eCTAS Train-the-Trainer – Part 2

Application Basic and Complex

Training Team

Ontario Health

Session Logistics

Intended Audience

Integration(s): Basic, Complex

Resources responsible for training and supporting triage nurses on use of the eCTAS application

This session is being recorded

Press  **to mute. Press**  **to unmute.**

Agenda

Learning Objectives:

1. Generating Clinically Appropriate CTAS Scores (e.g., Modifiers)
2. TOA Queue & Printing Triage Summary
3. Special Features
4. Troubleshooting, Downtime & Errors
5. Resources
6. Next Steps

Important: This training is on the use of the eCTAS application only, all triage Nurses must complete the CTAS Participant Course prior to using eCTAS to triage real patients.

Generating Clinically Appropriate CTAS Scores

- Clinical Judgement & eCTAS (e.g., Modifiers)
- Alerts
- Case Scenarios & Low Scores
- CEDIS-Specific Modifiers

CEDIS Complaints & Modifiers List

Recap

CEDIS: Canadian Emergency Department Information System

CEDIS Complaint List (169 complaints) have corresponding:

Base Scores

CTAS 1 *Resuscitation – constant reassessment*

CTAS 2 *Emergent – reassess q 15 minutes*

CTAS 3 *Urgent – reassess q 30 mins*

CTAS 4 *Less-Urgent – reassess q 60 mins*

CTAS 5 Non-urgent – reassess q 120 mins

+

Modifiers

Signs, symptoms and medical issues - displayed in order of CTAS acuity

Selected or **deselected** to modify the base score and dynamically generate the best possible/most appropriate CTAS score

eCTAS is a Clinical Decision-Support Tool

Recap

The Nurse's clinical judgement/assessment skills are used WITH eCTAS to reflect the patient's condition AND to generate the best CTAS score

Nurses:

1. Choose most appropriate CEDIS Complaint (or change it)	e.g., Chest Pain (Non-Cardiac Features) = **CTAS 5** **vs.** Chest Pain (Cardiac Features) = CTAS **2**
2. Enter applicable Vital Signs →	• Trigger **modifiers** to **appear**, be **highlighted** and/or be **auto-selected** by the system • Potentially **increase** the CTAS score
3. Select/Deselect Modifiers, if clinically appropriate →	• Increase/decrease the CTAS score
***ONLY use CTAS Override as a last resort →**	• Generate a higher CTAS score when higher scoring modifiers don't appear or correspond to patient's condition

eCTAS is designed around CTAS Guidelines

- CTAS Guidelines
- Modifiers nurses might question

Vital sign ranges that **trigger** modifiers

- Adult heart rates <60 or >90 will trigger Pulse Rate modifiers
- Paediatric vital signs may trigger the “Vital Signs Outside the Limits of Normal” modifier

eCTAS displays visual cues to support decision-making

- Alert stating higher acuity score might be appropriate
- Highlighting modifiers to increase CTAS Score

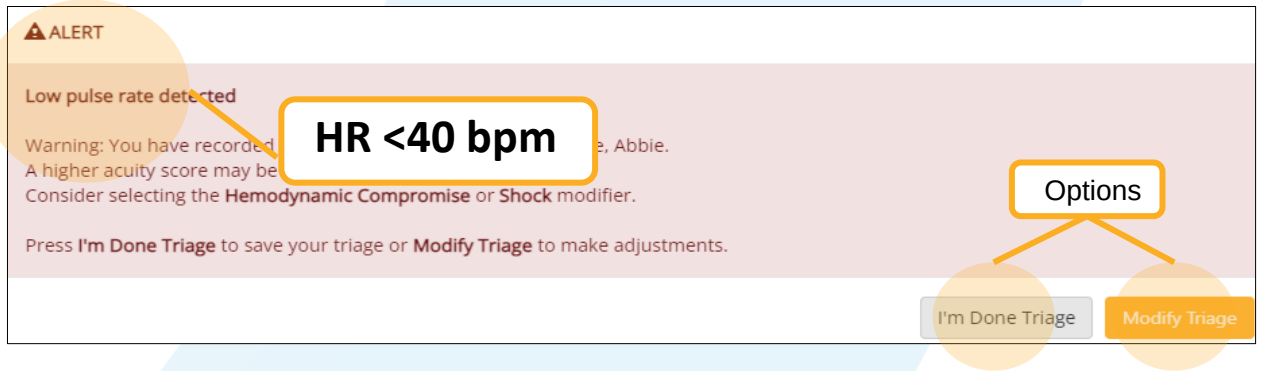
Note: Posting updated **Paediatric Vital Sign charts** can be helpful for Nurses at Triage

Alerts: Adult Heart Rate

If…

1. **Adult HR <40 bpm**,
2. CTAS 3, 4, 5 and
3. Nurse attempts to save the record

(i.e., hits I’m Done Triage button)



Vital Signs & Adult Alerts

DEMO

At Triage

The patient presents with a weakness and a pulse rate below the limits of normal. The patient is lethargic and confused with a GCS of 14.

In eCTAS

	Nurse Input	CTAS Score
Patient Stated Complaint	Weakness	
Chief CEDIS Complaint	General weakness	4
Vital Signs	T 37.5, Pulse Rate: 39, R 16, BP 90/56, GCS 14	3
Modifiers	**Pulse Rate / Pressure Abnormal (Hemodynamically Stable)** is auto-selected	3
	Shock and **Hemodynamic Compromise** are highlighted in yellow	3
Demonstration of Adult Low HR Alert	Attempt to Save record → MODIFY, Manually select Hemodynamic Compromise	2

Vital Signs

DEMO

At Triage

The patient presents with a fever and a pulse rate above the upper limits of normal. Patient states they have a history of uncontrolled atrial fibrillation, and it is normal for him to have a high heart rate.

In eCTAS

	Nurse Input	CTAS Score
Patient Stated Complaint	Fever	
Chief CEDIS Complaint	Fever	4
Vital Signs	T 37.9, Pulse Rate: 110, R 20, BP 110/84	3
Modifiers	**Pulse Rate / Pressure Abnormal (Hemodynamically Stable)** is auto-selected	3
	Shock and **Hemodynamic Compromise** are highlighted in yellow	3
	Manually deselect **Pulse Rate / Pressure Abnormal (Hemodynamically Stable)**	4

Pain Modifiers

DEMO

At Triage

The patient presents with back pain. The patient gives a pain rating of 9/10; however, you observe the patient appears well with normal vital signs. The patient is walking and speaking with no obvious signs of discomfort, drinking coffee and playing with child.

