CHAPTER 1
Introduction

Triage is a system of clinical risk management employed in Emergency Departments worldwide to manage patient flow safely when clinical need exceeds capacity. Systems are intended to ensure care is defined according to patient need and in a timely manner. Early Emergency Department triage was intuitive rather than methodological and was therefore neither reproducible between practitioners nor auditable.

The Manchester Triage Group was set up in November 1994 with the aim of establishing consensus amongst senior emergency physicians and emergency nurses about triage standards. It soon became apparent that the Group's aims could be set out under five headings.

1. Development of common nomenclature
2. Development of common definitions
3. Development of robust triage methodology
4. Development of training package
5. Development of audit guide for triage

Nomenclature and definitions

A review of the triage nomenclature and definitions that were in use at the time revealed considerable differences. A representative sample of these is summarised in Table 1.1.

Despite this enormous variation, it was also apparent that there were a number of common themes running through the different triage systems; these are highlighted in Table 1.2.

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Table 1.1

Hospital 1		Hospital 2		Hospital 3		Hospital 4	
Red	0	A	0	Immediate	0	1	0
Amber	<15	B	<10	Urgent	5–10	2	<10
		C	<60	Semi-urgent	30–60		
Green	<120	D	<120				
Blue	<240	E	—	Delay acceptable	—	3	—
		FGHI					

Table 1.2

Priority	Maximum times (minutes)			
1	0	0	0	0
2	<15	<10	5–10	<10
3		<60	30–60	
4	120	<120		
5	<240	—	—	—

Table 1.3

Number	Name	Colour	Maximum time (minutes)
1	Immediate	Red	0
2	Very urgent	Orange	10
3	Urgent	Yellow	60
4	Standard	Green	120
5	Non-urgent	Blue	240

Once the common themes of triage had been highlighted, it became possible to quickly agree on a new common nomenclature and definition system. Each of the new categories was given a number, a colour and a name and was defined in terms of ideal maximum time to first contact with the treating clinician. At meetings between representatives of Emergency Nursing and Emergency Medicine nationally, this work informed the derivation of the United Kingdom triage scale as shown in Table 1.3.

As practice has developed over the past 20 years, five-part triage scales have been established around the world. The target times themselves are locally set, being influenced by politics as much as medicine, particularly at lower priorities, but the concept of varying clinical priority remains current.

The development of Telephone Triage

After a period where all Emergency Departments in the Manchester area were using 'Manchester Triage' and using it on the telephone to triage callers to the ED (prior to NHS Direct), it became apparent that although all Emergency Department staff were using the same language of triage, the interface with paramedic colleagues still faced a language barrier. Key collaborators within the ambulance service recognised that applications of the Manchester Triage method would be extremely useful within the ambulance service and a further group of clinicians across acute care settings and the ambulance service was set up to explore this. Telephone Triage emerged as one of the products of this collaboration and had been used successfully for both secondary triage (since 2006) and latterly primary triage (2012) of those patients accessing care by telephoning ambulance services in a number of ambulance services across the United Kingdom and internationally.

Triage methodology

In general terms, a triage method can try and provide the practitioner with the diagnosis, disposal or clinical priority. 'Manchester Triage' is designed to allocate a clinical priority. This decision was based on three major tenets. First, the aim of the triage encounter is to aid clinical management of the individual patient, and this is best achieved by accurate allocation of a clinical priority. Second, the length of the triage encounter is such that any attempts to accurately diagnose a patient are doomed to fail. Third, it is apparent that diagnosis is not accurately linked to clinical priority. The latter reflects a number of aspects of the particular patient's presentation as well as the diagnosis; for example patients with a final diagnosis of ankle sprain may present with severe or no pain and their clinical priority must reflect this. In Telephone Triage, the allocation of this clinical priority is inherently linked to a place of definitive clinical care, and in the highest priority, a mode of emergency transport to this care.

