Triage protocol for non-clinical staff

Advice correct as of July 2014

Practices should have sound triage policies and protocols in place to help non-clinical staff to deal with emergency situations. Training staff in how to follow them will assist in safeguarding against criticism should a patient come to harm because of a delay in seeing a doctor, receiving advice or being directed to emergency treatment.

As a matter of good risk management, appointment systems would benefit from some method of identifying patients who should be seen urgently or referred to the Emergency Department. One way of doing this is to equip your receptionists with training and simple guidance so that they can carry out rudimentary triage of requests received.

Effective triage is an integral part of general practice and is better based on clinical need rather than catering to the most persuasive or demanding patients. This requires the adoption and dissemination of written guidelines for staff to ensure that patients seeking appointments are appropriately clinically prioritised – and providing appropriate training and support tools for all front-office staff. It also requires ongoing audit of requests for appointments (and home visits) and how they were managed.

General practices need to make provision for both urgent and routine appointments, as well as appropriately managing emergencies. An effective triage system could help direct patients to the most appropriate appointment slot at the most appropriate time, and identify patients who have an immediate medical need, and are thus at greater risk.

What is a triage protocol?

When a patient calls up for an appointment there are three broad areas they fall into (assuming that they do need an appointment):

1. Emergency – immediate need: they need to be directed to the Emergency Department or an ambulance should be called
2. Urgent – need to be seen that day
3. Routine – need an appointment, but not same day.

Practices require a process to follow when all the appointments for the morning/afternoon times are gone, but a patient needs an urgent appointment (eg, slotted in as an extra, the call is put through to a GP/nurse). Obviously if a case is sufficiently urgent to require an ambulance transfer to the ED, it would be inappropriate to offer an urgent appointment.

What non-clinical staff should ask the patient

The objective is to provide the GP with the correct information. The staff member should:

- Start by finding out the patient’s name, address and date of birth
- Ask what the problem is. If the patient does not want to divulge this, the staff member should explain that they need a very brief explanation of the problem to make a decision as to whether to interrupt the doctor or not.
- Establish how long the patient has had the symptoms, their severity and whether the patient has any previous major health problems.

When to interrupt the doctor

There are particular symptoms to look out for depending on the type of patient.

Very worried adult, experiencing:

- Chest pain
- Difficulty breathing
- Abdominal pain
- Fitting
- Altered consciousness
- Psychology distress
- Severe allergy

Very worried parent, unwell child and persistent:

- Diarrhoea
Vomiting
Fever
Lethargy
New rash

Very worried pregnant woman with:
- Pain/bleeding/reduced movement
- Ruptured membranes

In these cases always err on the side of caution – if in doubt, ask the GP.

Concern checklist
- Does your practice have a triage policy/triage guidelines?
- Are the people who take calls in your practice trained in triage?
- Does your telephone system have an option for urgent phone calls or calls requesting same-day appointments?
- Do you collect and analyse call data as part of your practice’s service analysis/risk management procedures?

Introducing protocols
If you want staff to willingly follow a protocol, it is better to ensure they were involved in drafting it. Consider:
- Referring staff to external training and/or provide it in-house
- Providing scripts and simulation rehearsal
- Providing tools such as flow charts and algorithms.

There should be a process whereby receptionists can reflect on their triage with senior receptionists or a member of the clinical team.

Some patients do not like non-clinical staff asking clinical questions so a new triage system may need to be explained to patients.

Why are protocols important?
If an established patient of yours comes to harm because of delay in either seeing you, or being given advice and directed as to where/how to seek emergency treatment, you may be held responsible. Arguing that there are system issues such as staff shortages may, in mitigation, help to explain how the harm occurred but it is not a defence. If a patient asserts that he or she came to harm as a result of delayed assessment and treatment, inevitably the doctor may have difficulty defending his/her actions and those of the practice.

A successful defence would require demonstrating that the practice had evidence-based policies and protocols, that they were sound and that the staff were trained in the application of those policies and protocols, and that there were robust notes recording the content of the relevant telephone or front desk inquiries.

Further information
- Urgent Care – A Practical Guide to Transforming Same-day Care in General Practice – www.primarycarefoundation.co.uk

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+44 113 243 6436
or email us at: querydoc@mps.org.uk
www.mps.org.uk

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