In eCTAS

	Nurse Input	CTAS Score
Patient Stated Complaint	Back Pain	
Chief CEDIS Complaint	Back Pain	5
Vital Signs	Pain: 9/10	2
Modifiers	**Acute Central Severe Pain (8-10)** is auto-selected	2
	Deselect **Acute Central Severe Pain (8-10)** → **Acute Central Moderate Pain (4-7)** next lower Pain Modifier is auto-selected	3

Changing the Chief CEDIS Complaint

DEMO

At Triage

The patient comes in stating pain in their eye after cleaning their oven today.

In eCTAS

	Nurse Input	CTAS Score
Patient Stated Complaint	Right Eye pain	
Chief CEDIS Complaint	Eye Pain **Change Complaint** to Chemical Exposure, Eye	5 2
Vital Signs	Temp 37.2, Pulse 90, RR 20 (Normal) Pain 7/10 Peripheral Acute (CTAS 4)	2
Modifiers	**Acute Peripheral Moderate Pain (4-7)** is auto-selected (CTAS 4, no change to score)	2

Patient Condition Changing & Modifiers

DEMO

At Triage

The patient is intoxicated, and only rouses to verbal stimuli.

In eCTAS

	Nurse Input	CTAS Score
Nurse Assessed Complaint	Intoxicated	
Chief CEDIS Complaint	Substance Misuse/Intoxication	4
Vital Signs	Pulse Rate: 110 GCS: 11	3 2
Modifiers	**Pulse Rate / Pressure Abnormal (Hemodynamically Stable)** is auto-selected	3
	Hemodynamic Compromise and **Shock** are suggested in yellow	3
	Altered Level of Consciousness (GCS 10-13) is auto-selected	2
	Manually select **Unconscious**	1

CEDIS-Specific Age-based Modifiers for Paeds

DEMO

At Triage

Parents present with a 2-week-old infant with a concern about worsening jaundice. Baby is sleeping, however responds to touch, but opening eyes and crying. Parents state the child is drinking and having wet diapers as expected.

In eCTAS

	Nurse Input	CTAS Score
Patient Stated Complaint	Jaundice	
Chief CEDIS Complaint	Neonatal Jaundice	3
Vital Signs	Normal (Temp 37.2, HR 132, RR 42) – no change	3
Modifiers	Entering (or Updating) a DOB will auto-select **Infant <= 30 Days of Age** modifier	2

Important: Always attempt to enter an **actual Date of Birth for children** (instead of choosing Paeds cohort and an Estimated Age).

CEDIS-Specific Hypertension Modifiers

When the Chief CEDIS complaint is:

Pregnancy Issues > 20 weeks (**CTAS 4**) or **Postpartum Issues** (CTAS 5) corresponding **Hypertension** modifiers will appear in the list

If SBP > 140 **OR** DBP > 90

CTAS 3
Hypertension SBP > 140 **or** DBP > 90 will be auto-selected

If SBP > 160 **OR** DBP > 100

CTAS 2
Hypertension SBP > 160 **or** DBP > 100 will be auto-selected

CEDIS-Specific & Hypertension Modifiers

DEMO

At Triage

29-year-old female presents 8 hours post delivery of a full-term following a normal pregnancy with no issues during delivery. After arriving home 2 hours ago, the patient describes headache and upper abdominal pain. Normal sensation and movement in limbs, no facial droop noted.

In eCTAS

	Nurse Input	CTAS Score
Patient Stated Complaint	8 hours Post-partum, headache, abdo pain	
Chief CEDIS Complaint	Postpartum issues	5
Vital Signs	Pain 3/10 Central, Acute T 37.8, Pulse 86, BP 156/88	4 3
Modifiers	**Acute Central Mild Pain (<4)** is auto-selected	3
	Hypertension SBP>140 or DBP > 90 is auto-selected	3
	Headache+/-Edema+/- Epigastric Pain +/- Visual Disturbance +/- Extremity Weakness is manually selected	2

Selecting the Best Modifiers

to reflect the patient's condition and generate the best CTAS score

DEMO

At Triage

Patient arrives with family member who explains the patient tried to cut their wrist. Patient has minor cuts on their wrist. Family member tells the Nurse that the patient has clinical depression but has recently expressed suicidal intent through social media.

In eCTAS

	Nurse Input	CTAS Score
Nurse Assessed Complaint	Self Harm	
Chief CEDIS Complaint	Depression / Suicidal / Deliberate Self Harm	4
Vital Signs	Normal	4
Modifiers	Manually select **Active Suicidal Intent**	2

CEDIS Complaints with Base CTAS Score of 4 or 5

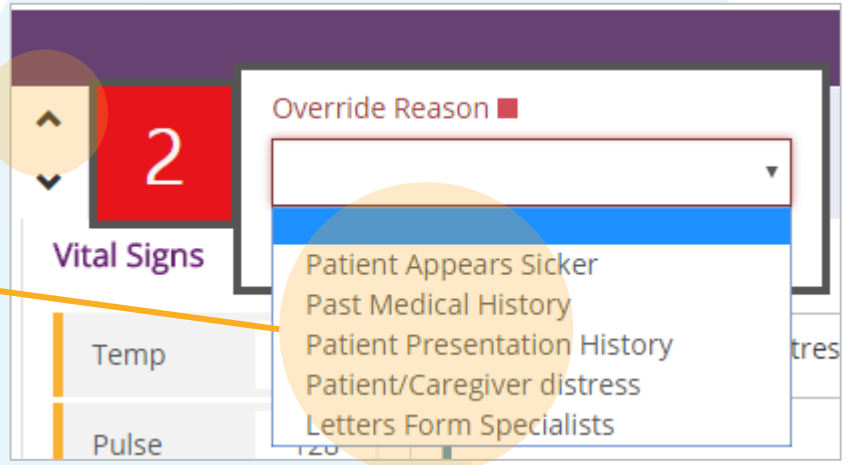
- Laceration/Puncture *…do they have a bleeding disorder or active bleeding?*
- Lumps Bumps *…is there a more appropriate Chief CEDIS Complaint?*
- Prescription requests *…is the patient reporting significant pain?*
- UTI *…is the patient becoming septic?*

