Canadian Emergency Department Triage and Acuity Scale (CTAS): Rural Implementation Statement

Society of Rural Physicians of Canada Emergency committee (SRPC-ER) Working Group*

BACKGROUND
The *Canadian Emergency Department Triage and Acuity Scale* (CTAS) has been recognized as a significant improvement in standardizing triage in Canadian emergency departments (EDs), both urban and rural. Since its publication an increasing number of Canadian EDs have implemented the CTAS. It was intended to improve patient care through more appropriate triaging of patients, but a number of adverse effects from its implementation have been encountered in rural EDs.

In many rural communities, family physicians or general practitioners (GP/FP) provide all care, emergency or otherwise. In general, these communities have a small number of physicians who spend many hours on-call, often providing care in the emergency department (ED), but also caring for hospital in-patients, doing obstetrical deliveries and visiting patients in nursing homes. Some of the same physicians also function as GP anesthetists, or GP surgeons in their communities. Night call is often provided from home.

Nursing staff in the rural ED is similarly not specialized. In many communities the same nurses provide care on the medical-surgical ward, obstetrical ward, recovery room and the intensive care unit.

While the volume of patients in the rural ED is generally lower than in the urban setting, the range of pathology is the same as that seen in tertiary care centres.

In 1999 the Society of Rural Physicians of Canada's Emergency committee (SRPC-ER) began discussions on the issues raised by the implementaion of the *Canadian Emergency Department Triage and Acuity Scale* (CTAS) in rural communities. By 2000, the CTAS became the major issue before the committee, and work began to develop a rural implementation process. A focus group was held at the SRPC annual meeting to delineate the issues faced in various rural communities using the CTAS.

Various rural physicians reported some combination of the following.

- Inappropriate categorization of patients.
- Delays in triage due to inadequate staffing of nurses.
- Delayed initial resuscitation (CPR, IV access, defibrillation) while waiting for physician arrival.
- Inappropriate triage of pediatric cases.
- Ambulance using a different triage scale resulting in an ED unprepared for seriously ill patients.
- No communication between ambulance and ED, resulting in unnecessary delays in care after arrival in hospital.
- Physicians not called to the ED until after patient arrival, resulting in unnecessary delays in patient care.
- No reference to obstetrical patients in the CTAS.

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Statement approved by the Society of Rural Physicians of Canada, the Canadian Association of Emergency Physicians, L'Association des médecins d'urgence du Québec, and the National Emergency Nurses Affiliation.

The English version of this Joint Statement has also been published in *Outlook*, the official publication of the National Emergency Nurses Affiliation (2002;25[2]:24-5) and in the *Canadian Journal of Rural Medicine* (2002;7[4]:271-4). La version française de cet énoncé est disponible sur le site www.caep.ca.

- Strict adherence to the time frames in the CTAS resulting in physicians being called in at night for non-urgent cases. This was increasing the already difficult on-call burden on physicians, with several expressing intent to leave. This posed a threat to access to emergency care in a number of communities and proved to be the most prevalent issue.

The SRPC-ER volunteer working group wrote a draft statement to address these issues, which was revised with input from another focus group of rural physicians at the SRPC conference in April 2001. Further revision based on input from Dr. Michael Murray, chair of the National CTAS Working Group, took place in the summer of 2001.

It was approved in principle by the National CTAS Working Group in April 2002 and further revision, with input from the Canadian Association of Emergency Physicians (CAEP), L'Association des médecins d'urgence du Québec (AMUQ) and the National Emergency Nurses Affiliation (NENA), took place from April to August 2002.

The statement was then approved by CAEP, AMUQ, NENA, and SRPC.

The Statement

Introduction

The *Canadian Emergency Department Triage and Acuity Scale* (CTAS) was developed by CAEP in 1998.[1] The objectives of CTAS were to "more accurately define patients' needs for timely care and to allow emergency departments to evaluate their acuity level, resource needs and performance against certain operating 'objectives.' "[1] The National CTAS Working Group believes that Canadians living in rural communities are entitled to the same level of emergency medical care as urban residents.

