Practices should have sound triage policies and protocols in place for non-clinical staff to deal with emergency situations. Training staff in how to follow them will safeguard against criticism should a patient come to harm because of a delay in seeing someone, giving 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 a rudimentary triage.

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 promulgation 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 collection and analysis of data on 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. Allowing inappropriately triaged cases to swamp the practice could prevent the provision of ongoing care. An effective triage system could help direct patients to the most appropriate appointment at the most appropriate time, and identify patients who have an immediate medical need.

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 need a process for when all the appointments for the morning/afternoon 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.

If the receptionist directs a patient to the Emergency department or calls a 999 ambulance for a patient, the duty doctor should be informed. This action should be documented in the patient record.

**What should concern you**

- Does your practice have a triage policy/triage guidelines?
- Are the people who take calls in your practice trained in triage?
- Are staff trained to recognise what constitutes an emergency?
- Does your telephone system have an option for urgent phone calls or calls requesting same-day appointments?
- If incoming phone lines are busy, do you have a message advising patients to call 999 in an emergency situation?
- 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.

Consider informing patients using the practice website, the practice leaflet, signs at the reception desk and posters in the waiting room.

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 where/how to seek emergency treatment, you may be held responsible. Arguing that there are “too many patients – not enough doctors” may be an explanation of how the harm came to happen, 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 faces a strong “hindsight bias”.

A successful defence would require evidence-based policies and protocols that the practice had sound triage policies and protocols, that the staff was trained in the application of those policies and protocols, and that there were good 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