Generate the most appropriate CTAS score

DEMO

1. Enter Vitals Signs,
2. Use modifiers as clinically appropriate to reflect the patient's condition,
3. Change the CEDIS Complaint, if appropriate
4. Last resort: Override

- If clinically appropriate, use arrows to override CTAS score
- Select **Override Reason**



Generating Clinically Appropriate CTAS Scores

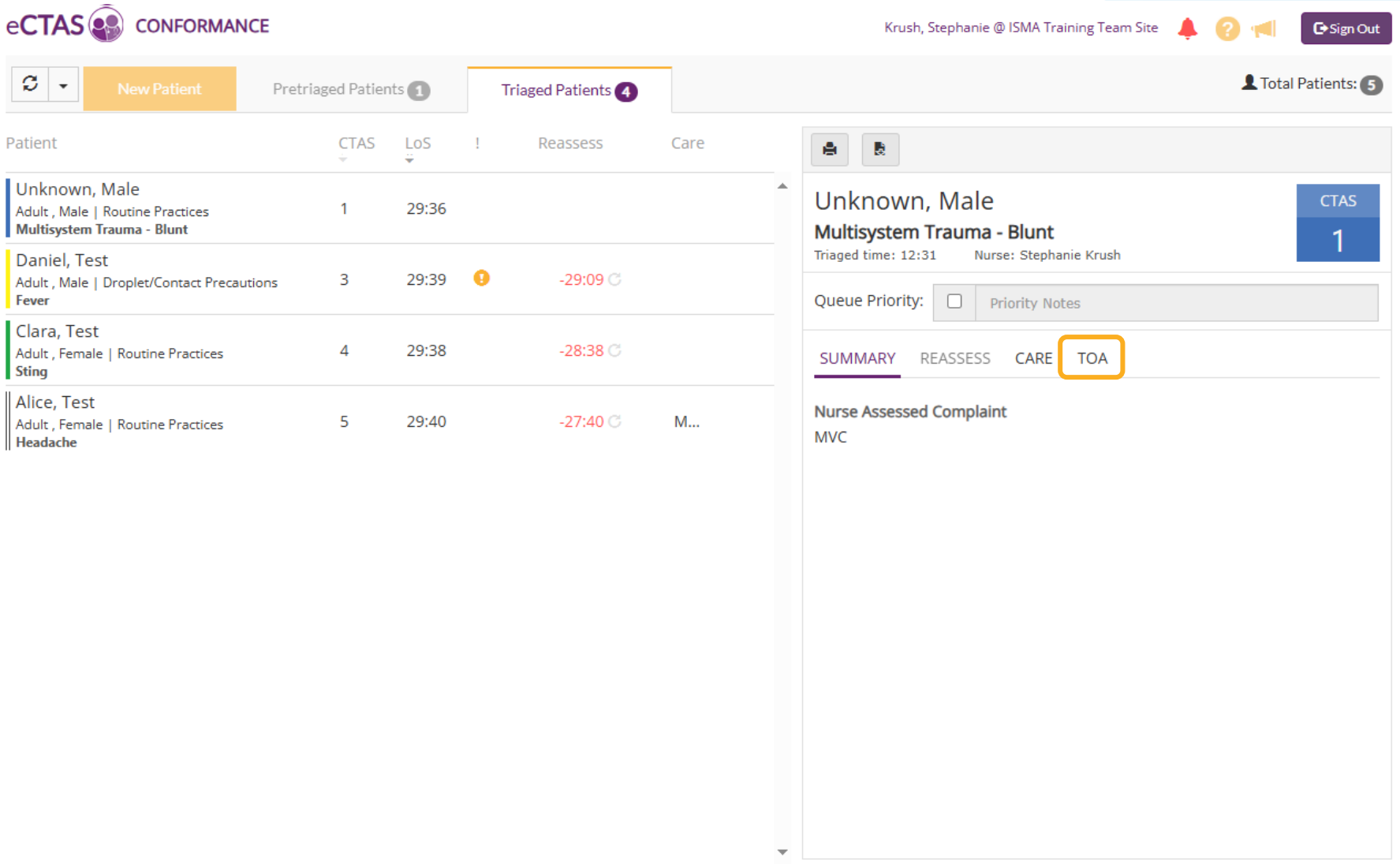
- ✓ Clinical Judgement & eCTAS (e.g., Modifiers)
- ✓ Alerts
- ✓ Case Scenarios & Low Scores
- ✓ CEDIS-Specific Modifiers

Break:

TOA Queue & Printing Triage Record

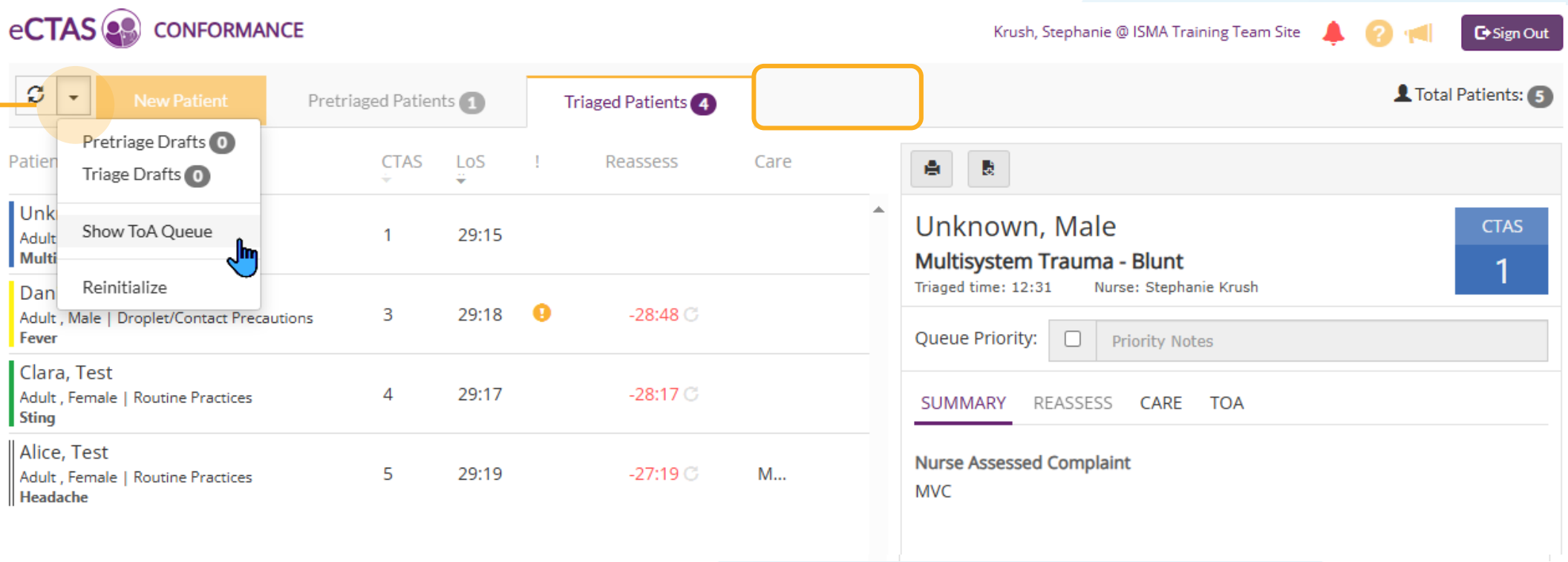
Transfer of Accountability

DEMO



TOA Queue

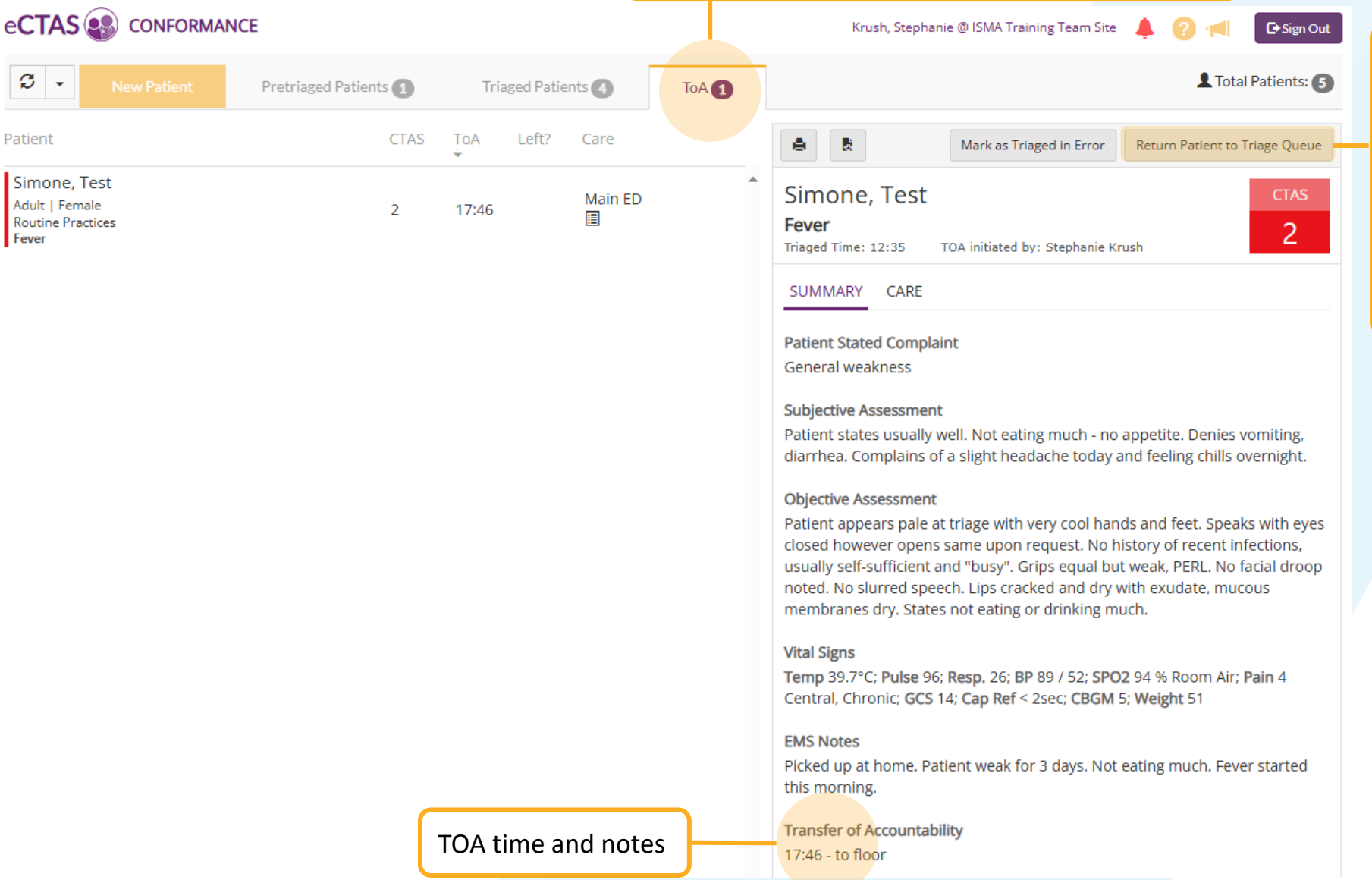
Click arrow and select option to **Show** or **Hide** TOA Queue