Since the publication of the document, many Canadian EDs, both urban and rural, have adopted its recommendations. Patient flow has been altered to allow patients to be seen by a triage nurse upon first entering the ED. Nursing staff have been trained in its application.

Triage by nursing staff, when applied as per the CTAS document, can be very helpful in sorting patients waiting for care.

Problems have arisen in sparsely staffed rural EDs when trying to implement this system. Some institutions have provided inadequate training to their nursing staff for proper implementation. Physician resources have been strained when trying to accommodate the time frames suggested in the document for non-urgent problems. This has led to friction between physicians and ED nursing staff, and increased job dissatisfaction among rural physicians, many of whom balance ED work with family practice, hospital in-patient care, obstetrical deliveries and more. In some communities, the demand for strict adherence to quick response times could result in a loss of medical services: physicians may leave town. The CTAS document states, "The time responses are ideals (objectives) not established care standards." However, hospital administrators in many rural communities have demanded physician response within the time frames indicated by the document, despite the lack of evidence to support any "time-to-physician" recommendations. Hopefully research will uncover such data.

In order to address these issues, the following recommendations are intended to assist in the implementation of the CTAS guidelines in rural health care facilities.

Recommendations

1. The CTAS definitions and descriptions of triage Levels I to V should be accepted by rural as well as urban EDs. See section 6 of the CTAS:[1] "Rural Emergency Health Care Facilities."

2a. Nursing staff should be trained in the use of the CTAS.

2b. Nursing staff should be involved in the implementation and monitoring of protocols and medical directives

2c. Rural hospitals must have adequate RN staffing to ensure timely triage for all patients.

3. ED nursing staff should be trained to provide initial resuscitation, including CPR, starting IVs and defibrillation and be familiar with ACLS standards. A pediatric assessment course such as ENPC is desirable.

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4a. Ambulance services and EDs should use a common triage scale to reduce the risk of misunderstandings leading to inadequate mobilization of personnel.
4b. Ambulance services should notify receiving hospitals of CTAS Level I and II patients as early as possible.
4c. ED staff should then notify on-call physicians promptly of all CTAS Levels I and II patients coming by ambulance, prior to their arrival in the ED.
5. On-call physicians should be accessible at all times (e.g., by phone, pager), both so they can be called in as required and so they can give direction to ED nurses prior to their arrival.
6. The time frames recommended by the CTAS are reasonable times to **physician-directed care** (in the absence of evidence). Physician-directed care could include the following.
   - Care provided directly by the physician in person.
   - Telephone advice.
   - Care provided by nursing staff in accordance with medical directives agreed to in advance by the physician. See the next section for more information.*
7. The CTAS makes no reference to obstetrics. Because of the wide variation in obstetrical preparedness between rural EDs, each institution may wish to prepare guidelines for such emergencies. There are very few examples of such protocols available to this committee; hospitals with such protocols are encouraged to submit them for publication on the SRPC Web site (www.srpc.ca).

Protocol for CTAS Level V

*The SRPC-ER committee has developed a protocol (medical directive) for CTAS Level V patients presenting to the ED. Implementing this medical directive should allow rural and remote EDs to continue to provide a high standard of care to their patients while reducing the number of unnecessary visits to the ED by rural physicians. This is not intended to be a vehicle to solve overcrowding in urban EDs (see Box 1).

CTAS Level V includes conditions that may be acute but non-urgent as well as conditions that may be part of a chronic problem with or without evidence of deterioration. The investigation or interventions for some of these illnesses or injuries could be delayed or referred to other areas of the hospital or health care system.

CTAS Level V patients may be triaged by the registered nurse to receive care at a more appropriate time or place if all of the following criteria are met [(a) to (e) inclusive] without contacting the on-call physician.

a) The patient is 6 months of age or older.
b) Vital signs are deemed satisfactory by the nurse, and temperature is 35°C– 38.5°C (38.3°C for age >60 years).
c) The patient is assessed as CTAS Level V.
d) After the nursing assessment, there is no clinical indication that the patient may require urgent physician attention.
e) In borderline cases, or where the nurse is unsure, telephone consultation between the nurse and physician has determined that the problem is non-urgent.

