EDITORIAL

# Triage in accident and emergency departments and possible outlets for patients with less-than-urgent medical problems

Triage was originally a French term, which means separate, sift, select, or sort.[1] In Medicine, triage describes the process of determining priority of patient's treatment based on severity of their condition (Wikipedia definition). Yet to be more accurate, the word urgency should replace severity. It is true that many severe conditions require urgent care like acute myocardial infarction, stroke, etc. However, not all conditions with a severe/sinister outlook are urgent, for example, uncomplicated cancer of colon. Similarly not all conditions warranting urgent attention are severe in terms of prognosis if managed timely, for example, angioneurotic oedema of the upper airway. Triage is needed when resources are insufficient for all to be treated immediately.[2] In military, disasters, and certain other special circumstances like cold-water drowning, reverse triage may be employed to conserve resources for those likely to survive, through treating the less wounded/affected in preference to those in more dire states.[3] In daily civilian circumstances such as in accident and emergency (A&E) departments, standard triage principles, like the Canadian Triage and Acuity Scale,[4] are followed for life-threatening or limb-threatening conditions and are consequently allocated higher priority.

In Hong Kong, public hospitals under the Hospital Authority commenced employing triage systems in early 1990s. These were to replace the previous first-come-first-serve practice by prioritising patient care, with an experienced nursing officer on patrol to pick up apparently sicker patients in the queue. A common triage guideline is employed by all the 16 A&E departments of the Hospital Authority. The last version was updated in 2012.[5] Experienced nurses with mandatory classroom learning, on-site supervision/monitoring, and regular audit are deployed at the triage station to classify incoming patients into five categories through vital sign measurements and concise history taking. Triage category I is critical, II emergent, III urgent, IV semi-urgent, and V non-urgent. In most hospitals, triage categories I and II constitute approximately 5% of all A&E attendances. For triage category III, the percentage varies from 20 to 45%, while in categories IV and V it varies from 50 to 75%. The assigned triage category determines the place of management as well as waiting time. Categories I and II patients are usually managed quickly in a resuscitation room, respective waiting times being around 0 and within 15 minutes (95% achievable). For category III patients, in some hospitals the performance pledge of 90% for being seen within 30 minutes is increasingly non-achievable. This is due to the increasing disease complexity of elderly patients and more assessments being employed to risk stratify patients for hospitalisation or ambulatory care. Yearly triage audit reveals that all A&E departments can achieve 95% or more appropriate triage allocation. Notably, the authors of the article 'Validation of the Hong Kong Accident and Emergency Triage Guidelines' in the current issue found a substantial inter-rater reliability and validity.[6]

Utilisation patterns of A&E services by citizens vary widely worldwide. Influential factors include the financing and structure of health care, the geographical distribution of facilities, and their perceived standards, as well as access and availability of alternatives. Circumstances leading to inappropriate use of A&E services vary depending on the time of the day, specific days of the week, or during special festivals. Anxious parents bringing a febrile but apparently well child to the A&E department during the daytime when most general practitioners are available, is considered inappropriate. However, parents should not be blamed if the same scenario occurred at 3 am in the morning, when alternatives are scarce. After hours, alternatives do exist at the 24-hour clinics of all private hospitals and some general practitioner clinics, where citizens are able to afford such services and conscientious enough, can choose to attend. The A&E departments of public hospitals continue to be the safety net for Hong Kong residents.

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