TOA Queue

DEMO

Patients will remain in TOA Queue for 6 hours



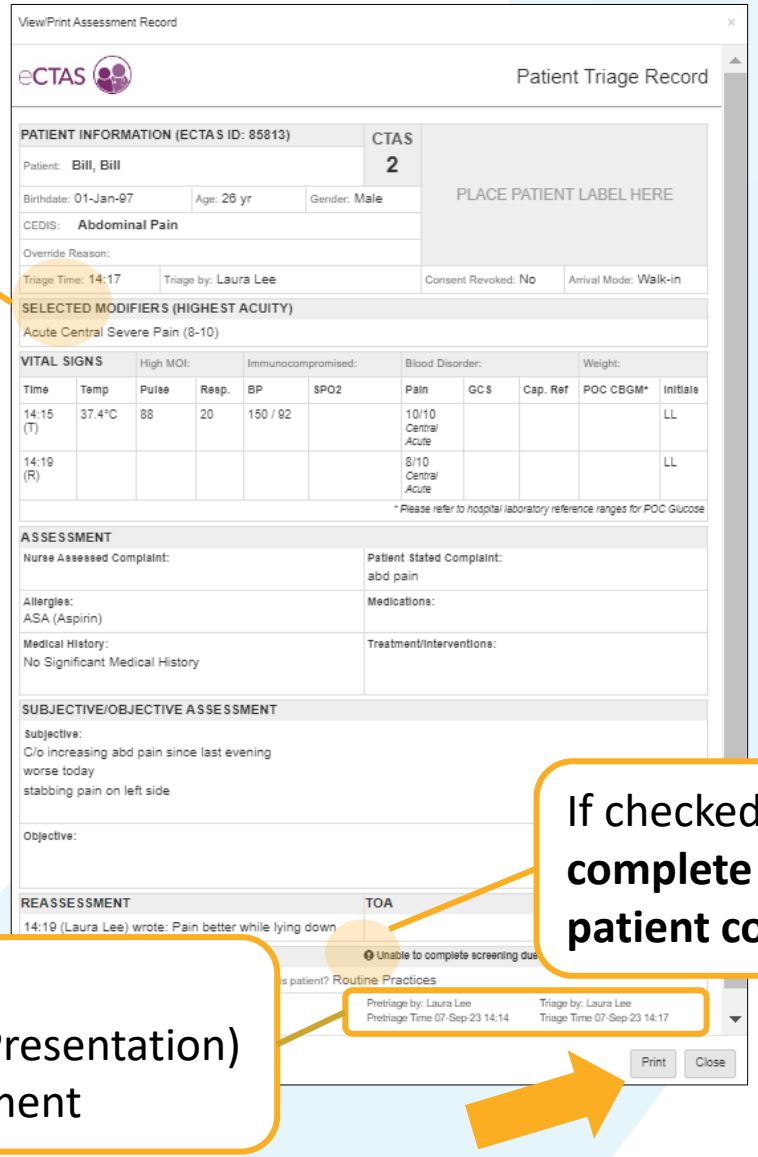
Return Patient will move patient back to Pretriaged or Triaged Patients Queue. Any notes from the original TOA will be deleted.

TOA time and notes

Printing Summary/Patient Triage Record

DEMO

Selected Modifiers affecting final CTAS score will appear



Note: Wait until the Patient Triage Record is fully loaded in the print preview window before clicking the **Print** button. This will ensure the full record is printed.

Care Location will appear in the printed record; Priority in Queue and Care Instruction details **do not**.

If checked off, **Unable to complete screening due to patient condition** will appear

- Date, Time
- Name of the **person** who completed Pretriage (Patient Presentation)
- Name of the **clinician** who completed the Triage assessment

