Triaging the emergency department, not the patient: United States emergency nurses' experience of the triage process

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Contribution to Emergency Nursing Practice:

- This study explored the experience and understanding of triage as a nursing process in emergency settings.
- Application of these findings may include the following:
  - A better understanding of how environmental constraints affect the decision-making capabilities of emergency nurses
  - Clear metrics and assessment mechanisms for triage competencies

Abstract

Introduction: Triage, as it is understood in the context of the emergency department, is the first and perhaps the most formal stage of the initial patient encounter. Bottlenecks during intake and long waiting room times have been linked to higher rates of patients leaving without being seen. The solution in many emergency departments has been to collect less information at triage or use an "immediate bedding" or "pull until full" approach, in which patients are placed in treatment areas as they become available without previous screening. The purpose of this study was to explore emergency nurses' understanding of—and experience with—the triage process, and to identify facilitators and barriers to accurate acuity assignation.

Methods: An exploratory qualitative study using focus-group interviews (N = 26).

Results: Five themes were identified: (1) "Sick or not sick," (2) "Competency/qualifications," (3) "Triaging the emergency department, not the patient," (4) "The unexpected," and (5) "Barriers and facilitators."

Discussion: Our participants described processes that were unit- and/or nurse-dependent and were manipulations of the triage system to "fix" problems in ED flow, rather than a standard application of a triage system. Our participants reported that, in practice, the use of triage scales to determine acuity and route patients to appropriate resources varies in accuracy and application among emergency nurses and in their respective emergency departments. Nurses in this sample reported a prevalence of "quick look" triage approaches that do not rely on physiologic data to make acuity decisions. Future research should focus on intervention and comparison studies examining the effect of staffing, nurse experience, hospital policies, and length of shift on the accuracy of triage decision making.

Key words: Triage; Emergency nursing; Qualitative research; Clinical decision making; Acuity assignation

Each year, 130.4 million patients present to emergency departments in the United States[1] who must be prioritized by acuity, or severity of condition, through triage. Triage, as it is understood in the context of the emergency department, is the first and perhaps the most formal stage of the initial patient encounter. However, the increasing number of tasks required by triage staff as mandated by regulatory agencies (eg, medication reconciliation, suicide screening) extends the time required to assess each patient, thereby slowing down patient flow. Bottlenecks during intake and long waiting room times have been linked to higher rates of patients leaving without being seen.[2–4] The solution in many emergency departments has been to collect less information at triage or use an "immediate bedding" or "pull until full"

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TABLE 1
Participants' demographics (N = 26)

Characteristic		Participants (%)
Gender	Female	88.6
	Male	11.4
Age	25–34	25.0
	35–44	18.2
	45–54	31.8
	55–64	20.5
	65+	4.5
Highest Educational Degree in Nursing	Nursing Diploma	2.3
	Associate	6.8
	Bachelor	54.5
	Master's	34.1
	Doctorate	2.3
Primary ED Role	Staff Nurse	36.4
	Charge Nurse	6.8
	Case Manager	2.3
	Clinical/Nurse Educator	20.5
	Clinical Nurse Specialist	6.8
	Director	9.1
	Manager	6.8
	Consultant	2.3
	Other	9.1
ENA Member	Yes	
	No	

Years of Experience	Mean	SD	Min	Max
As a nurse in all areas, including the ED	22.3	13.5	>1	45
As an emergency nurse only	18.2	11.7	>1	42
In current ED	11.4	9.4	>1	38
In all areas of emergency care, excluding nursing (eg, tech)	7.3	11.7	>1	43

approach, in which patients are placed in treatment areas as they become available, without previous screening.

Even in a formal triage process, patient acuity decisions are sometimes made in the absence of physiologic data and are dependent on nursing knowledge and assessment skills, as well as the interplay of social factors in the context in which the decision occurs.[5] This constellation of factors can result in mistriage, which is magnified in the absence of a formal triage process. Of specific concern is the practice of "across-the-room" or "quick-look" sorting, which reduces the number of cues available to the emergency nurse; research findings suggest that this may have impact on the accuracy of acuity assignation and thus affect patient outcomes.[6,7]

A recent integrative review of triage studies[8] discussed 4 similar themes[1]: clinical information[2]; education and experience[3]; characteristics, attitudes, and beliefs of triage nurses; and[4] environment of care. Further research was recommended by Stanfield,[8] especially of a qualitative nature, to explore how these different aspects of triage may be interrelated. The purpose of this study was to explore emergency nurses' understanding of—and experience with—the triage process, and to identify facilitators and barriers to accurate acuity assignation.

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