure all patient refusals of examinations, treatments and transfers are documented.
- Adopt structured communication practices to facilitate sharing of critical patient information between all members of the healthcare team, including for patient handoffs.
- Set physiologic parameters (red flags and/or lists of circumstances) for vital signs, pain scale, GCS, mechanism of injury etc. that trigger established responses by nursing and medical staff to unstable patients.

**Staffing**
- Ensure a process to match staffing resources with triage and patient acuity needs (e.g., flexible scheduling of medical, nursing, and support staff to assure that sufficient numbers of trained personnel are available).
- Establish and monitor response times for attendance in ED of on-call staff.
- Establish a second on-call schedule in the event the first on-call cannot be reached or cannot attend in the timeframe required.
- Ensure initial and ongoing competency of triage personnel (e.g., mentoring novice nurses, increasing triage education, updating, re-educating triage nurses).

**Physical Environment**
- Evaluate the physical layout of the ED and modify, as indicated to facilitate the flow of patients from the entrance to triage, and to ensure observation of waiting patients (e.g., triage waiting room can be visualized from the triage desk).

**Monitoring and Measurement**
- Track and review incidents involving inadequate triage assessment, including:
  - Patients who have left the ED without being seen and/or who have left the ED without being seen by a physician/nurse practitioner post triage (particularly CTAS Level );
  - Average time between patient arrival to being seen by physician and/or nurse for each triage category;
  - Average length of stay for individuals in each triage category;
  - Staffing shortfalls, particularly those that impact wait times.
- Implement formal strategies to help ensure consistent adherence to triage policies/practices (e.g., periodic chart/e-record audits, analysis of reported incidents/events, learning from medico-legal matters).
- Audit ED records for completeness of full triage documentation (e.g., triage level; time to triage; time of nurse and physician and/or nurse practitioner assessment).

**Note:** The Mitigation Strategies are general risk management strategies, not a mandatory checklist.