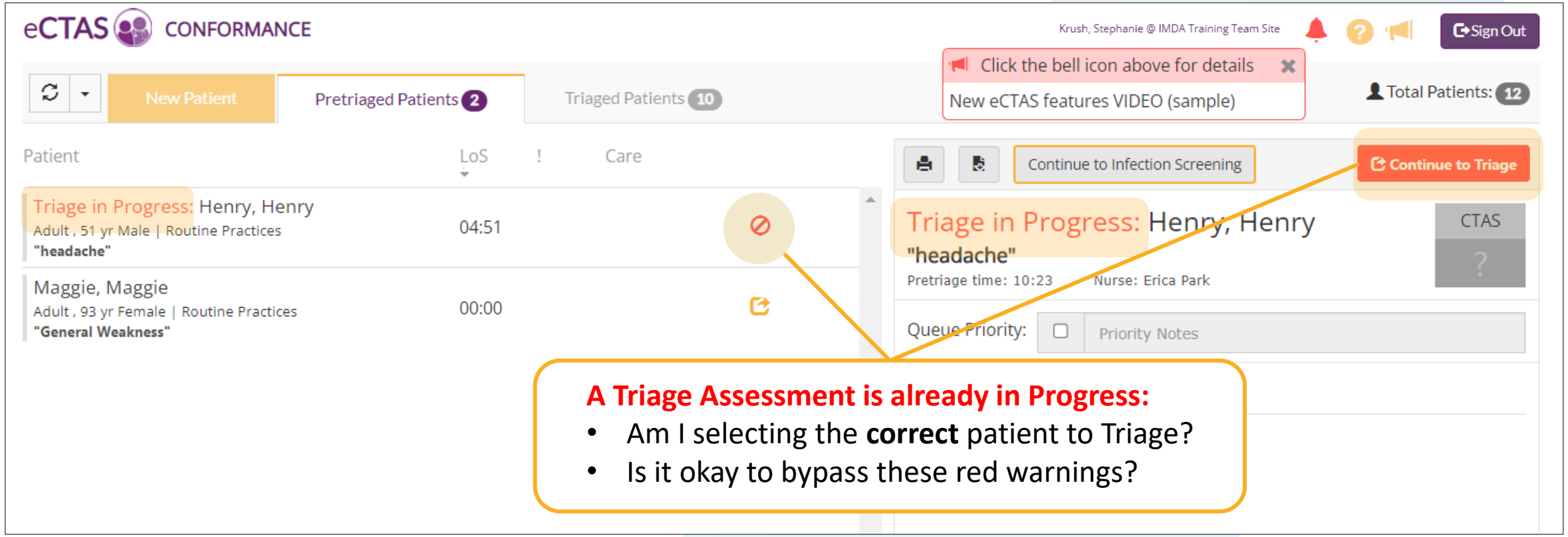
End of Section

- ✓ Transfer of Accountability
- ✓ TOA Queue
- ✓ Printing Triage Record

Special Features

- Triage In Progress
- Copy Assessments & Notes
- Recommended Assessments

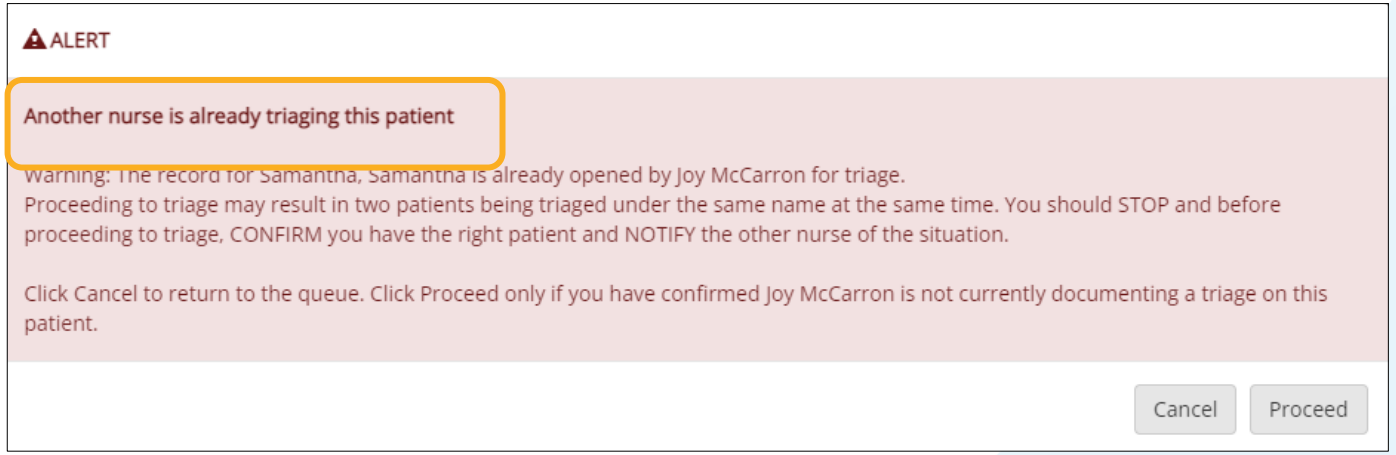
Triage in Progress Indicators/Alerts



Two Nurses open the same patient record

Warning for the First Nurse already triaging the patient

Warning for the Second Nurse who selected the same patient



The name of the **patient** and the name of the **other nurse** will appear in each alert.

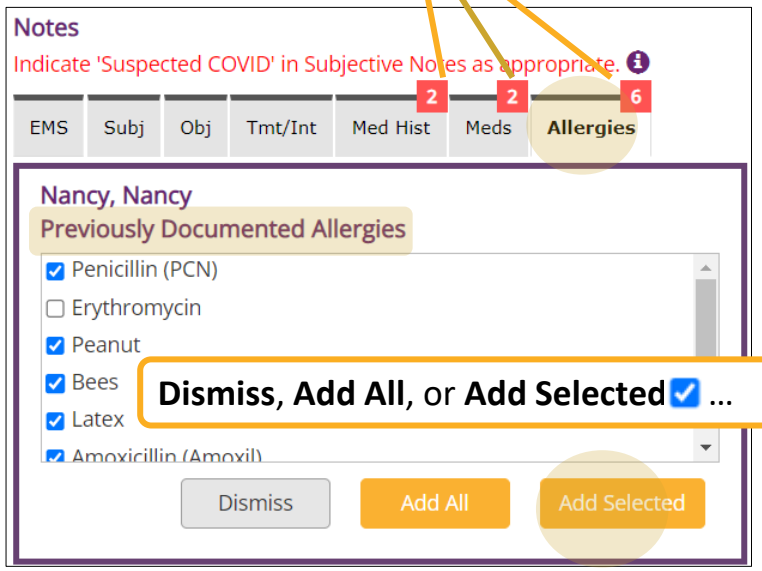
- **STOP**
- **CONFIRM** correct patient and
- **NOTIFY** the other Nurse

Patient Visits in Past 2 Years

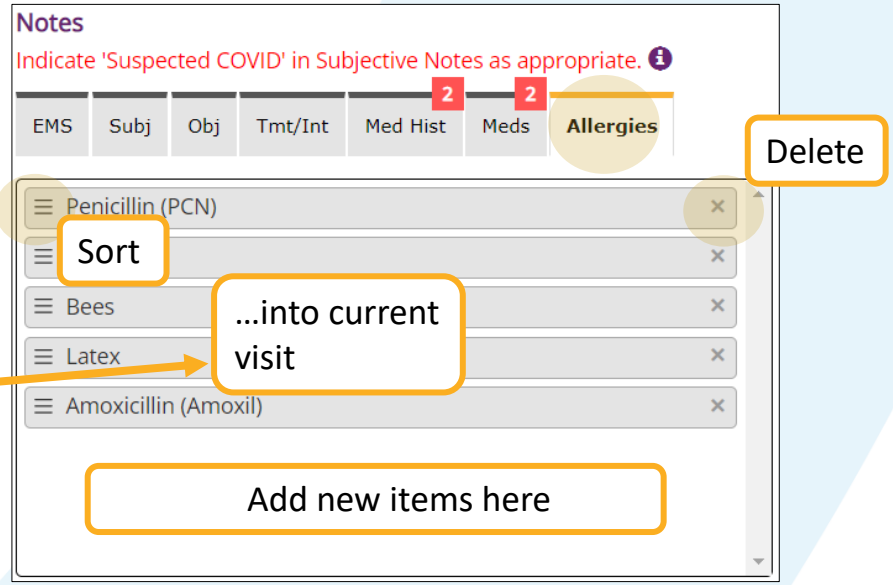
Copy Medical History, Medications, Allergies

DEMO

Number of previous entries from past triage records indicated in red box (maximum of 20)



Dismiss, **Add All**, or **Add Selected** ...

