



Review

The cognitive processes underpinning clinical decision in triage assessment: A theoretical conundrum?



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ABSTRACT

High quality clinical decision-making (CDM) has been highlighted as a priority across the nursing profession. Triage nurses, in the Accident and Emergency (A&E) department, work in considerable levels of uncertainty and require essential skills including: critical thinking, evaluation and decision-making. The content of this paper aims to promote awareness of how triage nurses make judgements and decisions in emergency situations. By exploring relevant literature on clinical judgement and decision-making theory, this paper demonstrates the importance of high quality decision-making skills underpinning the triage nurse's role. Having an awareness of how judgements and decisions are made is argued as essential, in a time where traditional nurse boundaries and responsibilities are never more challenged. It is hoped that the paper not only raises this awareness in general but also, in particular, engages the triage nurse to look more critically at how they make their own decisions in their everyday practice.

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Introduction

As acknowledged by [Watson in 2008](#): (p. 1667) “you cannot train people for the unfamiliar, but you can provide them with the tools to manage: critical thinking, evaluation and decision-making are acquired through education”. Triage aims to cope with situations of uncertainty in a fast-paced environment, with high-acuity patients ([Fry and Burr, 2001](#)) and involves applying ‘tools’ such as critical thinking, evaluation and decision-making to clinical reality. The nurse must utilise these skills appropriately to search for patient information cues, methodically assess these cues to formulate judgements and come to a decision to appropriately triage patients ([Cioffi, 1998](#)). See Box 1. This paper will review the theoretical background to, and discuss the clinical importance of, CDM in triage nurses’ assessments.

Box 1. Defining judgement and decision ([Dowie, 1993](#)).

Judgement
The assessment of
alternatives

Decision
The choice between
alternatives

Background

Overcrowding in A&E departments has been a cause for concern for many years challenging the ability to provide high quality patient care. This concern has been compounded by pandemic viral epidemics, staff shortages, the economic downturn and the increase in non-urgent attendees ([Hoot and Aronsky, 2008](#)). Such overcrowding constraints put staff, under significant pressure to formulate accurate clinical judgements ([Watson, 2006](#)). Notably, [Fry and Stainton state: \(2005, p. 216\)](#) “decision-making processes are central to triage gate-keeping and timekeeping processes – the practical accomplishments of triage”. To ensure staff, particularly the nurses, are able to effectively identify the urgent from the non-urgent, one model adopted was that of the triage system, where a designated nurse assigns individual treatment urgency according to severity of presentation ([Murphy, 1998](#)). Most triage systems guide the nurse through a series of algorithms to a logical choice of category ([Mackway-Jones et al., 2006](#)), whereby appropriately less time is directed to those with less urgent needs, that so commonly leads to departmental overcrowding ([Durand et al., 2011](#)). However, without also possessing the prerequisite intellectual and cognitive skills needed to manage complex information to make judgements, triage nurses’ decisions are equally liable to be unsafe as a high level of clinical skill is still required to employ the algorithm ([Watson, 2006](#)). It is this skill that requires greater exploration, given that nurses are accountable for the outcomes of their decisions ([NMC, 2004](#)).

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Triage assessment

Gerdtz and Bucknall (2001) described triage as a dynamic decision-making process, which prioritises patients, not on order of arrival to A&E, but on their immediate need for medical care. The term originates from 19th century military hospital transportation and medical intervention for wounded soldiers. Key judgements made then were targeting treatment towards soldiers with treatable injuries; whereby they would be fit to return to battle over those arguably more seriously injured for whom return to battle was not a possibility (Bradley, 2007). Evolving from these tough origins, the goals of triaging today are providing a method of assessment with regard to treatment acuity through the allocation of a triage code and identifying and initiating appropriate interventions for those requiring emergency care (Beveridge et al., 1998). The nurse must endeavour to identify a process of injury or illness and reduce potential detrimental effects through rapid assessment and decision-making (Cone and Murray, 2002).

Dougherty and Lister (2008, p. 28) state assessment requires “accurate and relevant observations to gather, validate and organise data and to make judgements to determine care and treatment needs”. It is through both observing and, where possible involving the patient in the assessment, that the nurse can validate her discernment and make appropriate clinical judgements. Decision-making then requires the triage nurse to interpret, discriminate and evaluate information. The accuracy of the decision is, to a significant extent, determined by the quality and nature of the data obtained. To this end, the quality of history taking, assessment and examination, made to elicit data from which decisions are made, will, in itself, influence rates of mortality and morbidity (Gerdtz and Bucknall, 2001).

