

The Canadian Triage and Acuity Scale: Education Manual

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CTAS National Working Group

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Course Goals

1. Describe origins and role of triage
2. Review/enhance assessment skills
3. Apply standards of emergency nursing
4. Introduce CEDIS Presenting Complaint List
5. Prioritize patient care using CTAS
6. Demonstrate understanding of ED processes

CTAS Five Level Triage

Level 1 - Resuscitation

Level 2 - Emergent

Level 3 - Urgent

Level 4 - Less Urgent

Level 5 - Non-Urgent

Module 1

Fundamentals of Triage

Module One Objectives

- Historical basis of triage
- Purpose and value of triage
- Unique nature of emergency patients
- Professional role and personal characteristics of the triage nurse
- Triage nursing skills
- Triage process

Evolution of Triage

- Military roots
- Introduced to hospitals in early 1960s
 - Number of cases increasing
 - People with non-urgent conditions come to EDs for treatment
- Initially, a 3-level triage (emergent, urgent, deferrable/non-urgent) was used
- In 1999, CTAS 5-level triage implementation guidelines published as recommended national guidelines

Origins of CTAS

- National Triage Scale – Australia ACEM 1994
- CAEP Triage and Acuity Scale – Canada 1995
- CTAS – Canada (CAEP, NENA, AMUQ) 1999
- Paediatric CTAS (above + CPS, SRPC) 2001
- Adult CTAS revision 2004
- CEDIS Complaint list (+ revision) 2003 & 2008
- Adult CTAS revision 2008
- Paediatric CTAS revision 2008

What is Triage?

The National Emergency Nurses' Affiliation's (2002) definition of triage is: 'a sorting process utilizing critical thinking and a standardized set of guidelines in which an experienced RN assesses patients quickly upon their arrival in an ED to:

- Assess and determine severity of presenting problems
- Process patients into a triage category and streaming to an appropriate location
- Determine access to appropriate treatment
- Effectively and efficiently assign appropriate human health resources.'

Rationale for the Development of CTAS

- A national standard for triage
- Improved patient care
- Increased triage reliability and validity
- Site & personal performance indicators
- National benchmarks

The Benefits of Triage

- Ensures critically ill or injured receive priority attention
- Establishes acuity and anticipates resources needed
- Predicts how long the patient can safely wait
- Supports effective utilization of space and resources
- Supports surveillance
- Improves communication and public relations

Avoiding Triage as 'Access Block'

■ Streaming

- Lean processing (six sigma) to improve ED efficiencies is being broadly implemented
- One goal is shortening the time from arrival to emergency physician
- Streaming patients directly to the most appropriate place in the ED is key to success
 - This can be accomplished by rapid triage 1st or triaging the patient after directing them to an appropriate area
 - Typical ED design changes include internal waiting rooms, limiting stretcher time to patients who don't need them, and rapid assessment zones

Triaging with Overcrowding

■ Triage Drift

- Concept of ‘normalization toward the mean’
- The knowledge that a patient will need to be assigned to the waiting room, may lead the triage nurse to ‘uptriage’ a CTAS 4 or 5 patient in the hopes of shortening their wait
- Similarly there may be subconscious pressure to ‘downtriage’ certain patients based on ED space limitations
 - For example a patient may be assigned a CTAS 3 rather than CTAS 2 score feeling it unacceptable to assign level 2 patients in the waiting room
 - A CTAS 3 patient may also be downtriaged to CTAS 4 to make them more appropriate for fast track.

Emergency Patients are Unique

- Unscheduled/episodic
- Anxious and distressed
- Patient and care providers are strangers
- Patients experience symptoms/not a diagnosis
- Span all ages and types of emergencies
- Often lack primary care

Emergency Patients are Unique

“Not all patients are as well as they appear and not all patients are as sick as they think.”

What are your thoughts on that statement?

What are some unique characteristics?

Role of Triage Nurse

1. Assessing patients and determining acuity
2. Communicating with health professionals
3. Determines treatment location
4. Initiating treatment protocols/first aid measures
5. Monitoring and reassessing
6. Participating in patient flow
7. Documenting

Triage Nursing

What makes a good triage nurse?