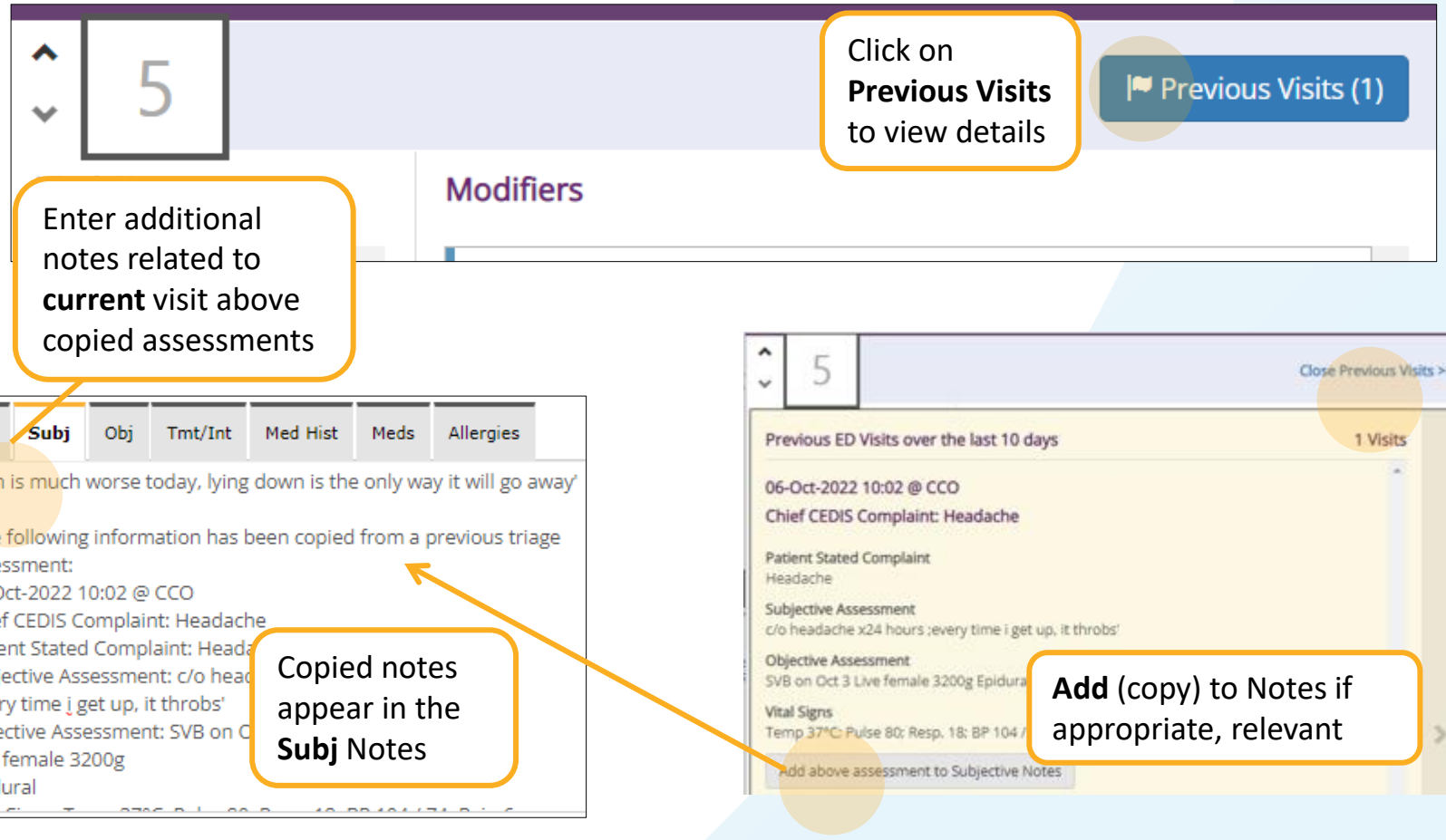


Important: Red indicators will only appear if the patient's Last Name, First Name, Health Card Number, Gender **and** Birthdate match past visits within the past **2 years and** the **Patient Does Not Consent** checkbox had **not** been checked off during previous visits.

