
Triage and follow-up in emergency departments

EDITORIAL

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Both individual procedures and the totality of care ensure a safe clinical pathway

The emergency patient's encounter with the hospital starts in the emergency department. The public's notions of medical benefit place a key value on rapid admission and medically correct reception in case of acute illness or injury. This implies adequate diagnostics, correct assessment of overall risk, necessary monitoring in the emergency department and a justifiable time schedule for examination and treatment. The organisational structure of the health services and the capacity and skills of the health personnel must not be such as to delay or detract from the clinical pathway at the pre-hospital stage, through the emergency department and other departments.

How should the hospital organise the work of its emergency department? How can we succeed in making the combined efforts of doctors, nurses, bioengineers and radiographers appear appropriate to the patients and their next of kin, and function effectively in a medical sense? In this issue of our journal, Stine Engebretsen and collaborators describe the use of initial triage (assessment of level of urgency) in Norwegian emergency departments ([1](#)). With the aid of questionnaires and interviews, the authors have studied how triage is organised and defined. The objective of the study was to identify the organisation of triage and the use of triage scales for surgical and medical patients. Altogether 45 of 56 Norwegian emergency hospitals responded, and all of them reported that emergency patients underwent an assessment of their level of

urgency. 76 % reported to use a triage scale. In most emergency departments, triage was assigned to nurses. Triage was used while waiting for the doctor's attention. This study of triage does not include treatment quality and clinical pathways.

In practice, all parts of the health services (at the pre-hospital as well as the hospital stage) perform triage of emergency patients. Triage in the emergency department is one of many factors that have an impact on safe clinical pathways. Other factors include clinical skills among paramedics, doctors and nurses, the focus that each clinical department places on its emergency patients, the organisation of the hospital, the ability of the health personnel to communicate among themselves, the availability of diagnostic imaging and laboratory services, whether the patient has been brought to the correct department, and the correct level of treatment. How do we measure the quality of the treatment provided in the emergency department? Appropriate treatment within an individually appropriate time frame must be ranked first. The sense of being provided with good care which is felt by the patient and next of kin is important. Appropriate performance of each individual procedure is essential for safety and quality.

Justifiable treatment consists of much more than just the sum of correct individual procedures. The clinical pathway through the emergency department must be seen in the context of the rest of the pathway. The particularist approach is insufficient. The length of stay in the emergency department depends on the examinations and procedures that are normally performed there in the hospital in question. A brief stay in the emergency department is critical for certain categories of patients. For some patients, preliminary observation in the emergency department may be safer than being moved as quickly as possible to a thinly staffed hospital ward. Facilitating appropriate clinical pathways is a management responsibility. In the context of the planned reorganisation of the hospitals in Oslo, the County Governor of Oslo and Akershus called for an analysis of clinical pathways [\(2\)](#).

Several groups of patients with a high level of urgency are encompassed by established team functions including a doctor, a nurse and others upon arrival at the emergency department. The guidelines for reception of multi-trauma patients represent a defined triage system [\(3\)](#). The guidelines for cardiac arrest and other acute coronary diseases presuppose the immediate presence of a doctor [\(4\)](#). The same applies to established standards for reception of patients with acute diseases of the aorta. In these situations, the distribution of roles and functions within the team is of key importance. Effective work performed by the emergency department will only have an impact if the next stages of the clinical pathway follow up on it. A relevant question is whether the clinical pathway can be deemed to be geographically/physically appropriate. Experience gained by Oslo University Hospital Ullevål with regard to the change of pathway for stroke patients, to the effect that emergency patients who will be given interventional treatment must be moved from Ullevål to Rikshospitalet (another journey by ambulance) under time constraints, illustrates the necessity of including geographical/physical aspects in a risk analysis [\(5\)](#). If the form of organisation results in waiting times and uncertain progress, the beneficial effect of the strongest links in the clinical pathway will be weakened.

Information provided by the referring doctor and the ambulance personnel serves as the basis for the work in the emergency department. In case of an emergency admission, the doctor who is on duty in the relevant clinical department will most often have

received advance notification. The workload and availability of the on-duty doctor will be of significance. Rapid medical attention in the emergency department will make a significant contribution. The competence of the on-duty doctor in his or her own speciality and in general clinical scope will in some cases be critical for progress and quality. Increased participation in the emergency department by an experienced senior consultant has an impact on clinical quality and training. In its report from an inspection of the emergency departments in 2007, the Norwegian Board of Health Supervision indicated that in order to ensure medical justifiability it was necessary to regard the activities of the emergency department in their totality (6).

Section 2-2 of the Specialised Health Services Act on the duty of justifiability stipulates that the individual patient be provided with comprehensive and coordinated services (7). The patient should receive treatment which is satisfactory with regard to each method and intervention in particular as well as medically and humanely satisfactory in general. In our analyses of functions and opportunities for improvement, the individual is our unit of analysis. Procedures and forms of organisation pass the test when they ensure a justifiable individual clinical pathway.

LITERATURE

1. Engebretsen S, Røise O, Ribu L. Bruk av triage i norske akuttmottak. Tidsskr Nor Legeforen 2013; 133: 285 – 9.
2. Helsetilsynet i Oslo og Akershus. Omstillingsprogrammet – Helse Sør-Øst – høring. Brev til Helse Sør-Øst 14.10. 2008.
3. Gaarder C, red. Traumemanual. Oslo: Oslo universitetssykehus, Ullevål, 2011.
4. Bendz B, Sunde K, Otterstad JE et al. Revidert veileder for hjertestans-behandling i Helse Sør-Øst. Oslo: Oslo universitetssykehus, 2012.
5. Akutt hjerneslag: internoverføring fra Ullevål til Rikshospitalet ved vurdering av intraarteriell intervensjonsbehandling. Ehåndbok, dokument-ID: 3664. Godkjent 1.3.2011. Oslo: Oslo universitetssykehus, 2011.
6. Mens vi venter... – forsvarlig pasientbehandling i akuttmottakene? Oppsummering av landsomfattende tilsyn i 2007 med forsvarlighet og kvalitet i akuttmottak i somatisk spesialisthelsetjeneste. Rapport 2/2008. Oslo: Helsetilsynet, 2008.
7. Lov om spesialisthelsetjenesten med kommentarer. IS-7/2010. Oslo: Helsedirektoratet, 2010.