POSITION STATEMENT – 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 (ATS) by registered nurses. It should be read in conjunction with the CENA Position Statement – Triage Nurse.

Rationale

When the demand for the emergency department (ED) services exceeds available resources it is both ethically and clinically necessary to identify those patients who are in more urgent need of emergency care. In Australia emergency nurses perform the triage role using the ATS. The application of the ATS is supported by an evidence-based guideline. 1-3 The function of ED triage is based on five core principles.

Principles

1. For all patients seeking emergency care, their level of urgency must be determined at point of entry to the ED (on arrival).

2. The ATS and the ATS guideline are the tools used to prioritise all patients according to clinical urgency.

3. When deciding urgency allocation of an ATS category should not be influenced by factors other than the patients’ clinical condition.

4. The allocation of an ATS category is made according to the maximum time a patient can wait for emergency care, including assessment and care provided by emergency nurses.

5. The provision of secondary triage tasks (such as ordering diagnostic investigations) must never delay other patients in the triage queue who are yet to be triaged.
Definitions

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

The triage nurse applies an ATS category in response to the question: “This patient should wait for medical [sic] assessment and treatment no longer than….“²

**Primary triage decisions** – “‘Primary triage decisions’ relate to the establishment of a chief complaint and the allocation of urgency.”¹

**Secondary triage decisions** - “Secondary triage decisions’ are concerned with expediting emergency care and disposition.”¹

**Complexity** – “relates 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

**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

**Urgency** – “:how quickly a patient needs to be seen in order to initiate treatment and prevent deterioration or further pain and suffering.”⁴

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. 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.  

Table 1 ATS categories and their maximum waiting times

<table>
<thead>
<tr>
<th>ATS category</th>
<th>ATS acuity (maximum waiting times)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (resuscitation)</td>
<td>Immediately</td>
</tr>
<tr>
<td>2 (emergent)</td>
<td>Within 10 minutes</td>
</tr>
<tr>
<td>3 (urgent)</td>
<td>30 minutes</td>
</tr>
<tr>
<td>4 (semi-urgent)</td>
<td>60 minutes</td>
</tr>
<tr>
<td>5 (non-urgent)</td>
<td>120 minutes</td>
</tr>
</tbody>
</table>

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) and who, ideally holds postgraduate qualifications in emergency nursing, to determine the clinical urgency of their presentation. (Refer to CENA Triage Nurse Position Statement)

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. 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. 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. CENA endorses the continued use of the ATS to prioritise patients by clinical urgency.
Position

- CENA endorses the use of the ATS to prioritise patients by clinical urgency.
- CENA does not endorse the practice of assigning an ATS score to a patient based specifically on the availability of medical care. A patient’s ATS score must reflect their clinical urgency for emergency healthcare, which may be provided by a range of emergency health care providers.
- 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.
- 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.
- 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 eg: 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.

Approved by the Board:

Review due:
References