When a "non-urgent" patient meets all of the criteria specified above, the patient will be advised that they have been assessed using a set of approved guidelines to determine the urgency of need for medical care and that their problem has been assessed as non-urgent at this time.

The nurse may carry out nursing intervention if appropriate or advise the patient to seek health care services later from a family physician's office, walk-in clinic, make an appointment, or return when the physician will be present in the ED. Always advise the patient that if she or he has further problems or if the condition worsens, to call the hospital or return to the ED. The nurse may use "Patient Letter" (Appendix 1).

Facilities may develop standardized treatment protocols for nursing care and symptom relief. For examples, go to the SRPC Web site.

Documentation / reporting

Documentation should follow the same process as all other

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ED visits, and should include the CTAS level, nursing assessment, any nursing interventions and discharge instructions. These should be reviewed by the on-call physician early the next day, and any suggested changes should be initiated by the physician and communicated to the nurse involved. Follow-up by the physician would be documented on the same outpatient form.

Evaluation / monitoring / audit

Ongoing monitoring is essential to ensure that the directives are effective and safe. Keeping a log of the patients triaged to receive care at a later time or in another location, and of any changes in care initiated by the physician will allow hospitals to monitor the effectiveness of the protocol and institute any necessary changes to improve the process. Monitoring, audit, and ensuring the protocols are kept up-to-date is the joint responsibility of the physicians and hospital.

Responsibility for care

Care provided by nursing staff under a medical directive remains the responsibility of the on-call physician. It is the responsibility of the physicians providing on-call services to the community to ensure that protocols and medical directives constitute good medical care, and that they remain up-to-date. It is the responsibility of the hospital to ensure that nurses have adequate training to implement the medical directives, and to monitor that they are being followed.

Reference

1. Beveridge R, Clarke B, Janes L, Savage N, Thompson J, Dodd G, et al. Canadian Emergency Department Triage and Acuity Scale: implementation guidelines. CJEM 1999;1(3 suppl). Available: www.caep.ca/002.policies/002-02.ctas.htm (updated 2002 Oct 2; accessed 2002 Dec 6).

Key words: Canadian Emergency Department Triage and Acuity Scale, triage, rural and remote

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Box 1. Medical directives / Treatment protocols

An example of an acceptable medical directive for CTAS Level IV patients in rural and remote hospitals is under development.

A number of rural hospitals have already developed a variety of medical directives so that physician-directed care can be initiated by nursing staff prior to the arrival of the physician. These vary in their detail and in the range of problems addressed. In some rural communities it may be necessary to implement more detailed or less detailed protocols than the one in this document. Examples of these are available on the SRPC Web site (www.srpc.ca). They can be downloaded and modified to accommodate local circumstances.

Communities with functioning protocols are invited to submit them to the SRPC-ER committee so they can be shared with others. Over time it is expected that these will form a comprehensive repository of well thought out and produced medical directives from across the country, and perhaps beyond.

The CTAS is currently undergoing review. The SRPC is now represented on the National CTAS Working Group. Rural physicians are encouraged to send comments or suggestions for improvement to the SRPC representative on the National CTAS Working Group via the SRPC Web site.

Appendix 1. "Patient Letter"

Facility name
Mailing address
Phone number

Dear Patient:

The Emergency Department is intended for those patients who require medical attention on an emergent or urgent basis. You have been assessed by a nurse who uses a set of approved guidelines to determine the urgency of need for medical care. Your problem has been assessed as non-urgent at this time.

We recommend that you take the following action:

- Make an appointment to see your family doctor.
- Return to the hospital at _____ am/pm.

If you have any further problems, or if your condition worsens, please call the hospital or return to the Emergency Department.

Dr. XXXXXXXXXX
ED Medical Director

Dr. XXXXXXXXXXX
Emergency physician on call

_____ _____
Time Date

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