- Personal traits
- Cognitive characteristics
- Behavioral characteristics

Personal Traits

- Flexibility
- Autonomy
- Effective communication skills
- Assertiveness
- Patience
- Compassion
- Willingness to listen and learn



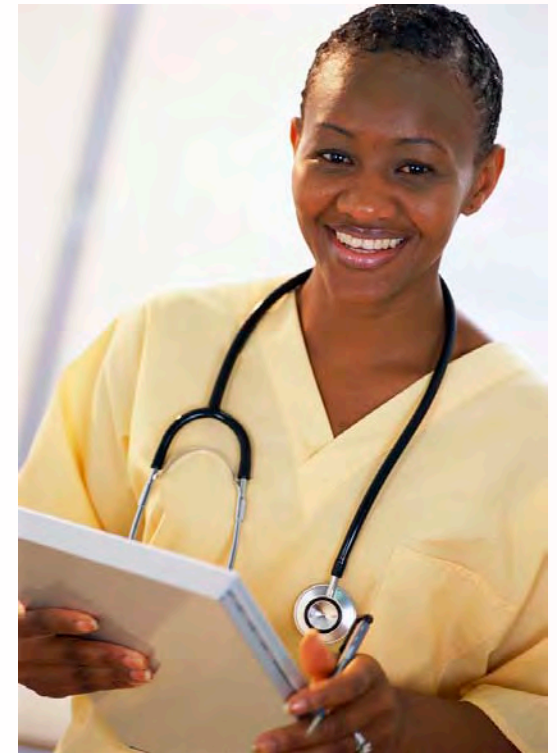
Cognitive Characteristics

- Diverse knowledge base
- Knows when not to act
- Uses critical thinking
- Able to make decisions quickly
- Able to prioritize



Behavioural Characteristics

- A patient advocate
- Works well under pressure
- Organized
- Able to improvise
- Applies intuition
- Confidence in judgment
- Trust in/reliance on peers



Triage Nursing Skills

- Public Relations
- Interviewing
- Critical Thinking
- Communication



Self-Assessment

Assessment	My Strong Characteristics	Areas Needing Work
Characteristics		
Personal Traits		
Cognitive Characteristics		
Behavioural Characteristics		

The Process of Triage

- Patient arrives ('critical look')
- Screened for infectious disease
- Triage assessment conducted
- Presenting Complaint (CEDIS) documented
- Modifiers considered
- Triage Level assigned (CTAS)
- Assigned to waiting/treatment area
- Symptom relief provided or nursing protocols initiated
- Waiting patients reassessed

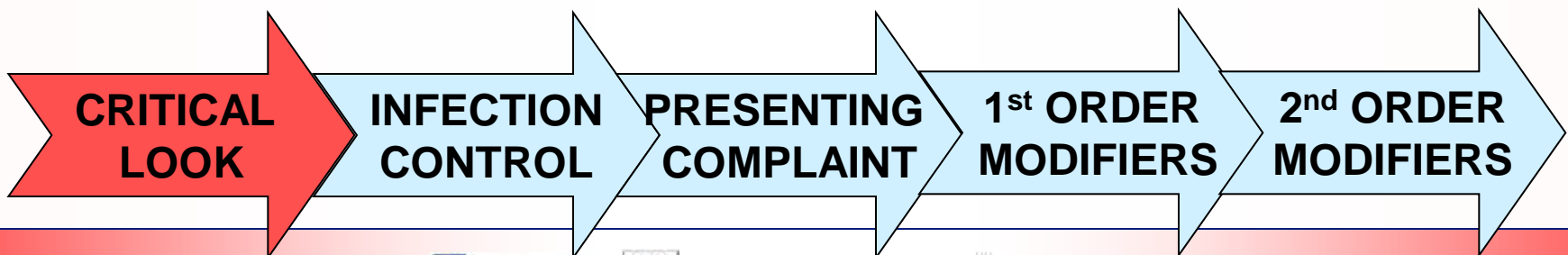
Patient Arrival

- A variable % of patients arrive by ambulance. Their acuity ranges across all triage levels
- More patients arrive by other means of transport (known as “walk-ins”). Their acuity also include all levels



