



POLICY ON THE AUSTRALASIAN TRIAGE SCALE

1. INTRODUCTION

The Australasian Triage Scale (ATS) is designed for use in Emergency Department settings (refer to ACEM's [S12 Statement on the Delineation of Emergency Departments](#)) throughout Australia and New Zealand. The role of the ATS is as a clinical tool for ensuring that patients are seen in a timely manner, commensurate with their clinical urgency. The ATS should only be used to describe urgency. Separate measures are required to describe severity, complexity, quality of care, workload and staffing.

2. PRACTICALITY AND REPRODUCIBILITY

As the ATS is primarily a clinical tool, the practicalities of patient flow must be balanced with attempts to maximise inter-rater reproducibility. It is recognised that no urgency measure reaches perfect reproducibility. Reproducibility within and between Emergency Departments can be maximised by application of ACEM's [G24 Implementation of the Australasian Triage Scale in Emergency Departments](#) and use of the Emergency Triage Education Kit (ETEK). Triage accuracy and system evaluation can be assessed by comparison against guidelines. Patterns of triage category distribution, Intensive Care Unit admission, and mortality by triage category should be comparable between peer hospitals of similar role delineation. Admission and transfer for admission rate by triage category is also a useful comparison between peer hospitals, for the higher and lower urgency categories. These benchmarks for Emergency Departments of different role delineation should be reviewed from time to time as disposition practices change.

3. APPLICATIONS

3.1 Procedure

All patients presenting to an Emergency Department should be triaged on arrival by a specifically trained and experienced members of a clinical assessment team which may be nursing, medical or combined. The triage assessment generally should take no more than two to five minutes with a balanced aim of speed and thoroughness being the essence, and the triage assessment and ATS category allocated must be recorded. There should be a process and staffing in place to ensure continuous re-assessment of patients who remain waiting, and, if the clinical features change, re-triage of patients accordingly. A member of the clinical assessment team may also initiate appropriate investigations or initial management, according to organisational guidelines.

A member of the clinical assessment team applies an ATS category in response to the question: *"This patient should wait for medical assessment and treatment no longer than..."*

4. DESCRIPTION OF SCALE

AUSTRALASIAN TRIAGE SCALE CATEGORY	TREATMENT ACUITY (Maximum waiting time for medical assessment and treatment)	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 INDICATION AND THRESHOLDS

The indicator threshold represents the percentage of patients assigned ATS Categories one (1) through to five (5), who commence assessment and treatment within the relevant waiting time from their time of arrival. For the definition of “commencement of assessment and treatment” see [G24 - Guideline for the Implementation of the Australasian Triage Scale in Emergency Departments](#). Staff and other resources should be deployed so that thresholds are achieved progressively from ATS Categories 1 through to 5 Performance indicator thresholds must be kept under regular review.

Where Emergency Department operation is limited through overcrowding and access block, staff should be deployed so that performance is maintained in the more urgent categories unless the potential severity or the efficient streaming of particular cases is determined by the emergency physician in charge to be the most efficient use of human resources to maximise the efficiency, quality and safety of patient care in the department. 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 of the same role delineation. Emergency Departments should audit particular high risk outcomes (e.g. ICU admission, febrile neutropaenia, thrombolysis) to ensure that the ATS is identifying those requiring time critical intervention.

7. REFERENCES

- 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.
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- Forero, R. and P. Nugus, *Australasian College for Emergency Medicine (ACEM) Literature Review on the Australasian Triage Scale (ATS)*. 2012, University of New South Wales - Simpson Centre for Health Services Research, South Western Sydney Clinical School Centre for Clinical Governance Research: Sydney.

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8. DATES AND NOTES

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