Insight and Perspectives

a publication of Endurance Insurance's Healthcare Practice

We are pleased to offer our latest installment of *Insight and Perspectives*. This newsletter is dedicated to sharing healthcare news, trends and developments impacting our brokers and insureds.

This installment features Dr. Robert Schafermeyer's article on *Effective Triage in the Emergency Department: Improve Safety and Reduce Risk*, which focuses on potential pitfalls in the Emergency Department triage process that can result in delays and errors in the treatment of patients.

As always, we appreciate your continued support and thank you for selecting Endurance to be a part of your risk and insurance programs.

About Us

Our U.S. and Bermuda teams provide healthcare professional liability coverage to non-profit and for-profit hospitals and other healthcare organizations.

Contact Us

Kim Morgan
Senior Vice President, Healthcare Practice Leader – Bermuda
kmorgan@endurance.bm
+1.441.278.0923

Kim Willis
Senior Vice President, Healthcare Practice Leader – U.S.
kwillis@enhinsurance.com
+1.636.681.1205

If you would like to subscribe to Insight & Perspectives, please email us at endurancecommunications@endurance.bm

Effective Triage in the Emergency Department: Improve Safety and Reduce Risk

By Robert Schafermeyer, MD, FACEP, FIFEM, FAAP
Professor Emeritus Carolinas Medical Center
Adjunct Professor Emergency Medicine, University of North Carolina
Past President of American College of Emergency Physicians
rschafermeyer@acep.org

Missed diagnoses, delays in care and inadequate patient assessments are contributing factors to liability claims in the Emergency Department (ED) and often result from multiple breakdowns in the diagnostic process beginning with the triage assessment. This article focuses on pitfalls in the ED triage process that can result in errors and delays in the evaluation and treatment of patients.

Many factors can adversely impact the triage process, placing the patient at risk and exposing the ED provider and healthcare facility to liability. Although triage is commonly performed in the location where the patient enters the ED, it can also occur at the bedside. Triage should be viewed as a process; the location is not as important as the fact that triage assessment should be prompt and accurate. The ED triage staff must collect the right information in a short amount of time to make a correct assessment.

Emergency Department Staffing & Procedures

Evaluating whether adequate resources are devoted to triage in terms of space, equipment, and experienced staff should be a key focus when assessing triage risks. When reviewing ED staffing during risk assessments, we sometimes find that triage is conducted by inexperienced nurses. Unfortunately, nurses with less than a year of experience may not understand the subtleties of disease or injury presentation and may take longer to evaluate patients needing urgent care. Therefore, more senior nurses should serve as triage officers. The Emergency Nurses Association (ENA) has established minimum qualifications for the role which include advanced training, experience and education.

Delays in the triage process may also result from not having enough space or enough staff to effectively triage patients during peak volume times. For example, one hospital had significant hourly variations in the number of patients presenting to triage. After performing the recommended analysis, the hospital identified that during peak hours, a city bus dropped off a significant number of patients who then made their way to the ED, overloading the triage waiting area. To help solve this problem, a backup staffing plan is now triggered when the triage nurse has more than a 15 minute backlog. When the triage area reaches this critical point, a second nurse is assigned to help with assessments and facilitate patient throughput.

Another facility noted that after implementing an electronic medical record (EMR) system, triage times had become markedly longer. In addition, several patients with critical illnesses experienced significant delays before treatment was initiated. This situation was remedied when the number of

Continued over

required entries in the EMR were reduced to include only key information needed in the triage process. Following this change, triage times returned to what they were prior to the EMR system implementation.

The Importance of Patient History in Triage

Questions – it is all about the questions. Asking too many questions, asking the wrong questions or not asking enough questions can all cause delays in the evaluation and treatment of patients in triage. When speaking to the patient, it is extremely important to ask about comorbidities and to find out what medications they take.

