Australasian College for Emergency Medicine
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POLICY ON
THE AUSTRALASIAN TRIAGE SCALE

1. INTRODUCTION

The Australasian Triage Scale (ATS) is designed for use in hospital-based emergency services throughout Australia and New Zealand. It is a scale for rating clinical urgency. Although primarily a clinical tool for ensuring that patients are seen in a timely manner, commensurate with their clinical urgency, the ATS is also a useful casemix measure. The scale directly relates triage code with a range of outcome measures (inpatient length of stay, ICU admission, mortality rate) and resource consumption (staff time, cost). It provides an opportunity for analysis of a number of performance parameters in the Emergency Department (casemix, operational efficiency, utilisation review, outcome effectiveness and cost).

2. PRACTICALITY AND REPRODUCIBILITY

As the ATS is a primarily clinical tool, the practicalities of patient flow must be balanced with attempts to maximise inter-rater reproducibility. It is recognised that no casemix measure reaches perfect reproducibility. Reproducibility within and between emergency departments can be maximised by application of the Guidelines for Implementation and widespread use of the training package.

Triage accuracy and system evaluation can be assessed by comparison against guidelines. Patterns of triage category distribution, ICU admission and mortality by triage category should be comparable between peer hospitals of similar role delineation. Admission rate by triage category is also a useful comparison between peer hospitals for the higher urgency categories. These benchmarks for Emergency Departments of different role delineation should be reviewed from time to time as disposition practices change.

Standards of consistency should also be regularly checked with studies of inter-rater reliability. An acceptable standard of inter-rater agreement is represented by a weighted Kappa Statistic of at least 0.6.

3. APPLICATION

3.1 Procedure

All patients presenting to an Emergency Department should be triaged on arrival by a specifically trained and experienced registered nurse. The triage assessment and ATS code allocated must be recorded. The triage nurse should ensure continuous reassessment of patients who remain waiting, and, if the clinical features change, re-triage the patient accordingly. The triage nurse may also initiate appropriate investigations or initial management according to organisational guidelines.

The triage nurse applies an ATS category in response to the question: *"This patient should wait for medical assessment and treatment no longer than…."*

3.2 Environmental and Equipment Requirements

The triage area must be immediately accessible and clearly sign-posted. Its size and design must allow for patient examination, privacy and visual access to the entrance and waiting areas, as well as for staff security.

The area should be equipped with emergency equipment, facilities for standard precautions (hand-washing facilities, gloves), security measures (duress alarms or ready access to security assistance), adequate communications devices (telephone and/or intercom etc) and facilities for recording triage information.

4. DESCRIPTION OF SCALE

ATS CATEGORY	TREATMENT ACUITY (Maximum waiting time)	PERFORMANCE INDICATOR THRESHOLD
ATS 1	Immediate	100%
ATS 2	10 minutes	80%
ATS 3	30 minutes	75%
ATS 4	60 minutes	70%
ATS 5	120 minutes	70%

5. PERFORMANCE INDICATOR THRESHOLDS

The indicator threshold represents the percentage of patients assigned Triage Code 1 through to 5 who commence medical assessment and treatment within the relevant waiting time from their time of arrival. Staff and other resources should be deployed so that thresholds are achieved progressively from ATS Categories 1 through to 5. The performance indicator thresholds shown are appropriate for the period 1998 – 2002 inclusive[1], and should be achievable in all Emergency Departments. Performance indicator thresholds must be kept under regular review.

Where Emergency Department resources are chronically restricted, or during periods of transient patient overload, staff should be deployed so that performance is maintained in the more urgent categories.

It is neither clinically nor ethically acceptable to routinely expect any patient or group of patients to wait longer than two (2) hours for medical attention. Prolonged waiting times for undifferentiated patients presenting for emergency care is viewed as a failure of both access and quality.

6. QUALITY ASSURANCE

Triage accuracy and system evaluation may be undertaken in part by reviewing the triage allocation against guidelines, triage category “footprint” of example diagnoses, average waiting time, admission rates and mortality rates in each triage category with peer hospitals. As practices such as disposition change over time, these benchmarks should be periodically reviewed.

7. REFERENCE

Commonwealth Department of Health and Family Services, Coopers and Lybrand Consultants. Development of Agreed Set of National Access Performance Indicators for: Elective Surgery, Emergency Departments and Outpatient Services. Canberra, July 1997, p106.

P06 Reviewed March 2006 (no changes made)
Revised November 2000
Adopted by Council November 1993