RISK REFERENCE SHEET

HIROC

Inadequate Triage Assessment/ Reassessment

Triage guidelines facilitate timely acuity-based patient assessments and prioritization of patient care within the emergency department (ED). The patient's presenting complaints and/or symptoms are the primary determinants of the triage acuity level which is determined utilizing Canadian Triage and Acuity Scale (CTAS) guidelines. Identifying patients who need to be seen ahead of those who can safely wait is the ultimate goal. The assignment of the triage acuity level also determines the optimal frequency of reassessment while the patient is waiting. Assigning a triage level requires experience and involves the rapid collection and integration of multiple factors including the potential for improvement and/or deterioration of the patient's condition thus underscoring the need to reassess and re-evaluate on a periodic basis. Collecting and documenting patient information, assessment(s), re-assessments, observations and potential interventions according to accepted organizational practices is a critical component of the triage process. The whole process occurs in the context of fluid ED dynamics.

COMMON CLAIM THEMES

System

- Inadequate staffing issues (e.g., only one triage nurse available) leading to delayed assessment and/or excessive patient volumes.

Knowledge and judgment

- Non-compliance with triage guidelines including inadequate assessments, vital signs monitoring and documentation.
- Inappropriate assignment of triage level (e.g., urgent vs. emergent).
- Delay in triaging.
- Failure and/or delay to recognize the gravity of patients' condition and/or presenting symptoms.
- Failure and/or delay to reassess patient frequently enough as per triage guidelines or with changes to patient condition and symptoms.
- 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 and/or documented as well as reassignment of triage level not considered.

Communication and documentation

- Failure to communicate appropriate and relevant information to receiving healthcare providers.
- Miscommunication from patient and/or family about presenting problem(s) or condition(s).
- Failure to document reassessments.

CASE STUDY

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, experts noted a number of omissions including a lack of recognition of the seriousness of the patient's presentation, non-compliance with the organization's reassessment expectations and an inadequate triage assessment, lacking in documentation of vital signs, pain scale and oxygen saturation.

Canadian Case Example

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MITIGATION STRATEGIES

Reliable Care Processes

- Adopt a formal triage acuity scale(s) (e.g., CTAS) to assist in prioritizing of adult and pediatric patients needs.
- Ensure immediate assessment and prioritization of patients' conditions as they arrive at the ED.
- Ensure regular re-assessment and treatment (if indicated) of triaged patients in waiting areas.
- Adopt standardized evidence based guidelines or protocols to support rapid transfer to the treatment area for patients who require immediate care and/or interventions (e.g., Rapid Assessment Zones for CTAS 3 patients).
- Implement formal tracking and follow-up strategies to ensure laboratory and diagnostic testing ordered are completed according to order requirements (e.g., stat vs. routine).
- 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.
- Ensure formal processes are in place for follow-up with patients who have been triaged and left ED without being seen for treatment by a physician or nurse practitioner.

Education

- Implement formal multifaceted and targeted strategies to support and enhance the ongoing timely and consistent triage assessment, monitoring and reassessments (e.g., interdisciplinary workshops, in-situ simulations and emergency skill drills; sharing of learnings and trends from periodic chart audits, extracts, analysis of reported incidents, and medical-legal matters).

Strategies for ED nurses and physician assistants

- Obtain and document a full set of vital signs (e.g., heart rate, respiratory rate, blood pressure, temperature), oximetry, Glasgow Coma Scale (GCS), and pain scale for assignment of triage level upon arrival to the ED.
- Ensure complete and timely documentation of all:
  - Patient risk factors (mechanism of injury, cardiac, co-morbidity, age, victim of violence, parental concerns, etc.);
  - Scheduled patient re-assessments (as per CTAS guidelines) prior to physician and/or nurse provider assessment, including re-evaluation of chief complaint;
  - Patient refusals of examinations, treatments and transfers;
  - Medical directives implemented (name of initiator, directive name and/or number, and date time initiated, follow-up on ordered tests);
  - Follow-up interactions with the patient and/or subsequent communication with primary care provider;
  - Discharge instructions provided (including the name of or copy of printed discharge instructions);
  - Action taken in response to the patient leaving without being seen, leaves against medical advice and elopements.
- For patients at risk for suicide, ensure timely and consistent documentation of:
  - The patient's current level of care or supervision (e.g., 'constant observation with sitter in attendance');
  - All scheduled and ad hoc risk assessments and checks and rounds (based on acuity and level of care or supervision).

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Documentation and Communication

- Adopt a standardized and structured communication practices to facilitate sharing of critical patient information during various patient handoffs and transfer points (e.g., Emergency Medical Services (EMS), triage, assessment, admission).
- Implement strategies to support and encourage patients and families on when and how to inform staff of condition changes while waiting for service.
- Adopt a ED-specific:
  - On-call and second on-call contingency plan (i.e., specific action to be taken when the on-call physician, practitioner or team does not respond or is unable to respond in an appropriate timeframe);
  - Chain of command ('escalation' process), including the names, titles and current phone numbers of the ED team members in the line of authority.
- Implement formal strategies to develop and maintain an environment which supports and expects:
  - Assertive and respectful questioning and challenging of care decisions (in order to obtain clarity and/or to advance patient safety concerns);
  - Zero tolerance of intra- and inter-disciplinary bullying and intimidation.

Staffing

- Adopt a standardized 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).

Physical Environment

- Conduct periodic evaluations of the physical layout of the ED to facilitate the flow of patients from the entrance to triage, to ensure observation of waiting patients (e.g., triage waiting room can be visualized from the triage desk

Monitoring and Measurement

- Implement formal strategies to monitor and measure the effectiveness and efficiency of, and adherence to:
  - Triage assessment and reassessment protocols and documentation requirements;
  - Structured communication processes;
  - Escalation and chain of command protocols;
  - On-call and second-call/backup plans;
  - Physician and non-physician attendance and response times to requests for a consult and attendance;
  - Medical directives.
- Implement formal strategies to share learnings from ED-related incidents with the interdisciplinary team(s) and leadership (e.g., learnings from chart audits, trigger tools, incident reports, team debriefs, critical incident, quality of care and quality improvement committee reviews, medical legal claims, coroner reports and related recommendations).

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Date last reviewed: September 2020