it has been eroded by a system that tries to squeeze more and more out of less and less.

Prior to CTAS our department had a classification of patients as Emergent, Urgent, Deferrable, or Scheduled. There was a vague understanding amongst paramedics, doctors and nurses about just what these terms actually meant, but the system generally worked well for those who had enough experience to apply it. If, for any reason, the triage nurse was particularly worried about a patient, an asterisk would be placed on the top of the chart to signify the sicker patients.

CTAS finally introduced a written scale that made sense and could reasonably be applied by any practitioner regardless of experience. I even published a small pamphlet, for patients in the waiting room, which explained the concept of CTAS and gave examples of which conditions would merit which level of urgency. There was no more need for asterisks as our team learned to triage patients correctly.

Then began the inevitable decay. The government knew that a compilation of CTAS data could be used to determine the average acuity of patients visiting a department and thereby determine its level of funding. I noticed that our nurse managers began encouraging triage nurses to "push the envelope" with triage scores so that our acuity was high enough to maintain or improve funding. This flu season I finally witnessed CTAS evolve (or mutate) from a creature of patient care into a monster of bureaucracy. Every cold or flu was a CTAS Level III. Technically, they all had difficulty breathing, didn't they? Every pain was at least an 8/10. Every child with the slightest fever was potentially meningitis and was scored as such. We have scored ourselves into a corner so that it is impossible to see all these urgent patients within the time frames suggested by the scale. And now, amongst the sea of CTAS Level IIIs that clutter my desk, the really sick ones are once again marked with an asterisk.

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[Dr. Michael Murray responds:]

To the Editor: The *Canadian Emergency Department Triage and Acuity Scale* (CTAS)[1] was introduced as a tool to identify patients requiring priority care but, for several reasons, there has been "gaming" in its application. Dr. Reddoch highlights an example of misapplication of CTAS for other purposes. Optimal CTAS application requires regular audit, review, education and retraining. Without evaluation and quality improvement processes, triage standards will drift, and it is likely that CTAS levels will regress to the middle — CTAS Level III.

Recent CTAS revisions[2] are based on the CEDIS chief complaint list[3] and objective modifiers that allow for less subjective "interpretation" of triage levels. These revisions were necessary in order to make CTAS more objective, to ensure better standardization and more reliable comparisons between centres. They will also reduce the "gaming." The revised CTAS guidelines have been incorporated into computer assisted triage software[4] that can potentially reduce inter-observer variability.

To maximize the likelihood that CTAS is being applied appropriately, emergency department leaders should review the new guidelines and develop a plan for their implementation. This plan should incorporate training, audit and CQI (continuous quality improvement) processes, and it may include computer-assisted electronic triage modules.

Comments and questions should be addressed to ctas@caep.ca.

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