Canadian Triage and Acuity Scale - Rural implementation

Introduction

The Canadian Triage and Acuity Scale (CTAS) was developed by the Canadian Association of Emergency Physicians (CAEP) in 1998 and published as **Implementation Guidelines for the Canadian ED Triage and Acuity Scale**. The objectives of the CTAS scale were to "more accurately define patients' needs for timely care and to allow emergency departments to evaluate their acuity level, resource needs and performance against certain operating objectives."

The CTAS national working group believes that Canadians living in rural communities are entitled to the same level of emergency medical care as urban residents.

Since the publication of the document, many Canadian emergency departments, both urban and rural, have adopted its recommendations. Patient flow has been altered so patients are seen by a triage nurse upon first entering the department. Nursing staffs have been trained in its application.

Triage by nursing staff, when applied as per the CTAS document, can be very helpful in sorting and prioritizing patients waiting for care.

Problems have arisen in sparsely staffed rural emergency rooms (ERs) when trying to implement this system. Some institutions have provided inadequate training to their nursing staff for proper implementation. Physician resources have been strained trying to accommodate the timeframes suggested in the document for non-urgent problems. This has led to friction between physicians and ER nursing staff, and increased job dissatisfaction among rural physicians, many of whom balance ER work with family practice, hospital inpatient care, obstetrical deliveries, etc. In some communities, the demand for strict adherence to quick response times could result in a loss of medical services, i.e. physicians may leave town. The CTAS document states, "The time responses are ideals (objectives) not established care standards." However, hospital administrators in many rural communities have demanded physician response within the timeframes indicated by the document, despite the lack of evidence to support any 'time to physician' recommendations. Hopefully research will uncover such data.

In order to address these issues, the following recommendations are intended to assist in the implementation of the CTAS guidelines in rural health care facilities.

Recommendations

1. The CTAS definitions and descriptions of triage levels one to five be accepted by rural as well as urban ER. *See part 6 of the CTAS: "Triage in Rural Emergency Health Care Facility."*

2a. Nursing staff should be trained in the use of the CTAS.

2b. Nursing staff should be involved in the implementation and monitoring of protocols and medical directives.

2c. Rural hospitals must have adequate RN staffing to ensure timely triage for all patients.

3. ER nursing staff should be trained to provide initial resuscitation including CPR, starting IVs and defibrillation and be familiar with ACLS standards. A pediatric assessment course such as ENPC is desirable.

4a. Ambulance services and emergency departments should use a common triage scale to reduce the risk of misunderstandings leading to inadequate mobilization of personnel.

4b. Ambulance services should notify receiving hospitals of CTAS level one and two patients as early as possible.

4c. ER staff should then notify on-call physicians promptly of all CTAS level one and two patients coming by ambulance, prior to their arrival in the ER.

5. On-call physicians should be accessible at all times (by phone, pager, etc.), both so they can be called in as required, and so they can give direction to ER nurses prior to their arrival.

6. The timeframes recommended by the CTAS document are reasonable times to **physician-directed care** (in the absence of evidence). Physician-directed care could include:

- Care provided directly by the physician in person
- Telephone advice
- Care provided by nursing staff in accordance with medical directives agreed to in advance by the physician. See below for more information.

7. The CTAS makes no reference to obstetrics. Because of the wide variation in obstetrical preparedness between rural ERs, each institution may wish to prepare guidelines for such emergencies. There are very few examples of such protocols available to this committee; hospitals with such protocols are encouraged to submit them for publication on the Society of Rural Physicians of Canada (SRPC) website.

Protocols

The SRPC-ER committee has developed a protocol (medical directive) for CTAS level five patients presenting to the ER. Implementing this medical directive should allow rural and remote ERs to continue to provide a high standard of care to their patients while reducing the number of untimely visits to the ER by rural physicians. This is not intended to be a vehicle to solve overcrowding in urban ERs.

An example of an acceptable medical directive for CTAS level four patients in rural and remote hospitals is under development.