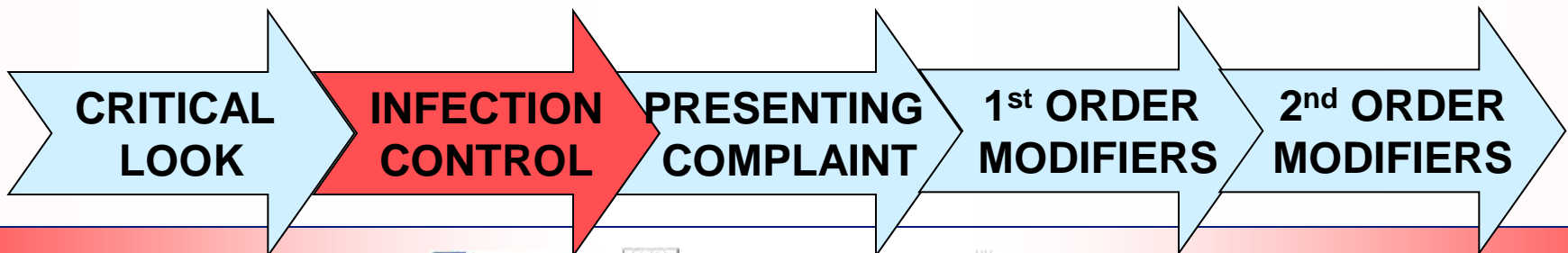
Critical Look

- 'Critical first look' across-the-room begins as soon as the patient arrives in the ED
- Perform a quick check of
 - A: Airway**
 - B: Breathing**
 - C: Circulation**
 - D: Disability (neurological)**
- Should take 3 to 5 seconds
- Take action as indicated



Infection Control Screening

- **Screening requirements vary by region**
- If positive (eg ILI, FRI), appropriate protective measures (respiratory etiquette, hand washing, isolation) need to be taken
- Use latest information available (from provincial, state, or national guidelines)



Subjective Assessment

The “story” in the patient’s own words:

- Their account of why they came to the hospital
- The symptoms they are experiencing
- Pain severity
- The injury history (mechanism of injury)
- Their concerns

Selecting Presenting Complaint (CEDIS)

- Patient driven
 - “What concern brought you to the ED today?”
 - Headache, Cough, SOB, etc.
 - “Which of the complaints bothers you most?”
 - “My fever and shaking chills!”
- Nurse driven
 - “Patient complains of leg swelling & moderate thigh pain, but nurse note moderate SOB.”
 - Could choose SOB or Lower extremity pain



Objective Assessment

Draws on observable indicators (signs):

- Wounds, rashes, bleeding, cough, etc.
- Vital signs
- Reaction to pain
- Other indicators



Triage Decision

Based on the critical look, chief complaint, subjective and objective assessments, application of modifiers as required, then decide:

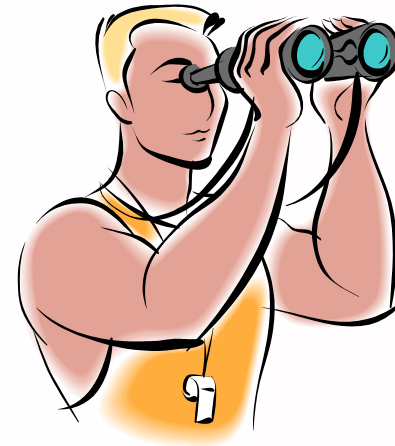
What is the patient's priority?

Triage Documentation

- Patient Name / Age
- Date and Time
- Presenting Complaint (CEDIS)
- Subjective Assessment
- Objective Assessment
- 1st & 2nd Order Modifiers
- CTAS Level
- Triage Nurse ID
- Allergies/Medications
- Immunizations
- Relevant Past History
- Interventions at triage
- Disposition
- Reassessment

When Line-ups Form

- Scan for critically ill patients and move them to the front of the line
- Anticipate re-prioritization
- Know the status of available treatment areas
- Stay calm, request help when required



The goal is to triage patients within
10 to 15 minutes of arrival

Patients in the Waiting Room

- The number of patients waiting and their wait times have been increasing.
- Advise patient to return to triage desk if condition changes
- Depending upon hospital/site policies and medical directives, triage nurse may need to:
 - Initiate diagnostics
 - Provide symptom relief
 - Dispense analgesics
- If numbers are overwhelming, call for assistance

Patients in the Waiting Room

- How do you set priorities for treatment bed/physician assessment when you have five CTAS Level 3 patients waiting?

How long can this patient safely wait?

Patient Reassessment Guidelines

Level 1 – Continuous nursing care

Level 2 – Every 15 minutes

Level 3 – Every 30 minutes

Level 4 – Every 60 minutes

Level 5 – Every 120 minutes

Never change the initial triage level.

Always document acuity level changes & change priority accordingly

Always document reassessment findings.

Module One - Review

Questions?



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