Triage: The Sorting of Patients

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Triage is derived from the French word *trier*, to sort or sift; it is defined as the sorting of patients according to urgency and need for care.[1] Triage has become something much different than sorting in many emergency departments worldwide. Over the course of time, triage evolved into a place, an area of entry for patients seeking emergency services. In the ED setting *triage* is a verb, not a noun; it is the process of quickly assessing a patient and determining whether he or she is sick or not sick.

Triage should simply be organizing patients by acuity and facilitating their need to see a physician or advanced practice provider (APP). In truth, once the patient is brought to an area that can facilitate a medical screening examination, triage has been performed. Emergency nurses must use the true meaning of triage and apply it to practice.

Expectation of Care in the Emergency Department

Waiting in an emergency department may be dangerous, frustrating, and costly. Long wait times have been directly correlated with poor patient outcomes.[2] The inability to register and treat patients and determine their disposition efficiently compromises safety, satisfaction, and efficiency.[2] The time between arrival and physician contact is directly correlated with an effective and efficient triage process.[3] A major obstacle affecting arrival–to–physician contact time is assignment of a triage category, which can result in patients having a longer wait time.[4]

Methods for Improving the Triage Model

The development of a successful triage process to facilitate patient movement is paramount in improving throughput and requires a team approach. Several processes have been developed to accomplish just this, such as immediate bedding, protocol orders, utilization of a GRASP (greets, reassures, assesses, sorts, and prioritizes) nurse, the pivot-and-pass process, and rapid triage assessment. An overview of each of these approaches is presented in this article.

A process implemented at The University of Utah Emergency Department used immediate bedding for higher-acuity patients who were disbursed to the main emergency department and nonurgent patients were taken to an intake area, where they underwent a medical screening examination by an APP and a quick-look assessment by a registered nurse (RN). Patients were then moved to a rapid treatment unit, where protocols or standing orders were used. These patients were placed in recliners or chairs rather than on stretchers, which aided in movement of the patients after diagnostic tests or interventions were performed. All patients requiring beds in the main emergency department were immediately placed in the beds after the charge nurse was alerted to their presence. In instances in which beds were unavailable, an RN and APP began treatment and assessment of these patients in the intake area, which provided a systematic way to prioritize and sort patients who were waiting for beds. This redesign of patient flow significantly reduced wait times and increased patient satisfaction scores.[5]

Some hospitals have implemented a GRASP nurse at the point of entry for the patient. The GRASP nurse initially greets, reassures, assesses, sorts, and prioritizes the patients in the emergency department. The point of the GRASP emergency nurse on the patients' entry into the hospital is 2-fold. The greeting portion allows the patients to realize that an RN understands their complaint and its urgency. The GRASP nurse then performs a quick assessment and can prioritize the patients for entry into the full triage area, where a more thorough assessment can be completed. Second, the GRASP nurse is able to easily identify those patients who are in need of expedited care in the main department. The GRASP RN also further enhances the triage process by accurately sorting the patients while also providing excellent customer service to patients on their arrival.[6]

The pivot-and-pass approach is immediate front-door identification of sick patients. There are several different methods used in this approach. First, if space and a provider are available, the patient is immediately brought to the

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treatment area. The traditional triage area is bypassed. The pivot method results in decreased door-to-physician or door-to-APP times, resulting in improved patient safety and satisfaction.[7] The options for the pivot-and-pass approach may include a 5-level triage acuity scoring system such as the Emergency Severity Index.[8] If an acuity is not assigned initially, an acuity will need to be assigned during the intake process. Lack of available space in the department may dictate holding patients in the waiting area; acuity assignment or quick-look assessment should be completed for all patients in the waiting area.

A process implemented at the University of Pittsburgh Medical Center viewed walk-in patients the same as patients arriving via ambulance. Previously, the walk-in patients received a full assessment from the triage nurse and were moved to the registration area, the chart was walked to the main emergency department for review by the charge nurse, and a bed was assigned. Use of the new process in which patients were brought immediately to a bed assigned by the triage nurse allowed patients to avoid long waits and potentially dangerous delays in the waiting area. Once the department reaches capacity, the traditional triage process is initiated. The University of Pittsburgh experienced a 28% reduction in door-to-physician or door-to-APP time after implementing this process.[9]

The rapid triage assessment is designed to sort patients according to their triage acuity and then direct the patients to the appropriate ED area for initial interventions. A rapid triage assessment is an expedited version of triage that encompasses only pertinent history and physical examination based on the presenting complaint. The nurse performing this assessment is located at the front desk and is not in a triage area. The patient's first encounter is with the nurse; the assessment and assignment of acuity begin at this point. This methodology uses a quick-look approach, and patients who need care urgently are immediately brought to the treatment area. Implementation of this rapid triage method has decreased the door-to-triage time by up to 75%.[10]

It is clear that emergency departments must provide efficient and cost-effective high-quality care. Traditional triage processes have become outdated and are in need of a change. Hospitals are attempting to redesign and restructure the triage process because it often creates bottlenecks in patient flow and ED throughput. Reductions in waiting times for ED patients result in positive patient experiences and decrease the likelihood of poor outcomes due to treatment delays. Triage is a process that emergency nurses own, and emergency nurses therefore must direct its navigation into the future.

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