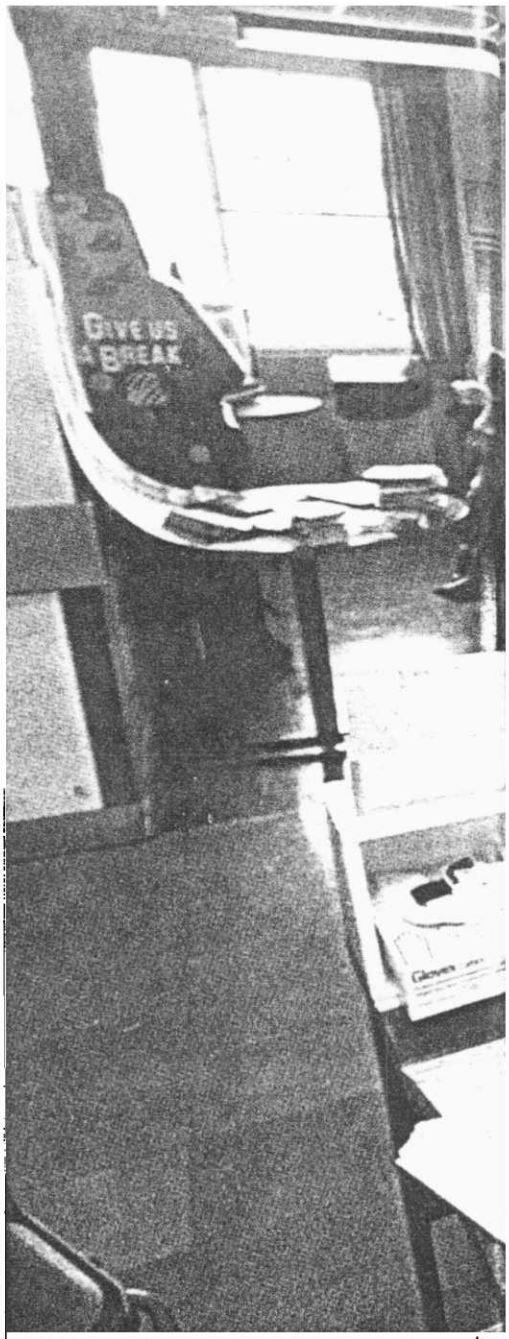
COMMUNICATION

TRIAGE BY TELEPHONE

Can the telephone help accident and emergency departments overburdened by inappropriate attenders? Ethel Buckles and Michael Carew-McColl describe the successful use of an extended triage system



OVER the past 30 years, there has been a steady increase in the number of new (first-time) attenders at accident and emergency (A&E) departments, but little or no new money available to fund them. Wood and Cliff have concluded that if major A&E departments are not to be overwhelmed, an urgent solution needs to be found to the problem of providing services for patients with minor injuries who do not require hospital care[1].

In Preston, our A&E workload has increased by one third over the past eight years. Nursing staff levels actually declined over this period and, although there was a marginal increase in medical staffing, it became clear that this situation could not be allowed to continue.

No department with finite resources can allow itself to be drained by the increasing demands of the general public. The people who suffer most are the severely ill or injured patients, who require prompt attention and treatment and make appropriate use of our skills.

The standard triage system, which we introduced two years ago, provided us with useful insights into the reasons why people attend A&E. It also made us realise that many inappropriate attenders had little perception of their own problems or where the best place was to have them treated. In addition, they did not appreciate the difficulties they caused by distracting A&E staff.

We informed our health authority of our concern and it encouraged us to provide some answers. It was felt that placing a time limit on the treatment of injuries or illness was too blunt and insensitive an instrument to deal with this problem. Inspiration came from the frequently heard complaint that we never stop answering the phone.

We decided to install a telephone with several lines at the triage desk so that:

- General practitioners and other primary health carers could telephone to discuss their patients with the A&E triage nurse.
- Prospective patients could telephone the triage nurse before they attended, whenever practical.

In addition, the triage nurse could assess unannounced attenders, decide where each patient could best have his problem dealt with, and might then refer the patient elsewhere.

The idea seemed sound, but we were naturally concerned to gain support from the many groups affected by our proposed system.

We presented the concept by stressing the potential benefits to those patients who most required our assistance. The prospect of more efficient and cost-effective patient care appealed to our management. The local community health council was aware of our motives and was most supportive. But would the general practitioners agree?

We arranged a lunchtime meeting and invited all the local general practitioners, practice managers, receptionists, community and other primary health care nurses from health centres, local prisons and industry. A letter accompanied the invitations outlining the present situation and explaining our proposals.

