International Emergency Nursing 22 (2014) 47–51

Contents lists available at SciVerse ScienceDirect

International Emergency Nursing

journal homepage: www.elsevier.com/locate/aaen

Review

Reducing uncertainty in triaging mental health presentations: Examining triage decision-making

Anne-Marie Brown RN, MN, Clinical Nurse Specialist [a], Diana E. Clarke RN, PhD, Associate Professor and Associate Dean (Research) [b,*]

[a] Mental Health Program, Health Sciences Centre, Winnipeg, Canada
[b] Faculty of Nursing, University of Manitoba, Winnipeg, Canada

ARTICLE INFO

Article history:
Received 25 July 2012
Received in revised form 18 January 2013
Accepted 22 January 2013

Keywords:
Emergency department triage
Mental health
Decision-making theory
Uncertainty
Cognitive Continuum Theory

ABSTRACT

Little is known about how emergency department (ED) nurses make decisions and even less is known about triage nurses' decision-making. There is compelling motivation to better understand the processes by which triage nurses make decisions, particularly with complex patient populations such as those with frequently emotive mental health and illness issues. While accuracy and reliability of triage decisions generally have been improved through the introduction of standardised triage scales and instruments, other factors such as lack of knowledge or confidence related to mental health issues, past experiences that may elicit transference and countertransference, judgments about individuals based on their behavioural presentations may impact on decisions made at triage. In this paper, we review the current research regarding the effectiveness of triage tools particularly with mental health presentations, present a theoretical framework that may guide research in understanding how triage nurses approach decision-making, and apply that framework to thinking about research in mental health-related triage. Developing a better understanding of how triage nurses make decisions, particularly in situations where issues related to mental health and illness may raise the levels of uncertainty, is crucial to ensure that they have the skills and tools they need to provide the most effective, sensitive, and compassionate care possible.

Introduction

One of the few certainties in nursing practice is *uncertainty*. Uncertainty in healthcare is considered an 'unavoidable reality' in virtually all clinical practice activities (Hammond, 1996; Thompson and Dowding, 2001. Since clinical decisions made in emergency departments (EDs) can involve risk to life and limb, they can be some of the most scrutinised in healthcare. Mental health presentations pose a particular challenge to ED healthcare providers with an inherent level of risk. For example, if a suicidal patient leaves the ED without being seen and subsequently dies by suicide, there is no doubt that there will be scrutiny in many venues and at many levels. If little is known about how ED nurses make decisions (Considine et al., 2007; Gerdtz and Bucknall, 2001; Lee et al., 2006), less is known about triage nurses' decision-making (Cone and Murray, 2002), and less still about how triage nurses make decisions about mental health presentations. In this paper we will explore triage decision-making for mental health presentations, reviewing the use of structured triage tools, and presenting a conceptual framework that may be used to guide further thinking and research on the topic.

Triage decision-making

General hospital emergency departments (EDs) provide rapid access to emergency services for acutely ill patients who arrive in unpredictable patterns and present with entrance complaints of varying severity, necessitating a system of prioritisation that aims to ensure patients receive safe treatment within time frames that will not negatively impact their prognosis (Farrohknia et al., 2011; Ng et al., 2010). As part of this rapid assessment and prioritization, nurses' triage decisions are considered critical in determining the patients' flow through the department (Chung, 2005). The concentration of decision-making may be higher in EDs than almost any other area of healthcare (Croskerry, 2002) and the decision-making at triage is remarkably different than other areas of nursing practice (Bakalis, 2006; Chung, 2005). Nurses working at triage are typically the first to assess a patient and determine their trajectory for care (Evans, 2005). Triage nurses are also typically quite isolated in the ED and, as a result, commonly arrive at decisions without input from their colleagues (Chung, 2005). It is not

* Corresponding author. Address: 217 Helen Glass Centre for Nursing, University of Manitoba, Winnipeg, Manitoba, Canada R3T 2N2. Tel.: +1 204 474 6771; fax: +1 204 474 7683.
E-mail address: diana.clarke@ad.umanitoba.ca (D.E. Clarke).

1755-599X/$ - see front matter © 2013 Elsevier Ltd. All rights reserved.
http://dx.doi.org/10.1016/j.ienj.2013.01.005

simply the number of decisions made at triage or the challenges and risks of prioritising to ensure the most appropriate patient is seen next that raises the level of complexity; it is also the degree of uncertainty that exists within the environment. In an ED where the majority of patients are unknown and "their illnesses are seen through only small windows of focus and time" (Croskerry, 2002, p. 1184), levels of uncertainty run very high.

In most modern EDs, where all patients need to be seen and resources need to be available for every patient seeking care, timely access becomes a defining feature of triage. Patients determined to have more urgent treatment needs receive the most immediate access to the available resources. Thus, the definition of ED triage used to inform the Canadian Triage Acuity Scale (CTAS) is: to rapidly identify those with urgent, life threatening conditions who need quick treatment; to determine the most appropriate treatment area; to provide ongoing assessment of patients; to decrease congestion in treatment areas; and to contribute information that helps define department acuity (Beveridge, 1998). Triaging individuals presenting with mental health and psychiatric problems occurs within this context and relies on the same process which has raised concerns including lack of mental health training or expertise by the nurse conducting the urgency ratings (Broadbent et al., 2010) or lower levels of comfort with triaging mental health presentations (Clarke et al., 2006; Wand and Happell, 2001).

