

Consultant triage of minor cases in an accident and emergency department

A. D. REDMOND and N. BUXTON

North Staffordshire Trauma Centre, Hartshill, Stoke-on-Trent

INTRODUCTION

There is no doubt that many patients who attend accident and emergency (A&E) departments have minor conditions which do not always merit immediate hospital treatment and could be treated by a general practitioner (GP) (Davison *et al.*, 1983; Cliff & Wood, 1986).

Such patients are termed 'inappropriate attenders', as they are not considered emergencies by the staff of the A&E department and may not have had an accident. The time and resources required to deal with these conditions may be taken from that allocated to more serious or 'appropriate' cases.

Attempts to re-educate those who have waited several hours are unlikely to be successful. Most attempts at dealing with the problem are based on nurse triage (Parmar & Hewitt, 1985; Bailey *et al.*, 1987). On arrival in the department, patients are seen by a nurse who assesses the priority of their condition then patients wait to see the doctor. As more urgent cases arrive their wait will become prolonged. A recent study in one department has shown that even appropriate cases may face increased delay when this method is employed (Read, 1991). Another difficulty with nurse triage is the limitations that may be placed on a nurse's practice. It has been shown that nurses can adhere to X-ray protocols as well as an A&E officer (Macleod & Freeland, 1992) and steer patients successfully to their GP (Carew-McColl & Buckles, 1990). The overall impact on a department may still be limited.

The efforts to triage those with very minor conditions may be out of proportion to the time spent dealing with the patient. An alternative strategy would be to see and treat the very minor cases as they arrive. It is in fact not uncommon for senior members of the A&E medical staff to triage and sometimes treat patients in this way when departments are particularly busy. This study developed this practice further by placing an A&E consultant at the triage desk.

METHODS

The A&E consultant saw 100 patients as they entered the ambulant area of the A&E department over three separate shifts (morning, afternoon, night).

Patients were either: (1) given advice or immediate simple treatment (usually a simple dressing) and discharged from the department; (2) referred directly to the treatment nurse in the main department or sent directly to the X-ray department; or (3) referred for more detailed examination and assessment by the A&E officer.

RESULTS

Of 100 patients seen by the A&E consultant 34 were given advice or simple treatments and discharged immediately from the department. The average time in the department was less than 5 min. Twenty-two were referred directly to the treatment nurse in the main department without seeing the A&E officer. The average time in the department for this group was 41 min. Twenty-two were referred directly to the A&E officer and spent an average 1 h 9 min in the department. Twenty-two were sent to the X-ray department and then seen by the A&E officer and spent an average 1 h 19 min in the department.

The average time in the department was about 50 min for this group. A similar sample from the same shift the previous week spent an average of 1 h 8 min in the department.

There have been no complaints or comments from patients or GPs concerning the altered procedure.

DISCUSSION

Most A&E departments present their patients with a series of hurdles. They wait to see the triage nurse then wait to register. They wait to see the A&E officer then wait to have a radiograph. They wait again for the radiograph to be viewed then again to have their treatment.

This system may be required for some of the patients but not for all. This small study suggests that a significant number of patients could be diverted from the main flow of patients at various stages, most noticeably on arrival.

Even when this new strategy was imposed temporarily on the old procedure it produced a reduction in the time the patient spent in the department. If integrated more fully, even greater reductions could be achieved.

The system ensured the consultant knew about every patient in the minor side of the department and allowed him to direct the treatments of the A&E officer. It prevented him of course from being available for the major cases but in this department another consultant was already detailed to this task. In multi-consultant departments it may be helpful to use consultants or other experienced medical

staff in this way, particularly at busy times. A selective employment of this system is more cost effective and avoids the fall in concentration that may accompany prolonged exposure to apparently minor complaints. It may also be possible to use suitably trained and experienced nurses in this role. Although they are not able to give the advice of a consultant nurses may prove to be more effective than they are at present if allowed to act upon their triage decisions. Clinical nurse practitioners could further increase the effectiveness of a nurse in this role if the triage nurse could refer directly to them.

The patient's charter suggests all patients should be seen by a health care professional as soon as they arrive in an A&E department. For many, this could be the only one they see.

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