

For Immediate Release

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Carleton Place & District Memorial Hospital Foundation
Carleton Place, ON

The Importance of Triage



Andrea Monette, RN at CPDMH, performing the triage assessment with patient Jane McLaughlin.

Any patient that has visited the emergency department of the Carleton Place & District Memorial Hospital (CPDMH) has been ‘triaged’. Triage is a brief clinical assessment, performed by a registered nurse that determines the time and sequence in which patients should be seen by the physician in an emergency. The assessment involves a brief physical evaluation of the patient which includes a history of the illness and /or injury and a measurement of vital signs. With over 21,600 visits to the CPDMH’s emergency department in 2005/06, triage is essential to ensure prompt identification of patients with high-risk conditions as well as the efficient operation of the emergency department.

“Triage has been put in place to ensure that patients are treated in order of their clinical urgency and that treatment is received in a timely manner”, stated Mona Williams, Nurse Manager of the Emergency Department. “I know it can be frustrating to wait to see a physician when a patient is sick, however, the waiting may be because the ambulance has arrived with a patient who has a life threatening condition, needing immediate treatment.”

The goal of triage is to see all patients within 10 minutes of arrival in order to:

- ❑ rapidly identify patients with urgent, life-threatening conditions;
- ❑ help determine the most appropriate treatment for patients;
- ❑ provide ongoing assessment of patients; and
- ❑ provide information to patients and families regarding services, expected care and waiting times;

Through the assessment process the patient is assigned acuity rating based on a 5 level triage scale called the Canadian Triage and Acuity Scale (CTAS). The following is a brief explanation of the five levels of the CTAS:

1. **Resuscitation** refers to conditions that are a threat to life or limb (or imminent risk of deterioration) requiring immediate aggressive interventions and may include illnesses such as cardiac arrest, trauma, shock, respiratory distress, or seizures. These patients are always seen immediately by the nurse and physician
2. **Emergent** refers to conditions that are a potential threat to life, limb, or function, requiring rapid intervention or delegated acts and includes illnesses such as chest pain, allergic reaction, overdose, and psychotic episodes
3. **Urgent** refers to conditions that could potentially progress to a serious problem requiring emergency intervention. May be associated with significant discomfort or affecting ability to function at work or activities of daily living.
4. **Less Urgent** are conditions related to patient age, distress, or potential for deterioration or complications that would benefit from intervention or reassurance within 1 to 2 hours.
5. **Non-Urgent** are conditions that may be acute but non-urgent, as well as conditions which 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 even referred to other areas of the hospital or health care system.

“We want to provide the best possible care to the community, however sometimes there are events that are beyond our control preventing us from treating a patient as soon as we would like”, continued Ms. Williams. “Through the triage system the triage nurse will continue to monitor all patients waiting for care to ensure that their condition does not deteriorate and that care is provided as soon as possible.”

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