A number of rural hospitals have already developed a variety of medical directives so that physician-directed care can be initiated by nursing staff prior to the arrival of the physician. These vary in their detail and in the range of problems addressed. In some rural communities, it may be necessary to implement more detailed or less detailed protocols than the one in this document. Examples of these are available on the SRPC website: http://www.srpc.ca/. They can be

downloaded and modified to accommodate local circumstances.

Communities with functioning protocols are invited to submit them to the SRPC-ER committee so they can be shared with others. Over time, it is expected that these will form a comprehensive repository of well thought-out and produced medical directives from across the country, and perhaps beyond.

The CTAS is currently undergoing review. The SRPC is now represented on the CTAS working group. Please send comments or suggestions for improvement to your SRPC representative on the CTAS working group.

SRPC-ER working group members

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CTAS level five protocol

CTAS level five includes conditions that may be acute, but non-urgent, as well as conditions which may be part of a chronic problem with or without evidence of deterioration. The investigation or interventions for some of these illnesses or injuries could be delayed or referred to other areas of the hospital or health care system.

CTAS level five patients may be triaged by the registered nurse to receive care at a more appropriate time or place if all the following criteria are met, i.e. criteria (a) to (e) inclusive, without contacting the on-call physician:

a) The patient is six months of age or older.
b) Vital signs are deemed satisfactory by the nurse, and temperature is 35-38.5°C (38.3°C for age > 60 years)
c) The patient is assessed as CTAS level five.
d) After the nursing assessment, there is no clinical indication that the patient may require urgent physician attention.
e) In borderline cases, or where the nurse is unsure, telephone consultation between the nurse and physician has determined that the problem is non-urgent.

When a "non-urgent" patient meets all of the criteria specified above, the patient will be advised that they have been assessed using a set of approved guidelines to determine the urgency of need for medical care and that their problem has been assessed as non-urgent at this time.

The nurse may carry out nursing intervention if appropriate, or advise the patient to seek health care services later, e.g. family physician's office, walk-in clinic, make an appointment, or return when the physician will be present in the ER. Always advise the patient that if s/he has further problems or if the condition worsens, to call the hospital or return to the emergency department. May use "patient letter" - see attached.

Facilities may develop standardized treatment protocols for nursing care and symptom relief. For examples go to http://www.srpc.ca/

Documentation/reporting

Documentation should follow the same process as all other ER visits, and should include the CTAS level, nursing assessment, any nursing interventions, and discharge instructions. These should be reviewed by the on-call physician early the next day and any suggested changes be initiated by the physician and communicated to the nurse involved. Follow-up by the physician would be documented on the same outpatient form.

Evaluation/ monitoring/audit

Ongoing monitoring is essential to ensure that the directives are effective and safe. Keeping a log of the patients triaged to receive care at a later time or in another location, and any changes in care initiated by the physician, will allow hospitals to monitor the effectiveness of the protocol and institute any necessary changes to improve the process. Monitoring, auditing, and ensuring the protocols are kept up-to-date is the joint responsibility of the physicians and hospitals.

Responsibility for care

Care provided by nursing staff under a medical directive remains the responsibility of the on-call physician. It is the responsibility of the physicians providing on-call services to the community to ensure that protocols and medical directives constitute good medical care and that they remain up-to-date. It is the responsibility of the hospital to ensure that nurses have adequate training to implement the medical directives and to monitor that they are being followed.

Patient letter:

Insert facility name, mailing address and phone number

Dear Patient:
The emergency department is intended for those patients who require medical attention on an emergent or urgent basis. You have been assessed by a nurse who uses a set of approved guidelines to determine the urgency of need for medical care. Your problem has been assessed as non-urgent at this time.

We recommend that you take the following action:

- Make an appointment to see your family doctor.
- Return to the hospital at _____ AM/PM.

If you have any further problems or if your condition worsens, please call the hospital or return to the emergency department.

Dr. _____ ; time; ER medical director; date; ER physician on-call