College of Emergency Nursing Australasia

Position Statement
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# Triage and the Australasian Triage Scale

## Purpose

This document outlines the College of Emergency Nursing Australasia (CENA) position on the practice of emergency department triage and the application of the Australasian Triage Scale by registered nurses. It should be read in conjunction with the CENA position statement – *Triage Nurse*.[1]

## Definition

Triage: A process of assessment of a patient on arrival to the ED to determine the priority for medical care based on the clinical urgency of the patient's presenting condition.[2] Triage enables allocation of limited resources to obtain the maximum clinical utility for all patients presenting to the emergency department.[3]

Primary triage decisions: Primary triage decisions' relate to the establishment of a chief complaint and the allocation of urgency. [3]

Secondary triage decisions: Secondary triage decisions are concerned with expediting emergency care and disposition. [3]

Complexity: Refers to the difficulty of the presenting complaint and the resources involved in finding a solution to the complaint. A low ATS category with a highly complex problem may consume more resources and workload than a high acuity ATS presentation.[4, 5]

Severity: The extent of musculoskeletal or organ system derangement or physiologic decompensation for an individual patient with the condition. Patients with higher severity of illness are more likely to consume greater healthcare resources and stay longer in hospitals than patients with lower severity for the same diagnosis. Severity does not necessarily overlap with acuity, in that a non-acute patient might nonetheless be relatively severely ill.[4, 5]

Urgency: Urgency refers to how quickly a patient needs to be seen in order to initiate treatment and prevent deterioration or further pain and suffering.[5]

## Background

Triage is the point at which formal emergency department care begins and is used to sort presenting patients on the basis of clinical urgency. A national triage system (National Triage Scale) was first introduced in Australia in 1993. This was revised in 2000 and was renamed the Australasian Triage Scale (ATS). The intent of both these scales was to provide a commonly understood and consistent way of defining urgency to ensure that patients are seen in a timely manner appropriate to their level of urgency. Both scales have been validated as a means of providing a standardised approach to triage and have formed the basis of other triage systems in operation internationally.[4]

The Australasian Triage Scale provides nationally consistent standards for the maximum time patients are considered safe to wait for emergency care and the categories are shown in Table 1.[6]

Table 1: ATS categories and their maximum waiting times

| ATS Category | ATS waiting times | Performance indicator threshold |
|---|---|---|
| 1 (Resuscitation) | Immediate | 100% |
| 2 (Emergent) | 10 minutes | 80% |
| 3 (Urgent) | 30 minutes | 75% |
| 4 (Semi-urgent) | 60 minutes | 70% |
| 5 (Non-urgent) | 120 minutes | 70% |

All patients presenting to the emergency department should be immediately assessed by a suitably qualified registered nurse who has been educated for the triage role using the principles outlined in the Emergency Triage Education Kit (ETEK)[7] and who, ideally holds postgraduate qualifications in emergency nursing, to determine the clinical urgency of their presentation. Assessment of clinical urgency is achieved by observation of general appearance, collection of a focused history to identify chief presenting complaint and clinical risk, and collection and interpretation of physiological data using a primary survey approach. The relief of pain and / or suffering and risk management are legitimate reasons for increased clinical urgency and therefore allocation of a higher ATS category. This culminates in the allocation of an ATS category and should take no more than 5 minutes. While the patient is waiting, if their condition changes or they wait longer than the maximum waiting time, reassessment and re-triage may be required. The existing research-based literature and evidence demonstrates that the ATS is a valid scale for prioritization according to clinical urgency, or the time within which a patient must receive assessment and treatment.[5] The ATS remains a reliable tool for determining the clinical urgency of patients and their care, particularly in instances where the emergency department is compromised by access block, ED overcrowding, and demand for emergency health services. Of the five-level triage scales currently in use, the ATS is more reliable in terms of level of agreement than the Canadian Triage and Acuity Scale and Manchester Triage Scale.[8] When compared to 3 and 5 level scales, 5 level triage scales have increased levels of agreement, increased discrimination, increased sensitivity and specificity, and decreased rates of under-triage.[9] CENA endorses the continued use of the ATS to prioritise patients by clinical urgency.

## Position

1. CENA endorses the use of the ATS to prioritise patients by clinical urgency.
2. CENA does not endorse the practice of assigning an ATS category to a patient based specifically on the availability of medical care. A patient's ATS category must reflect their clinical urgency for emergency healthcare, which may be provided by a range of emergency health care providers.
3. The ATS categories and associated maximum time a patient can wait for emergency care and definitions of waiting times or 'time to treatment' should include the assessment and care provided by emergency nurses. Definitions of 'treatment', 'management' or 'care' that exclude physiological assessment and treatment by emergency nurses are unacceptable.
4. CENA does not support any position or practice whereby the existing 5 level ATS is modified to, or replaced by, a 3 or 4 level triage scales because of a lack of research data to support such action.
5. CENA does not support any position or practice to abandon urgency based triage whereby patients receive care based on any parameter other than clinical urgency for example: time of arrival, treatment stream. These systems may be used to support management of department flow, however patients with more urgent conditions should be seen first regardless of stream or other care models.
6. Quality improvement processes be implemented to monitor triage decision consistence and accuracy for the purposes of education and ongoing evaluation of departmental performance.

References


1. College of Emergency Nursing Australasia. *Triage Nurse*. 2009 [cited 2015 October]; Available from: http://www.cena.org.au/wp-content/uploads/2014/10/CENA_Position_Statement_Triage_Nurse.pdf.
2. Hodge, A., Hugman, A., Varndell, W., and Howes, K., *A review of the quality assurance processes for the Australasian Triage Scale (ATS) and implications for future practice.* Australasian Emergency Nursing Journal, 2013. 16(1): p. 21-29.
3. Department of Health and Ageing, *Emergency Triage Education Kit*. 2009: Canberra.
4. Varndell, W., Fry, M., Gallagher, R., and MacGregor, C., *Measuring patient dependency: performance of the Jones' Dependency Tool in an Australia adult emergency department.* Australasian Emergency Nursing Journal, 2013. 16: p. 64-72.
5. Forero, R. and Nugus, P. *Australasian College for Emergency Medicine (ACEM) Literature Review on the Australasian Triage Scale (ATS)*. 2012 [cited 2015 October]; Available from: https://www.acem.org.au/getattachment/64ecf9de-866d-437a-8f0b-402c6ab32414/ACEM-Literature-review-on-the-Australasian-Triage.aspx.
6. Australian College for Emergency Medicine. *Policy of the Australasian Triage Scale*. 2013 [cited 2015 September]; Available from: https://www.acem.org.au/getattachment/693998d7-94be-4ca7-a0e7-3d74cc9b733f/Policy-on-the-Australasian-Triage-Scale.aspx.
7. Department of Health and Ageing. *Emergency Triage Education Kit*. 2009 [cited 2013 January]; Available from: http://www.health.gov.au/internet/main/publishing.nsf/Content/casemix-ED-Triage+Review+Fact+Sheet+Documents.
8. van der Wulp, I. and van Stel, H., *Calculating kappas from adjusted data improved the comparability of the reliability of triage systems: a comparative study. .* Journal of Clinical Epidemiology, 2010. 63(11): p. 1256-1263.
9. Travers, D., Waller, A., Bowling, J., Flowers, D., and Tintinalli, J., *Five-level triage system more effective than three-level in tertiary emergency department.* Journal of Emergency Nursing, 2002. 28(5): p. 395-400.



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