Differences in priorities assigned to patients by triage nurses and by consultant physicians in accident and emergency departments

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Abstract

Study Objectives—To investigate whether the greater urgency assigned to accident and emergency patients by triage nurses than by accident and emergency doctors was uniform across all patient groups.

Design—Patients attending an accident and emergency department between 8.00 am and 9.00 pm over a six week period were assessed prospectively for degree of urgency by triage nurses, and retrospectively for urgency by one of two consultant accident and emergency doctors. Patients were grouped according to their clinical mode of presentation.

Setting—An accident and emergency department of a district general hospital in the Midlands, UK, in 1990.

Patients—1213 patients who presented over six weeks.

Measurements and main results—As might be expected, patients’ conditions were assessed as being more urgent prospectively than retrospectively. This finding, however, was not uniform across all patient groups. Nurses’ assessments of urgency tended to favour children and patients who presented with eye complaints and gave less priority to medical cases, particularly those with cardiorespiratory symptoms.

Conclusions—These findings have implications for all those involved in the organisation of triage systems and in the training of nurses in accident and emergency departments. It is essential that judgements on how urgently patients need to be seen are made in a completely objective manner.

The triage process at our accident and emergency department

The triage process at our study site was normative in character, and the triage categorisation system is given below:

CATEGORY ONE
Severe illness or injury requiring immediate care to combat danger to life or limb, and where a delay would result in deterioration.

CATEGORY TWO
Illness or injury requiring treatment within 60 minutes, but where the delay poses no threat to life or limb. The patient is not in severe pain, and poses no threat to self or others.

CATEGORY THREE
Injury or illness requiring treatment within 60–120 minutes, but where the delay poses no threat to life or limb. There is no threat of permanent disability or illness.

CATEGORY FOUR
Where a delay of 24 hours would make no appreciable difference to the clinical condition, and where subsequent referral may be made to the appropriate alternative specialty.

Our study department, like most others, was divided into different areas which performed different functions. The basic division was into major and minor areas. The major area served patients who had suffered major accidents, patients who required resuscitation, patients whose condition was likely to deteriorate and who required observation, and patients who needed to lie down while waiting, for example, those with back injuries. Patients in triage category one were routed automatically to this area. The minor area...
was divided into several cubicles for the treatment of minor injuries, and also contained specialist paediatric and ophthalmic treatment areas. All patients with eye injuries were routed to the ophthalmic area, regardless of urgency.

Method
The population described in this paper forms a subset of that described in our earlier work. All patients attending an accident and emergency department between 8.00 am and 9.00 pm over a six week period were recruited into the study except those who attended either by appointment (for example, to fracture clinics) or by prior arrangement for admission as inpatients. We have reported previously that only 1213 of 2515 patients who attended during periods when triage was supposed to be operating actually received an assessment decision from a triage nurse. That group forms the subject of this paper.

In addition to the triage nurse assessment, the degree of urgency of each patient was assessed retrospectively from the clinical record by either one of two consultant accident and emergency doctors, using the same criteria as those used by the triage nurses. A table comparing the assignments to priority groups performed prospectively by the nurses and retrospectively by doctors was constructed, and the degree of chance corrected agreement between the two assessments was estimated using Cohen's Kappa. This table can be simplified by grouping cases according to whether they were assessed as being of equal urgency (the central area of agreement) as being more urgent by the nurse than by the doctor (the top right "wing") or as being more urgent by the doctor than the nurse (the bottom left "wing"). Further analysis was undertaken using this simplified grouping.

An analysis was performed of the proportion of patients aged 15 years and under in each wing, and in the central area of agreement, and differences between the proportions were tested using a $\chi^2$ test.

Table I: Distribution by urgency of 1213 patients assessed both prospectively by a triage nurse and retrospectively by an accident and emergency clinician

<table>
<thead>
<tr>
<th>Treatment category</th>
<th>Retrospective priority group assigned by either of two clinicians</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 (Most urgent)</td>
<td>2</td>
</tr>
<tr>
<td>1 (Most urgent)</td>
<td>11</td>
<td>46</td>
</tr>
<tr>
<td>2</td>
<td>12</td>
<td>186</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>73</td>
</tr>
<tr>
<td>4 (Least urgent)</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
<td>309</td>
</tr>
</tbody>
</table>

Kappa=0.18
95% CI=0.12, 0.24
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A list of 30 modes of presentation was constructed using records from a pilot population, and all 1213 cases were assigned to one of these presentation modes using the information on the clinical record card and the triage record. In order to make larger groups for analysis, and to allow for overlap between modes of presentation (for example, suspected fracture/dislocation distal limb and sprain/soft tissue injury), 27 of these modes were combined into three categories, containing orthopaedic, surgical, and medical cases.

Initially, an attempt was made to categorise patients according to other criteria in addition to the presenting complaint, including social factors pertaining to attendance and pain score. The collection of data on these items during the pilot study, however, was so poor as to preclude their further use.

For each of the presentation modes and the larger groups, the proportions of cases in the two "wings" of each table were compared using a $\chi^2$ test with Yates's correction, or a two tailed Fisher's exact test where the expected frequency in any cell fell to less than five. This gives a measure of whether spread into the two wings from the central area of agreement is even, or is more in one direction than the other. To allow for simultaneous inference, significance was tested at a level of 0.017, a level set using a Bonferroni approach.

Results
Table I compares the overall assignment to priority groups as performed prospectively by the triage nurses and retrospectively by the two doctors. There was poor agreement between the two assessments (Cohen's Kappa=0.18: 95% confidence interval (CI)=0.12, 0.24) and it is clear that the nurses tended to give patients more urgent status than did the doctors, although the doctors obviously had the benefit of hindsight.