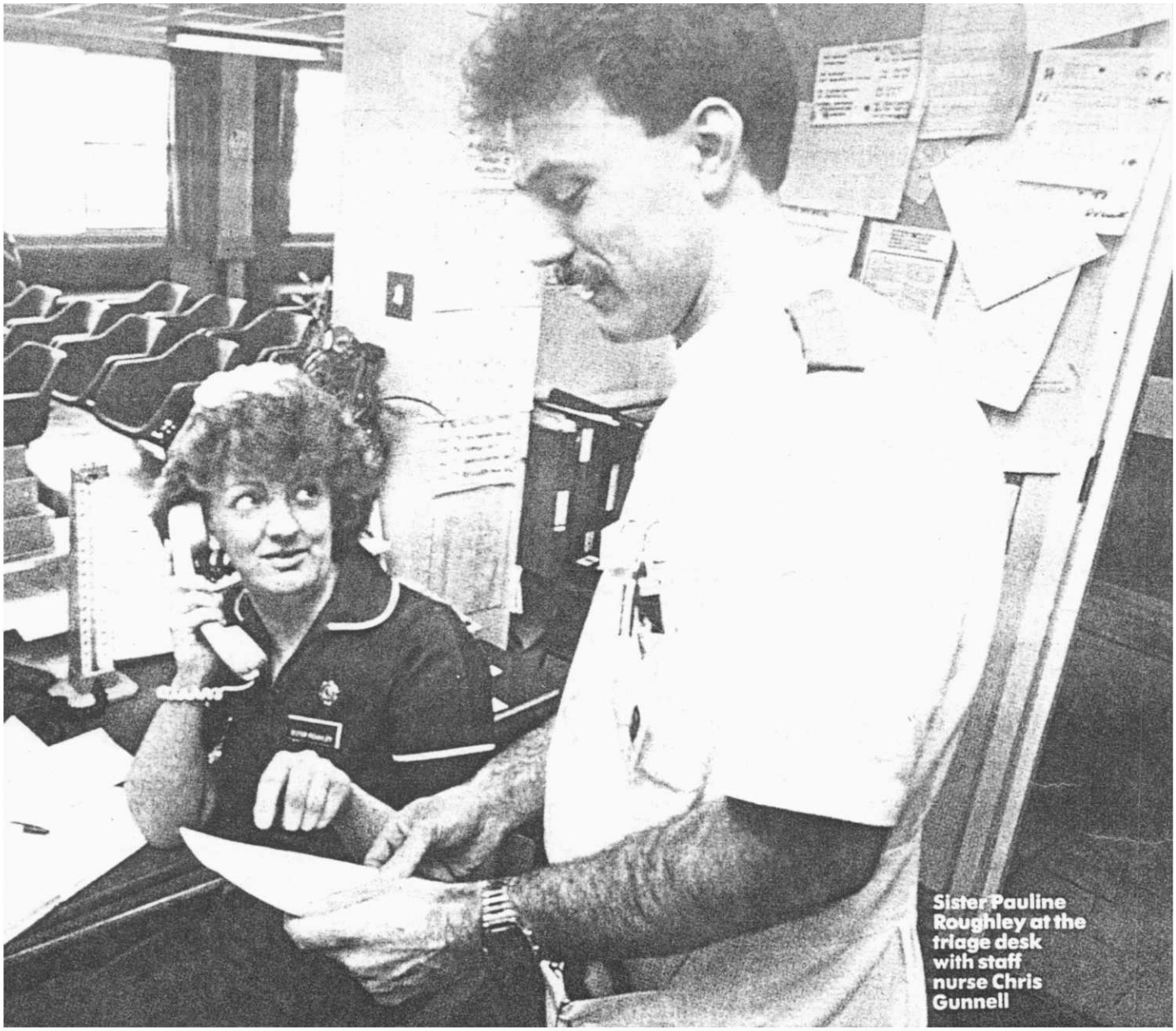
The general practitioners were very understanding and supportive and agreed to see patients redirected to them by the triage nurse (by phone if necessary). It was also agreed that if there was a dispute as to where the patient should be treated, every effort would be made to avoid making the patient feel that the game of 'pass-the-parcel' was being played.

We decided that, rather than have detailed protocols, we would have a decision framework as to how the triage nurse would conduct her activi-

Table 1. Role of the triage nurse

Triage nurse decides whether:

1. Patient requires A&E attention
2. Patient could be handled by A&E or GP
3. Patient could and should see GP
4. Patient requires help from another source
5. Totally inappropriate attendance



Sister Pauline Roughley at the triage desk with staff nurse Chris Gunnell

ties (Table 1). All phoned-in inquiries from whatever source would be documented (together with a note of the advice given). The same routine applied to all patients who were triaged away, with or without treatment, by the triage nurse. We called the system 'extended triage', and in November 1989 we were in business.

Initially, a senior doctor was immediately available to the triage nurse in case she had a query or ran into difficulties. Needless to say, the nurses were extremely apprehensive about their new role and were quickly made aware of their own shortcomings and the complexity of some of the clinical problems presented by telephone callers and attenders.

Regular lunchtime meetings were held at which a number of topics were discussed, but clinical examination techniques and a weekly digest of problems arising proved to be the most useful and supportive.

The system was introduced with spectacular publicity by the local press, which also published the triage number. We took care not to advertise too widely so that the triage nurse would not be overwhelmed by public enquiries. As confidence grew, we produced a poster advertising our extended triage service which was distributed to schools, factories, libraries and other public places.

Nearly a year after we began, we are taking stock of the current situation (Tables 2 and 3). Much remains to be done to make the system run optimally, but we are convinced that this is the way forward for all accident and emergency departments of any size. General practitioners no longer send us people to have their abscesses drained in the evening. Instead, they (or some-

Table 2. Triage calls over one week

Patients	47	34%
Parents	42	30%
GPs	30	22%
Nurses	8	6%
Relatives	7	5%
Others	4	3%
Total	138	

Table 3. Response to calls—one week March 1990

Accepted	57	41%
Accepted for later time	21	15%
Referred to GP	36	26%
Referred to GP (phoned)	4	3%
Reassured	10	7%
Dentist	8	6%
Others	2	2%
Total	138	