

Improved emergency department patient care via rapid assessment and triage

The value of early senior clinician involvement for patients in the emergency department is well established. Ardagh and colleagues in New Zealand demonstrated benefit from rapid assessment and triage as early as 2002. Since then, numerous studies have shown improvement across a range of emergency department metrics, including length of stay, the number of patients who leave without being seen, the numbers who leave before treatment is complete and waiting time. Most recently Abdulwahid and colleagues (2016) published a systematic review and meta-analysis supportive of the process, although they added a note of caution in the absence of robust cost–benefit analysis. Little is reported, however, on the potential for influencing patient ‘care’.

The process for rapid assessment and triage in the emergency department at the Royal Devon & Exeter Hospital is well established. The process is led by a senior clinician (duty consultant or middle grade) and includes a nurse and rapid assessment and triage assistant (foundation year 1 doctor, medical student or Band 3/4 nurse). The four elements of the rapid assessment and triage are followed:

1. The ‘meet and greet’: patients are given a warm welcome by the senior clinician soon (within 10 minutes for the large majority) after arrival. The ‘my name is...’ approach is used and the patient’s preferred name is sought. The dedicated rapid assessment and triage room has a sign reiterating the welcome. There are clear posters highlighting the identities of

various staff groups by uniform colour. Patients are offered water unless there is a clear clinical reason not to.

2. The multidisciplinary handover: a ‘team’ handover from the paramedic or ambulance technicians to the emergency department staff, with contributions positively encouraged from the patient and any relatives and/or carers. This enables a clear understanding of the events surrounding the presenting problem.
3. Rapid assessment and triage-directed investigations and management: the opportunity for the rapid assessment and triage team to organize investigations and formulate a strategy leading to patient disposal. The temptation to order tests in a scatter-gun approach is avoided; rather, tests necessary to positively support the clinical decision-making process are expedited. Some patients need no investigation. Analgesia or other therapy, including prompt antibiotics and fluid, may be prescribed and dispensed. Patients suitable for direct referral to specialty teams are processed accordingly, e.g. those with psychiatric symptoms without deliberate self-harm, and those who have been operated on within the last 72 hours.
4. Forecasting: the rapid assessment and triage concludes with the senior clinician sharing his/her view on likely disposal with the patient. He or she is told the next steps, a diagnosis or differential where possible and appropriate, and the likelihood of admission or discharge.

Rapid assessment and triage replaces the traditional approach to ambulance triage: a handover from crew to senior ‘majors’ nurse, in a corridor, with no clinician input. The efficiency benefits in terms of patient and departmental flow resulting from the multidisciplinary handover and investigation and management (rapid assessment and triage elements 2 and 3) are evident. The authors argue that patients derive further benefit, particularly from a care perspective, from the meet and greet and forecast (elements 1 and 4). Feedback derived from the NHS friends

KEY POINTS

- Rapid assessment and triage by a senior emergency physician is recognized as enhancing patient processing.
- It has four elements: the meet and greet, the multidisciplinary handover, investigation and management, and forecasting.
- Patient care is particularly improved by the meet and greet and forecasting.
- Rapid assessment and triage is consistent with the key message of both the Francis and Berwick reports: putting the quality of patients’ care first.

and family test and from care rounds (Lloyd, 2016) regarding the smiling welcome of the meet and greet is unsurprisingly positive. So too the early forecast.

Both the Francis (2013) report and Berwick (2013) report challenge health-care staff to put the quality of patients’ care first. Rapid assessment and triaging delivers this and the authors encourage its widespread adoption. **BJHM**

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Dr Adam D Reuben, Emergency Physician, Emergency Department, Royal Devon and Exeter NHS Foundation Trust, Royal Devon & Exeter Hospital, Exeter

Dr Gavin Lloyd, Emergency Physician, Emergency Department, Royal Devon and Exeter NHS Foundation Trust, Royal Devon & Exeter Hospital, Exeter EX2 5DW

Correspondence to: Dr G Lloyd (gavin.lloyd@nhs.net)