Letter

Emergency triage
THANKS FOR the interesting article, Navigating triage to meet targets for waiting times (Emergency Nurse, June), which describes an attempt to make patient flow through an emergency department (ED) more efficient.

We would like to take issue, however, with the article’s repeated assertion that triage makes patient flow unwieldy.

In Figure 1, the only part of the flow diagram that represents the Manchester Triage System (MTS) is the step called ‘triage and prioritisation of care’. The rest of the diagram represents the ED’s patient-registration system, which has nothing to do with the MTS.

Prioritisation using the MTS should take no more than two minutes and the unwieldiness of the process described in the article is due to the number of steps involved in the ED’s system of patient registration.

If recording MTS decisions was taking too much time, we suggest that the ED’s computer system, not the MTS, was at fault. This is a common problem in computerised triage solutions that clinicians have not helped to design.

We are happy to note that the senior team mentioned in the article recognised that the problems described were due to how MTS was used rather than the system itself, and that triage is most effective when undertaken by senior nurses, an important element of MTS.

The new process described in the article seems to be more streamlined and efficient, and clearly works well for patients and for the department. As the author explains, staff still prioritise patients, which means they still triage them, even though the process is now called ‘navigation’.

It appears that ED staff have replaced a validated prioritisation system that is used to triage millions of patients throughout the world with one which relies on senior nurses’ expertise. Such an approach is, by definition, without structure and therefore neither replicable nor auditable. This lack of structure may affect patient safety as the departmental knowledge of the MTS declines.

The baby appears to have been thrown out with the bath water, which is a shame; the author could have undertaken exactly the same system redesign while keeping the MTS.

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Book review

Human Anatomy
Frederic Martini, Michael Timmons and Robert Tallitsch
Pearson
£62.99 | 904pp
ISBN: 9780321761026

THIS, THE seventh edition of Human Anatomy, is being sold in a ‘value pack’ with Martini’s Atlas of the Human Body. Both books are detailed but easy to understand, and would be perfect for students approaching the subject of human anatomy for the first time.

Human Anatomy includes brief patient histories, descriptions of investigations, points to consider and diagnoses, and readers can check their knowledge against chapter reviews before continuing.

The Atlas of the Human Body, meanwhile, supplements its account of the major anatomy with fully labelled photographs of cadavers being dissected, which are easier to interpret than illustrations.

I recommend both books in this package to all students of anatomy.
Simon McGurk is a biomedical science graduate at the University of Birmingham

Trauma co-ordinators
IN RECENT years, there has been a renewed interest in the management of patients with major trauma, and having a dedicated major centre in a trauma network has emerged as the favoured model of care.

In this model, acute care and ambulance crews work together to ensure that patients are taken to the right destinations as soon as possible, that trauma teams are present at their arrival, and that they have early access to diagnostics and theatre.

Little has been said, however, about the later management of patients with trauma in hospital environments, even though the care received by such patients, especially those with multisystem trauma, is often fragmented and suboptimal.

In Australia and the United States, the care of such patients is overseen by trauma co-ordinators or trauma case managers. The purpose of these roles, which are different from that of the orthopaedic trauma co-ordinator, is to ensure that patients with major trauma are helped through the healthcare system as quickly and with as few complications as possible. Staff in these roles may also be involved in education and the promotion of evidence-based practice.

In the UK, the trauma co-ordinator role was investigated in a government-funded study in the late 1990s (Driscoll et al 1998). The researchers found that the co-ordinator they studied did not reduce lengths of stay but improved the quality of patient care and advocacy.

Given the increasing complexity of care, and the greater demand on staff to satisfy patient and public expectations, perhaps it is time to revisit the concept of trauma co-ordinators.

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Reference