SATH Children's Assessment Unit Improvement Programme

Workstream 3 – Triage Process & PGD's

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REASON WHY?

Patients not been triaged in timely manner.
Children presenting to an emergency setting should have a clinical assessment undertaken within 15 minutes of their arrival to determine their priority.
Nurses not following a set criteria for triaging , so unable to carry out accurate audit of the process
Triage is a system used to identify how urgently a patient needs to be see, highlighting those who are safe to wait and prioritise those who are seriously ill and needing urgent attention.

SMART AIM

S SPECIFIC M MEASUREABLE A ACHIEVABLE R RELEVANT T TIME-BOUND AIM

To facilitate a core group of Registered children's nurses who work in the Children's Assessment Unit (CAU) to become competent in conducting a Triage on all paediatric patients referred to the unit using the Manchester Triage system.

PLAN

To ensure an effective and timely triage is conducted for all paediatric patients in the Children's assessment unit

It was planned to provide an inhouse teaching package using the Manchester Triage System (MTS)

MTS is one of the most commonly used triage systems in Europe and is beneficial in enabling nurses to prioritise children based on clinical need, without making any assumptions as to what the diagnosis maybe.

In order to provide the in-house training, 3 senior members of staff were sent on a 'Train the trainer course'

It was intended to train all of the band 6's within a 6 month to 1 year period

Manchester Triage System

DO

3 Qualified nurses attended the Manchester Triage Training Instructor course (1 ACP, 1 PEF & 1 Sister) This allowed for the team to provide in house training

The nurses were enrolled with MTS and they completed the online pre course learning package, followed by attending a half day face to face session which was delivered by the inhouse instructors

Following the completion of 10 observed triages by the instructors, with appropriate feedback, the nurses were entered into the MTS data base as competent to practice

Observation and signing of staff proved difficult , due to staff allocations, CAU acuity, staff engagement and limited sign off instructors

STUDY

MTS requires the nurses to choose a flow chart based on the main symptom, they then carry out observations and ask questions. By using reductionist methodology, they stop at the highest priority discriminator - indicating the level of priority of in which a patient needs to be seen by a Doctor or ACP or receive an intervention
Priority is graded as:
Red – immediate review, orange – 10 minutes, yellow – 1 hour, green – 2 hours & blue – 4 hours

Initially some nurses reported that although the new system was clear to follow, they felt that they were not obtaining enough information, as they had been previously been taking a history asking questions to lead to diagnosis.
Feedback once embedded, and following support from the instructors has been positive.

There are now enough staff members trained in MTS to cover a 24-hour shift in CAU
The department currently has:
5 instructors
20 staff trained who are signed off
7 staff trained who are not yet signed off
5 staff booked to attend training

> * MTS is easy to follow
> * It improves patient safety as children are seen with in the correct time frame
> Amber Sorsby, Staff Nurse

> MTS has improved triage
> * The assessment is more factual and accurate
> *Patient safety is prioritised
> * It identifies patients whose clinical condition requires prompt treatment
> Kate Landers. Sister

ACT

Adopt – We plan to keep the MTS in CAU – enabling patients been seen in a timely manner and triaged appropriately to ensure their safety whilst in the unit.

In order for MTS trained staff to remain competent to practice triage, they need to carry our 10 audits per year, which need to be observed by the instructors and added to the MTS data base.

ACKNOWLEDGEMENTS & REFERENCES

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