Triage of mental health presentations

EDs have become the default centre for care for individuals and families in mental health or psychiatric crisis (Kirby and Keon, 2004). A wide variety of presentations on any one day can range from people experiencing acute episodes of anxiety or depression, to the chronically mentally ill with financial or housing problems, or to someone floridly psychotic and aggressive who has been brought in by police. Further, those who have attempted suicide and may initially require medical or surgical intervention will require mental health or psychiatric intervention as well. These presentations can be problematic for EDs primarily designed to assess and treat physical illnesses and trauma. As described by a participant in a recent study: "the first barrier is a fundamental one, and that is that they've come to the wrong place, it's a system problem; EDs are physically designed to achieve most of the things that work against us when we're trying to manage a mental health patient" (Weiland et al., 2011, p. 681).

Variations in the skill and comfort level among triage staff working with this patient population can be reflected in extended wait times for mental health presentations, lower rates of accuracy in triage decisions as compared to medical presentations, and decreased consumer satisfaction (Clarke et al., 2005). Although educational interventions have demonstrated a positive impact on nurses' comfort level and patient satisfaction (e.g., Clarke et al., 2007), an improved understanding of how triage decisions are made has the potential to focus education strategies and improve overall accuracy. Furthermore, a better understanding of ED triage decision-making has the potential to increase the accuracy and defensibility of these complex and crucial clinical decisions.

Mental health patients have reported that they feel they are stigmatized by ED staff, they wait longer, their access to ED care is inequitable and they are considered less of a priority when compared to patients with medical or trauma presentations (Broadbent et al., 2010; Clarke et al., 2007; Kirby and Keon, 2004; Wand and Happell, 2001). Accordingly, patient satisfaction with care can be adversely affected by their beliefs that ED staff belittle them or classify their symptoms as inappropriate for the ED (Strike et al., 2006). Such adverse interactions with ED staff may negatively impact a patient's willingness to seek ongoing care for mental health and addiction problems (Strike et al., 2006) and may further lead to inappropriate use of ED services (Barr et al., 2005) or to avoid care until a period of crisis (Clarke et al., 2007; Strike et al., 2006).

Accuracy and reliability of triage

A primary aim of ED triage is to identify those patients who can safely wait and those who cannot. Arguably a process that delays care to patients triaged at lower urgency levels must strive for accuracy (Goransson et al., 2008). One of the primary foci of the research on triage is the type and accuracy of triage and triage scales being utilised (Chen et al., 2010; Christ et al., 2010; Goransson et al., 2005; Grouse et al., 2009). Measuring accuracy in some instances has relied on using an expert panel to assess urgency levels to simulated patient scenarios and then assessing the degree to which study responses are in agreement with those of the expert panel (Olofsson et al., 2009).

For patients seeking emergency care, inaccurate triage results in the individual being over-triaged or under-triaged (Chen et al., 2010). Over-triage occurs when a patient is assigned a level of urgency which results in the patient being seen faster than is necessary (Considine et al., 2000, 2004). One study found that less experienced nurses over-triage, convinced it is safer practice (Considine et al., 2000); however experienced nurses have admitted to doing the same (Chung, 2005). While this situation does not typically pose a risk to the patient, it has the potential to delay wait times and adversely affect other patients waiting in the department (Considine et al., 2000; Olofsson et al., 2009). Although over-triaging mental health presentations is not usually a concern, some EDs admit to ("off the record", personal communication) triaging all patients who present with suicidal ideation as "emergent" in order to avoid any potential liability issues if the patient should leave before being seen. In some situations, however, this could be construed as overly cautious and could potentially lead to abuses of the system.

Under-triage describes the type of triage decision that results in an individual being assigned an acuity rating that is lower than is considered appropriate (Considine et al., 2000). Under-triage serves to prolong the wait time for a patient and delay their access to medical care. A patient who is under-triaged has the potential to experience serious negative outcomes including deterioration, prolonged pain and, in extreme circumstances, death while waiting (Considine et al., 2004). Patients who are under-triaged are also at risk to leave without being seen, raising concerns of patient safety, notably for mental health presentations with suicidal ideation or the potential for violence (Clarke et al., 2006). Users of mental health emergency services and their families report that they feel they are routinely under-triaged (Clarke et al., 2007). In support of this, a study of mental health presentations to a Canadian general hospital ED found that almost 50% of patients triaged as Level V (not urgent) required admission (Clarke et al., 2006) suggesting that these patients may have been under-triaged.

Studies of inter-rater reliability have also found wide variation in responses often across three triage categories (Considine et al., 2000) with the most accurate patient triage occurring at the most urgent and non-urgent ends of the scale (Ruger et al., 2007). It should be noted however, that a recent systematic review of the scientific evidence on triage scales concluded that "most triage scales present insufficient scientific evidence for assessing inter-rater agreement" (Farrohknia et al., 2011).

Arguably, wide variation in agreement can be influenced by the confidence and expertise of the triage nurse. Because triage nurses have admitted to a lack of confidence and expertise with mental health presentations (Broadbent et al., 2007; Clarke et al., 2006; Heslop et al., 2000; Kerrison and Chapman, 2007; Wand and Happell, 2001), any omission of mental health patient scenarios from