Professional judgement in triage CDM

Looking specifically at telephone triage, using a limited sample of five nurses, Edwards (1994) was able to demonstrate triage nurses generating and testing hypotheses, as to the most likely cause of the problem, based on information given by patients. The iteration of these hypotheses, the assessment of alternatives (see Box 1), were then weighed against their knowledge and experience, to allow the decision-maker to arrive at an overall evaluation of the situation (Maule, 2001). According to Harvey (2001) poor decisions are frequently linked to inaccurate judgements. Dowding and Thompson (2004) and Thompson et al. (2004) argue that judgement accuracy is reliant on *how* the individual combines and rationalises their prior knowledge of the information required *with* the type of information available to them.

The above study by Edwards (1994) concentrated on reporting the assimilation and analysis of information during the initial triage assessment, rather than describing the appropriateness of the outcomes reached from decisions made. Yet, is it possible to measure the quality of judgements and the subsequent decision made? Studies by Leprohon and Patel (1995) and Considine et al. (2000) have examined the appropriateness of nurse triage CDM. Leprohon and Patel (1995) explored the case records of 50 telephone calls received by 34 triage nurses. Patient record information was then given to a panel of experts, who were asked to judge what the optimal decision was for each call. The nurses' decisions were compared with this. Considine et al. (2000) used 10 scenarios based on patient cases to investigate the appropriateness of triage decisions in 31 nurses, by comparing the triage decisions with the consensus of an established expert panel. By using expert or peer consensus as the gold standard for CDM, both studies provided a standard for decision-making, which could generally be seen as matching

expert performance (Lipshitz et al., 2001). Interestingly, unlike Edwards (1994), the more recent studies failed to address the evaluation of the process of judgement and CDM in their appraisal of good nursing triage decisions. There appears to be a lack of relevant evidence as to how high quality judgements influence the specific clinical decisions made during triaging.

In 2001, Maule classified judgements as either static or dynamic: the former referring to one-off evaluations based on consistent information, whilst the latter dynamic judgements represent inputs into continually shifting situations. Unlike static judgements, dynamic judgements tend to be focused more on predicting the direction of change, rather than making accurate identification of the person's actual state. Arguably, the triage nurse must determine the most appropriate process, static or dynamic, to come to an optimal judgement. Box 2 looks to illustrate the dynamic nature of judgements, within triage situations. Emergency care is delivered in a fluctuating environment, thus predicting the direction of change in patients is an integral part of the initial triage assessment (Andersson et al., 2006).

Box 2. Dynamic professional judgements in triage.

During a busy evening shift a triage nurse is presented with a 24-year-old woman complaining of a fever and abdominal pain. Upon arrival:

- She reports 2-day history of lower right abdominal pain radiating to her back, worsening over the last 24 h. Pain score now 6/10.
- Her vital signs are within range, but she is pyrexial at 37.4 °C.
- Her last menstrual period was 6 weeks before presentation. She has had spottings of blood today.
- She has had 1 previous uncomplicated live birth and no history of sexually transmitted diseases.
- She denies any pertinent medical or surgical history.
- She denies fevers, chills, vomiting, constipation or diarrhoea.
- Her only current medication was an antipyretic (taken 2 h previously).

Before being able to finish triaging this patient, the triage nurse is also notified of a 66-year-old male presenting with shortness of breath. Upon arrival:

- He is coughing and wheezing.
- He appears breathless and cyanosed.
- He is finding it increasingly difficult to talk in full sentences and is becoming anxious.
- His vital signs are BP 148/89, HR 95, respirations 34 and temperature 37.8 °C, oxygen saturations have rapidly dropped from 95% to 78%.
- He denies taking any medication.

The nurse assesses (judges) the evolving situation, immediately giving the patient clearly desaturating higher priority, due to his potential rapid deterioration. He is taken directly for medical review. The first patient, given lower priority, waits to be seen by a physician. However, when reviewed later by a junior doctor, the differential diagnosis is of a possible ectopic pregnancy or acute appendicitis. If the second patient had not presented at that particular point in time, would the judgements and decision made by the triage nurse have been different? The reality of the dynamic environmental clearly must be recognised as having a bearing on assessments/judgements and decisions made.

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