Emergency Triage
Second Edition
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Preface to the second edition

It is now over 10 years since a group of senior emergency physicians and emergency nurses first met to consider solutions to the muddle that was triage in Manchester, UK. Little did we realise that the solution to our local problem would be robust enough (and timely enough) to become the triage solution for the whole United Kingdom. Never in our wildest dreams did we imagine that the Manchester Triage System would be generic enough to be adopted around the world. Much to our surprise, however, both of these fantasies are reality, and the MTS is used in many languages to triage tens of millions of Emergency Department attenders each year.

While the basic principles that drive the MTS (recognition of the presentation and reductive discriminator identification) are unchanged, it has become necessary to make some adjustments. The second edition incorporates the outcome of consideration of all the comments passed to us by users over the years (for which we are very grateful). It also seeks to include changes that reflect new practice such as the possibility of revascularisation for patients with stroke. Major changes include, by popular demand, new charts for Allergy and Palpitations together with amalgamations and expansions of other charts to keep the core number at 50. A few new discriminators have been introduced such as acute neurological deficit and significant respiratory history, while others have been redefined. In particular the discriminator for pain at priority 4 has been changed to recent pain to reflect the outcome of research that indicated that this would improve the clinical utility of the system. Overall, however, the changes (while significant) are few.

This new edition also seeks to put triage in the context of changes that are happening in many emergency care systems around the world. In the past 10 years the provision of emergency care has become the focus of political and thereby management attention. In particular the care of those patients with less urgent conditions (who make up the majority in most settings) has become a source of concern, since under-resourced systems that focussed (rightly) on patients with the highest clinical priority inevitably resulted in delayed care for those at the other end of the priority scale. In the consumer age this delay is unacceptable. It was easier to blame the clinical prioritisation system (triage) for this delay than it was to accept that the system was under-resourced, and this has meant that triage became out of vogue in some areas. Our standpoint has always been that triage is vital in all systems or circumstances where demand for care outstrips the ability to deliver it. We continue to believe that these circumstances occur occasionally in even the best managed and resourced systems, and frequently in those with the usual demands and staffing. Thus clinical prioritisation (whether called triage, initial assessment or anything
else) remains a central plank of clinical risk management in emergency care, and abandoning it completely is not an option. As we show in one of our new chapters, the outcome of the MTS triage process can be used constructively ‘beyond prioritisation’ and this underlines its developing usefulness to Emergency Departments.

Kevin Mackway-Jones, Janet Marsden, Jill Windle
Manchester, 2005
Preface to the first edition

Every day, emergency departments are faced with a large number of patients suffering from a wide range of problems. The workload varies from day to day and from hour to hour and depends on the number of patients attending and what is wrong with them. It is absolutely essential that there is a system in place to ensure that these patients are seen in order of clinical need rather than in order of attendance.

In the past year great steps have been made towards establishing a National Triage Scale in the United Kingdom; this follows on from similar work in Australia and Canada. This book is intended to allow practitioners of triage to work to a set standard when applying national scales to the patients presenting to their departments. The members of the multi-professional consensus group that designed this methodology hope that individual practitioners will use it to inform the triage process and ensure that their decisions are both valid and reproducible.

This manual contains the basic knowledge necessary for triage practitioners to begin to build their competence in performing triage. It is hoped that practitioners will find a useful source reference and aide-memoire.

Kevin Mackway-Jones, 1996