In one case study, a patient presented with the chief complaint of fatigue and shortness of breath. He was deemed not to be sick enough to be a priority 1 or 2 patient on the emergency severity index. The patient was in the ED for over an hour when a physician walking by the room heard him breathing rapidly and deeply, prompting her to evaluate him immediately. Within a short period of time, the patient was treated for diabetic ketoacidosis. Triage staff had not asked about comorbidities and the patient's diabetes mellitus was not documented.

In another case, a 70-year-old patient came to the ED with a laceration to the head. During the intake, the patient told the triage staff that a branch fell and hit him on the head but no one asked about comorbidities or his medications. He was seen approximately 50 minutes later by the emergency physician who asked additional questions about how the injury occurred and what medications he was taking. When the patient said he was taking the anticoagulant Coumadin, a stat head CT scan was obtained and neurosurgery was consulted to treat his large subdural hematoma. Fortunately, for this patient, the delay did not result in a serious adverse outcome, but it certainly could have if the delay had been much longer.

In addition to a listing of current medications, triage staff should specifically ask about drugs with a high risk for bleeding such as anticoagulants, drugs that affect vital signs such as beta-blockers, and drugs that affect mental status. Failure to obtain an accurate list of current medications early in the triage process may result in the patients receiving a lower treatment priority and a delay in the management of critical illnesses or injuries.

Atypical Presentations and Special Populations

It is also important for triage staff to know and recognize atypical presentations of critical illnesses. For example a 32-year-old man presented with left shoulder pain. He received a less urgent triage priority resulting in a significant delay before a physician evaluated him. When the physician entered the room, the patient had an emesis basin in hand. The physician asked if the patient had injured his shoulder, to which he answered "no". When asked if he was nauseated or had vomited he said "yes." The physician ordered an immediate EKG, which showed that the patient had an acute inferior myocardial infarction.

With the growing number of elderly patients presenting to the emergency department it is also important to have acute care protocols specifically geared for the elderly. "Undertriage" occurs frequently in the evaluation of elderly patients in both the pre-hospital and ED settings. Triage staff should be well versed in how to address altered mental status or memory problems, as well as fall risks in the older patient.

An Objective Approach and Performance Metrics Can Improve Triage

The information gathered at triage and the priority assigned to the patient can significantly affect the efficacy of the patient's evaluation and treatment. Inadequate or prolonged information gathering can result in significant delays in care. Further, triage can set the path of the patient's treatment for better or worse if the healthcare providers fall into the trap of diagnostic anchoring based on the triage assessment. This occurs when a provider frames a clinical problem around the first information received. It is a cognitive predisposition that explains our willingness to accept a patient's initial diagnosis made in the emergency room without further evaluation.

Performance improvement metrics should be in place to monitor the timeliness and accuracy of the triage process. Analysis of adverse events and claim trends can help determine where and why delays in patient evaluation and treatment occur and shed light on how patients present and move through the triage process.

To summarize, triage is a process that needs adequate resources and space, experienced and skilled triage staff, excellent communication skills to illicit a complete history, comorbidities, and medication use, and the ability to identify patients with critical medical needs with appropriate priority assignment so that they receive timely care. Reducing delays at triage enhances patient safety and reduces liability risks for providers as well as the healthcare organization. ◄

Resources:

Nishijima DK, Gaona S, Waechter T, et.al.; Do EMS providers accurately ascertain anticoagulant and antiplatelet use an older adults with head trauma? Prehospital Emergency Care 2016; 16:1 – 7.

Emergency Nurses Association Triage Policy: https://www.ena.org/SiteCollectionDocuments/Position%20Statements/TriageQualifications.pdf. 2011.

Emergency Nurses Association, American College of Emergency Physicians, Society for Academic Emergency Medicine, American Geriatric Society: Geriatric Emergency Department Guidelines: https://www.ena.org/about/media/PressReleases/Documents/Geri_ED_Guidelines.pdf; 2014.

ACEP and ENA Policy Statement: Triage Scale Standardization; https://www.acep.org/clinical---practice-management/triage-scale-standardization/; 2010.

* Dr. Schafermeyer is an emergency physician consultant for Sedgwick CMS.