In outline, the triage method put forward in this book requires practitioners to select from a range of presentations and then to seek a limited number of signs and symptoms at each level of clinical priority. The signs and symptoms that discriminate between the clinical priorities are termed *discriminators* and they are set out in the form of flow charts for each presentation – the *presentational flow charts*. Discriminators that indicate higher levels of priority are sought first, and to a large degree, patients who are allocated to the standard clinical priority are selected by default. In this way, it reflects the effective face to face triage methodology taught by the Manchester Triage Group. The clinical priority is inherently linked to a disposal: where does the patient obtain the definitive care which they require and what is the timescale within which this must be obtained for optimum

outcomes. The possible outcomes of Telephone Triage are simplified from the five categories system as there are fewer options available to the Telephone Triage practitioner.

The decisions which must be made are as follows:

- Does the patient need immediate and urgent care? (FtF Now)
- Do they need to be seen face to face by a clinician soon, but not immediately? (FtF Soon)
- Can medical or other care be delayed? (FtF Later)
- Can an 'advice only' route be followed, where the problem can be managed by giving self-care advice?

Face to face triage practitioners will note differences between the discriminators seen within face to face triage and those in the Telephone Triage method. For some discriminators used in face to face triage, it is impossible to ascertain without actually having the patient in front of the triage practitioner, whether the discriminator is fulfilled or not. Those discriminators are therefore not used in Telephone Triage. Slight changes are made to other discriminators in order for them to be more appropriate in a Telephone Triage setting.

Advice

Advice is presented on the charts at each level and is to highlight issues which can be discussed by the practitioner with the patient or caller. It is important that interim advice is given and that, if the patient is triaged to 'advice only', comprehensive advice is given and understanding is checked. The patient must know what to do should the situation change. A key premise of the advice in these charts is that it is general and may be adapted for use in specific settings. The algorithms, as in the case of the face to face algorithms, are evidence based and validated and must not be modified.

The decision making process is discussed in Chapter 2 and the triage method itself is explained in detail in Chapter 3.

Presentation priority matrix

Patients who are in the 'FtF Now' category are best served by the Emergency Ambulance Service and Emergency Departments, whatever their locations. Those requiring 'FtF Soon' or 'FtF Later' may have care delivered in a number of locations and by various providers. Thus the time to care in the 'FtF Soon' category will vary, depending upon those services available in that health economy. A mapping exercise should be undertaken locally to agree the appropriate dispositions arising from the triage decision (see Chapter 4). It is essential that the practitioner undertaking Telephone Triage is able to use up-to-date details about current local services such as dental emergency arrangements, telephone numbers of primary care facilities and the location of pharmacy provision.

Training for triage

This book and the accompanying course attempt to provide the training necessary to allow introduction of a standard triage method. It is not envisaged that reading the book and attending a course can produce instant expertise in triage. Rather this process will introduce the method and allow practitioners to develop competence at using the material available. This is the first step towards competence in using the system and must be followed up by audit and evaluation of the system in use.

Triage audit

The Triage Group spent considerable time trying to pin down 'sentinel diagnoses', that is diagnoses that could be identified retrospectively and which could be used as markers of accurate triage. For the reasons outlined above, it soon became apparent that even retrospective diagnosis could not accurately predict actual clinical priority at presentation.

Successful introduction of a robust audit method is essential to the future of any standard methodology, since reproducibility between individual practitioners and departments must be shown to exist. This is discussed in more detail in chapter 5.

Summary

Triage is a fundamental part of clinical risk management in all areas of urgent and emergency care when clinical load exceeds clinical availability. Emergency Triage promulgates a system that delivers a teachable, auditable method of assigning clinical priority in emergency settings. It is not designed to judge whether patients are appropriately in the emergency setting, but to ensure that those who need care receive it appropriately quickly. It can be used to monitor care and to signpost streams of care – these will be determined by local provision and actual availability.