CENNZ-NZNO Position Statement: Triaging Away

Endorsed at the 2007 CENNZ-NZNO 2007 Annual General Meeting

The College of Emergency Nurses believes that health care should not be denied to any patient requesting care from an emergency department. The College of Emergency Nurses does not support the practice of triaging away.

Definition. Triaging away refers either to a refusal to provide further care in the emergency department, or advice to the patient that they do not need care in the emergency department, based solely on the outcome of the triage interview.

Rationale. People present to emergency departments with a variety of conditions of varying severity, including health care needs that could be provided in a primary health care setting. Although the Ministry of Health states that the primary role of emergency departments is to provide emergency care the Ministry also states that care should not be denied to anyone who seeks it (Ministry of Health and District Health Boards of New Zealand, 2002). The Australasian Triage Scale assesses clinical urgency (ACEM, 2006) and is not intended as a tool to deny treatment (ACEM, 2004 a). Any intent to deny care on the basis of the triage interview creates a risk for the patient, the nurse, and the organisation. There is no provision in statements by the Ministry of Health or by the Australasian College of Emergency Medicine for utilising the triage interview and the triage decision to restrict access to the Emergency Department. There is no support in the health care literature for the practice of 'triaging away'.

Background to this position statement

The triage interview is a prospective assessment of clinical urgency (ACEM, 2006). Hospital EDs in New Zealand are required to use the Australasian Triage Scale (ATS) developed by the Australasian College for Emergency Medicine, and 'all patients presenting to an emergency department must be triaged on arrival by a suitably experienced and trained registered nurse or medical practitioner' (Ministry of Health and District Health Boards of New Zealand, 2002, p3).

Evidence to evaluate the safety and effectiveness of triage and discharge is scarce. A review of the literature identified a limited number of papers which investigated the effectiveness of triage as a means of reducing `unnecessary' emergency department attendances. The overall conclusion was that triage was an ineffective means of reducing these attendances, although the quality of the evidence was poor (New Zealand Health Technology Assessment, 1998). In one study, 5.5% of patients triaged as 'non-urgent' subsequently required hospitalisation (Young, Wagner, Kellerman, Ellis, & Bouley, 1996). A study of primary care in the ED utilised a modified triage process which classified patients into 'primary care' or 'accident and emergency' categories, finding that a significant proportion of the primary care group were referred to a specialist inpatient team or the fracture clinic. This implies that had triage been used to refer patients elsewhere, a significant proportion would have had to return to the hospital (Dale, Green, Reid, & Glucksman, 1995). ACEM (2004 b) states "that there has never been any

scientific research to support the contention that Australasian Triage Scale (ATS) 4 and 5 patients can be described as GP patients" (p12).

The College of Emergency Nurses draft policy statement clarifies the purpose of the triage interview and assignment of a triage code as a means of determining clinical urgency, and nothing else. Assigning a triage code of 4 or 5 does not mean that it is safe to decline or defer care, or to refer the patient to another health care provider.

References

Australasian College for Emergency Medicine. (2006). The Australasian triage scale. https://www.acem.org.au/getattachment/693998d7-94be-4ca7-a0e7-3d74cc9b733f/Policy-on-the-Australasian-Triage-Scale.aspx

Australasian College for Emergency Medicine. (2004a). Patient's right to access emergency department care. https://www.acem.org.au/getattachment/04898090-617f-4401-be8e-8067af8ba4e1/Policy-on-Patients-Rights-to-Access-Emergency-Depa.aspx

Australian College of Emergency Medicine (2004b). *Access block and overcrowding in Emergency Departments. Retrieved 14 December 2006, from* https://www.acem.org.au/getattachment/8c29d36e-27e2-40e7-9a1e-dfe73c5298ba/S127-Statement-on-Access-Block.aspx

https://www.acem.org.au/getattachment/0789ef2f-d814-4e86-af81-aad8b9e57c6d/Statement-on-Emergency-Department-Overcrowding.aspx

Dale, J., Green, J., Reid, F., & Glucksman, E. (1995). Primary care in the accident and emergency department: 1. Prospective identification of patients. *British Medical Journal, 311*, 423-426.

Ministry of Health and District Health Boards of New Zealand (2002). Service specification: Emergency Departments. Wellington: Ministry of Health.

New Zealand Health Technology Assessment. (1998). *Emergency department attendance: A critical appraisal of the literature. NZHTA report 8*: Department of Public Health and General Practice, Christchurch School of Medicine.

Young, G. P., Wagner, M., Kellerman, A., Ellis, J., & Bouley, D. (1996). Ambulatory visits to hospital emergency departments. Patterns and reasons for use. 24 hours in the ED study group. *Journal of the American Medical Association., 276*(6), 460-465.