Nurses tended to give higher priority to younger patients. This is shown in table II by the large number of children aged 15 or under in the group who were assessed as more urgent by the nurse than the doctor.

Table II: Proportion of patients aged less than 15 in three categories of agreement

<table>
<thead>
<tr>
<th>Age 15 or under</th>
<th>Doctor&gt; nurse</th>
<th>Agree</th>
<th>Nurse&gt; doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 15</td>
<td>21 (46%)</td>
<td>135</td>
<td>126</td>
</tr>
<tr>
<td>Age&gt;15</td>
<td>123 (85%)</td>
<td>460</td>
<td>349</td>
</tr>
<tr>
<td>Total</td>
<td>144</td>
<td>595</td>
<td>474</td>
</tr>
</tbody>
</table>

$\chi^2$ (2 degrees of freedom)=9.12: significance of difference p=0.014

Table III shows the list of presenting conditions and the number of cases assigned to each. The orthopaedic group was the largest, comprising 615 of the 1213 patients in the study, and the medical group was the smallest, with only 97 patients. Fourteen patients presented with a variety of psychiatric or social problems or reasons for attendance that could not be classified. The relative scarcity of intoxicated persons on this list can be explained by the classification being in terms of the presenting complaint, so that some of those with other presenting conditions might also have been intoxicated, and by the fact that the...
study period was between 8.00 am and 9.00 pm, and did not include late evening periods. Table III also shows that for orthopaedics the proportion of patients assigned to the nurse>doctor wing (216:258) was not significantly different from that assigned to the doctor>nurse wing (60:84, \( \chi^2 = 0.53 \) p = 0.47). Similarly, the proportions of patients assigned to the two wings of the surgical table did not differ significantly (\( \chi^2 = 1.86 \), p = 0.17). In the case of the medical table, however, the proportions of patients assigned to the doctor> nurse wing (23:121) was significantly more than that assigned to the nurse>doctor wing (25:232, \( \chi^2 = 19.36 \) p = 0.0001). This indicates that a significant number of medical patients attending the accident and emergency department were assessed as being more urgent by doctors, working retrospectively, than by nurses, prospectively.

There is also variation within each of the three categories. For those attending with eye complaints, the proportion of patients assigned to the nurse>doctor wing (77:397) was significantly greater than that assigned to the doctor>nurse wing (5:139, \( \chi^2 = 14.57 \) p = 0.0001). Eye patients, therefore, were seen as being more urgent at presentation by nurses than by doctors retrospectively, and this tendency was significantly greater than could be accounted for by hindsight alone. Within the overall medical category, those with cardiorespiratory symptoms were likely to be seen as less urgent by nurses (6:138) than by doctors (1:473, p=0.0011).

### Discussion

The reason for differences between nurses’ and doctors’ assessments of urgency in this study are twofold. Firstly is the difference due to the timing of the assessment: the fact that doctors seem less urgent in retrospect than at the time of presentation is hardly surprising. An example might be an elderly lady who has fallen heavily and has pain in the thigh upon trying to stand. The confirmation on x-ray that there is no fracture of the femur changes entirely the degree of urgency. Secondly there is also likely to be a difference because of the different professional perspectives of doctors and nurses. Other studies have found that nurses still assign higher degrees of urgency to patients than do doctors, even when both groups of assessors work prospectively.

A striking feature of our study is that the tendency of the nurses to give higher priorities was not uniform across all diagnostic groups. Why is this? Most of those who have worked in accident and emergency departments will appreciate the reasons for giving priority to children. They are often anxious and distressed by their illness or injury, and equally often are accompanied by parents who are at least as anxious and distressed, and usually more so. Whether the more urgent attention given is to the benefit of patients, parents, or staff, however, is a matter of debate.

It seems in this study that triage nurses awarded too little urgency to medical cases, in particular those with cardiorespiratory symptoms, and too much to ophthalmic cases. The latter finding is easily explained as, at the time of the study, the triage protocol emphasised giving priority to eye cases. This proved to be wrong when implemented as a strict rule and has since been changed. Each case is now assessed on its merits giving regard to aetiology, timing, subjective pain, and the age of the patient.

The former finding is more worrying. The lack of recognition of the urgency of medical cases is potentially serious. It may stem from the relative frequency of different modes of presentation and the ease with which they can be assessed. Orthopaedic cases formed over half of this study population, and many of these cases were traumatic in origin. Orthopaedic cases are the "bread and butter" of a nurse with experience in an accident and emergency department. Many of the surgical cases, likewise, were traumatic, and many nurses have experience not only of diagnosing but of treating these patients.

On the other hand, medical cases formed a small minority of the total. They are difficult to assess quickly by either medical or nursing staff. Although there are recognised methods of assessing trauma cases based on easily recorded physiological data (for example, TRISS—pulse, respiratory rate, coma score), most medical cases are complicated and used for inpatients (for example, APACHE). After this study, departmental protocols at the accident and emergency department were changed to make the assessment more objective, and extra training was introduced for nursing staff in the assessment of medical cases. Assessments are now based on physiological parameters, coupled with a high awareness of the possible speed of deterioration of such cases.

### Conclusion

This study has implications for those who operate triage systems, or who intend to do so. It is for
those who devise the systems, and the protocols that go with them, to decide whether the favouring of certain groups confers an overall benefit across all groups. Indeed, should the one individual patient benefit to the detriment of many others?

It is essential that triage nurses are completely objective in their assessments of urgency, even if this runs contrary to the raison d'etre of their profession. A screaming child may seem urgent, but is it really more urgent than the pale, clammy middle-aged man clutching his left arm? Triage is an extended nursing role and requires correct training in assessment and awareness of possible covert problems. The system requires repeated audit and retraining to achieve benefit, both to the patient and the accident and emergency department.

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