Emergency Nurses Association of NSW Inc.'s Response to ACEM Policy Documents – Guidelines for Implementation of the Australasian Triage Scale in Emergency Departments & The Australasian Triage Scale

The Emergency Nurses Association of NSW Inc. supports the concept of the use of the Australasian Triage Scale (ATS) for all Emergency Departments (ED). The primary function of the ATS is that of an urgency rating system for the care of patients. We do not support the implementation of an additional scale for the rural/remote regions. Triage should occur the same in the rural setting as that in the metropolitan setting, ie. if a Category 1 presentation requires immediate intervention this must occur irrespective of geographical location. Similarly, a Category 5 presentation that does not require medical intervention should be triaged the same whether they present to a metropolitan or a rural ED.

However, there are significant amendments required to the Guidelines for Implementation of the Australasian Triage Scale in Emergency Departments and to The Australasian Triage Scale documents.

The intention that the ATS be implemented to include the use of CLINICIAN SEEN as the measurement of waiting time has not been fully addressed in these documents and changes are required. The provision of Emergency Care requires Nursing, Medical and Paramedical services which may be delivered singularly or in any combination. Recognition of the nurse's autonomy in emergency care must be a feature of the tool. Not all patients that present to ED's require the service of a Medical Officer. Some patients require a nursing managed service only, or paramedical service only, where there is no need for medical officer intervention. This type of service provision occurs in ED's for various reasons, and is provided without medical advanced standing orders. The implementation of Emergency Nurse Practitioners is also occurring and must be anticipated by the guidelines.

Clinical assessment and treatment in ED's often is commenced by nurses particularly in relation to Category 2 & 3 patients. Nurses practise in advanced roles which must be recognised and accepted as occurring either in the presence or absence of Medical Officers. This however does not negate the need for Medical Officer presence/intervention, however, requires a recognition for the actual clinical practice that is occurring.

There should remain separate distinct recordings of time seen by, or intervention, by all clinicians. Separate recordings of these times should be recorded for medical, nursing and paramedical. It is essential that all times are recorded to allow an accurate assessment of each service as well as the whole ED.

The Emergency Nurses Association of NSW Inc. does not support any reduction in the benchmarks for Triage Categories. This has been introduced without consultation and should be returned to the original levels. With the implementation of clinician seen time we believe that the existing performance indicators can be achieved more frequently. The reduction in the levels of performance indicators is not only a perceived, but a real reduction in the standards of the provision of Emergency Care. The Association is totally opposed to the lowering of standards.

It is essential that the various computer programs currently utilised by ED's be modified to address the changes in the implementation of the ATS as a matter of urgency.

The implementation of the recommended changes (see below) would then truly support the intention of the ATS to be utilised as a tool to monitor and assess the service provision of Emergency Departments throughout Australia.

The following specific changes to the wording of the The Australasian Triage Scale and the Guidelines for Implementation of the Australasian Triage Scale in Emergency Departments document are essential (changes are highlighted, additions are in red);

The Australasian Triage Scale

3.1 *"This patient should wait for clinical assessment and treatment no longer than...."*

4.

ATS 1	Immediate	100%
ATS 2	10 minutes	95%
ATS 3	30 minutes	90%
ATS 4	60 minutes	90%
ATS 5	120 minutes	85%

5 Performance Indicator Thresholds

The indicator threshold represents the percentage of patients assigned Triage Code 1 through to 5 who commence clinical assessment and treatment within the relevant waiting time from their time of arrival. … It is neither clinically nor ethically acceptable to routinely expect any patient or group of patients to wait longer than two (2) hours for clinical attention.

Guidelines for Implementation of the Australasian Triage Scale in Emergency Depart

2.2 Time of Clinical Assessment and Treatment

Although important assessment and treatment may occur during the triage process, this time represents the start of the care for which the patient presented. The Clinician seen time shall reflect the earliest of the times recorded by the relevant clinicians providing treatment. A recording accuracy to within the nearest minute is appropriate:

2.2.1 It may be the time of first contact between the patient and the doctor initially responsible for their care. This is recorded as "Time seen by doctor".

2.2.2 Where a patient in the ED has contact exclusively with nursing staff it is the time of first nursing contact. This is recorded as "Time seen by nurse".

2.2.3 Where a patient is treated according to a documented, problem specific clinical pathway, protocol, or guideline approved by the Director of Emergency Medicine or other appropriately authorised director, e.g., Director Of Nursing, Clinical Nursing Director, Director of Medical Services, it is the earliest time of contact between the patient and clinical staff implementing this protocol. This time shall reflect the time closest to the time of the patient's arrival that is recorded in either the "Time seen by nurse" or "Time seen by doctor".

2.3 Waiting Time

This is the difference between the time of arrival and the time of initial clinical assessment and treatment. A recording accuracy to within the nearest minute is appropriate.

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