Copy Assessments

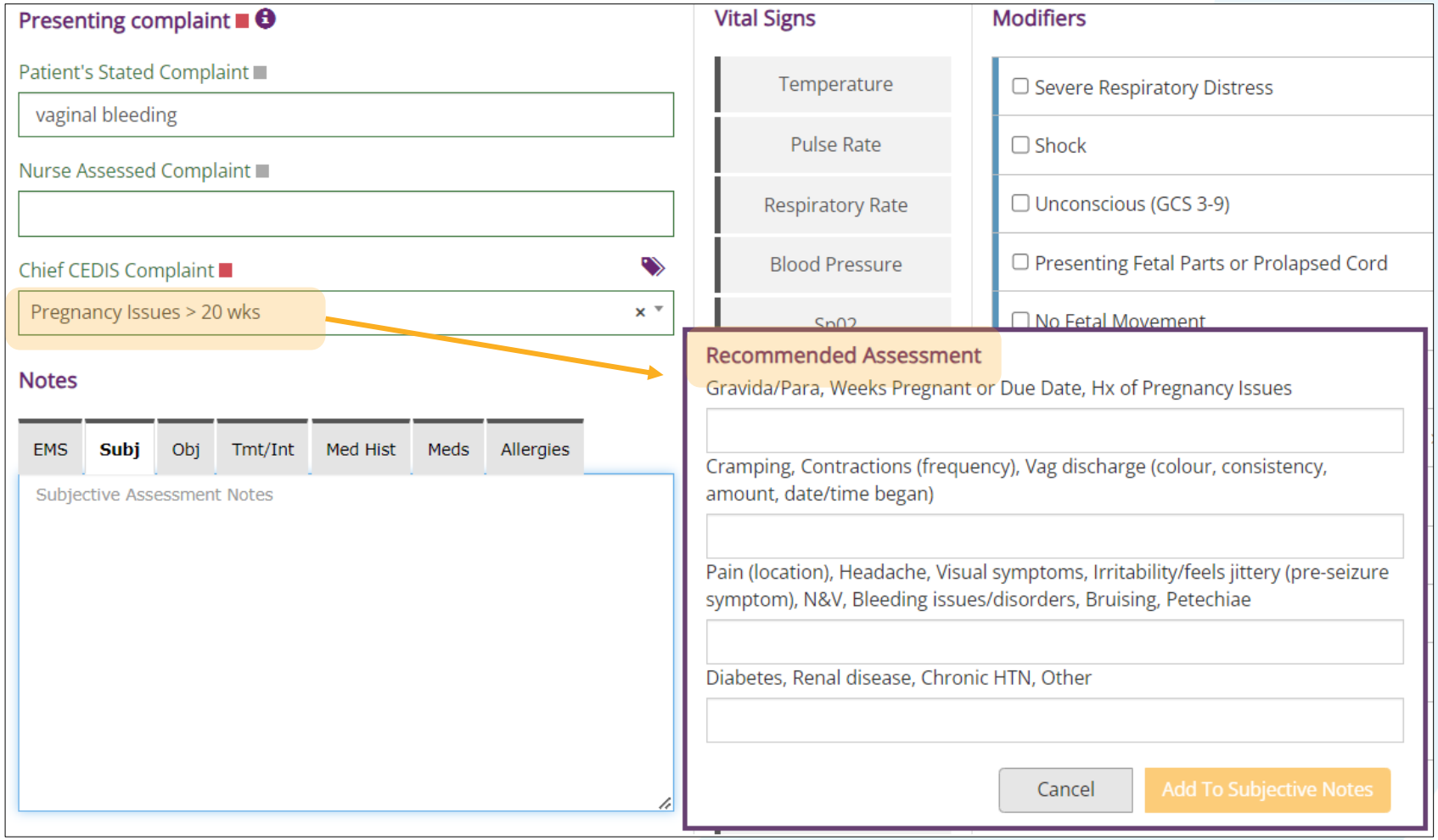
from Past 10 Days/Previous Visits Flag

DEMO



Important: Previous Visit flag will only appear if the patient's First Name, Last Name, Health Card Number, Gender and Birthdate match past visits. Also, the **Patient Does Not Consent** checkbox must **not** have been checked off during previous visits.

Special Feature: Recommended Assessments



Note: All Special Features can be found within the Clinical End User section of the Online Help, including a full list of [CEDIS Complaints with Recommended Assessments]

Recommended Assessments

DEMO

At Triage

Patient arrives with badly cut finger.

In eCTAS

	Nurse Input	CTAS Score
Nurse Assessed Complaint	Lacerated Fingers	
Chief CEDIS Complaint	Laceration/Puncture	5
Vital Signs	Normal	5
Modifiers	Manually select **Sutures Required**	4
	Manually select **Active Bleeding**	3
Add/Insert Recommended Assessments	Recommended Assessments saved to Subj Notes tab	3

Special Features

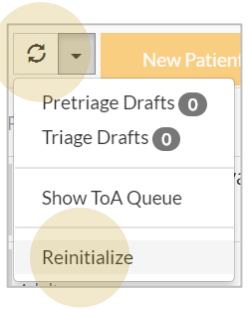
- ✓ Triage In Progress
- ✓ Copy Assessments & Notes
- ✓ Recommended Assessments

Troubleshooting, Downtime & Errors

- Self-Help
- ‘Sync Error’ Messages
- Downtime Contingency
- Clinical Documentation Errors
- Mark a Record as Triaged in Error

eCTAS Screens not updating as expected

Queues not syncing between different computers?



Options:

- Click on the **Refresh** button
- Press **Ctrl + F5** on keyboard
- If necessary, select **Reinitialize**

Important: Reinitializing will delete Drafts on the computer being used.

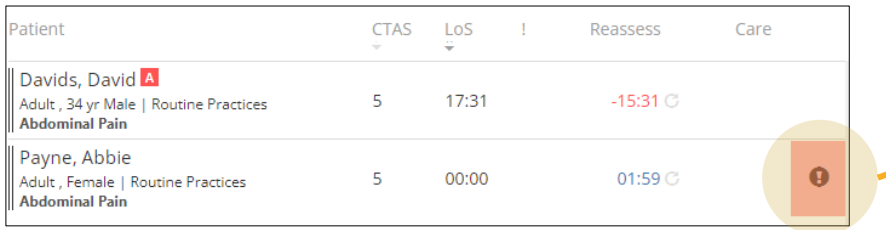
- Check the Status Page for communication about unexpected downtimes

Tip: Review the Troubleshooting and Support Contacts sections of the Online Help.

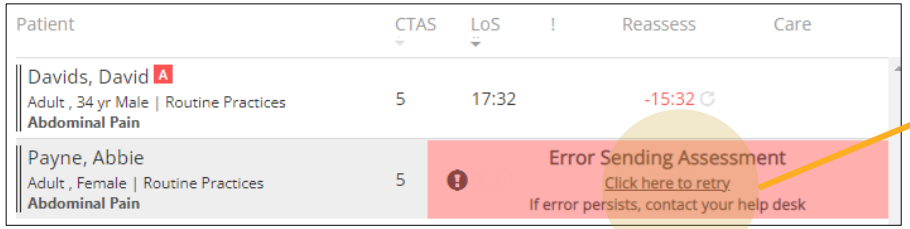
Note: If you have issues when **logging in to eCTAS**, it may be related to cookies. Try clearing your browser cache by pressing **Ctrl + Shift + Del** on your keyboard.

What to do if Sync Errors Alert Appears

Sync Error means the record is not saving to Ontario Health



A visual indicator will appear on the queue where a patient's Pretriage, Triage Assessment, Reassessment, or TOA, **fails to save**

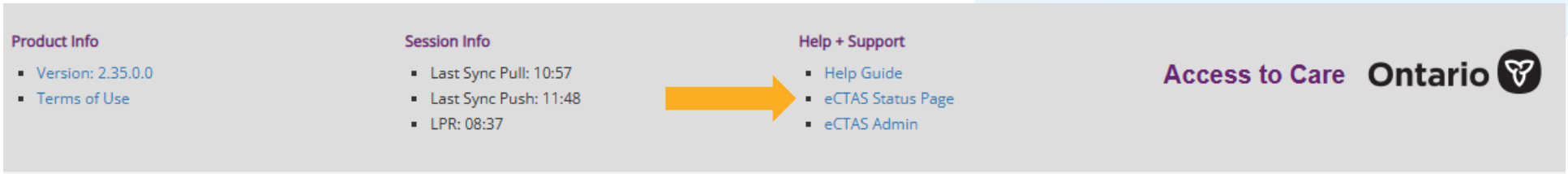


Try to save again by clicking on the error message.

Note: If the issue persists, your hospital eCTAS may be offline. Offline means eCTAS information is only being saved on your computer; it is not being synced to Ontario Health or your HIS – i.e., other computers will not display your entries. **Contact your Help Desk**.

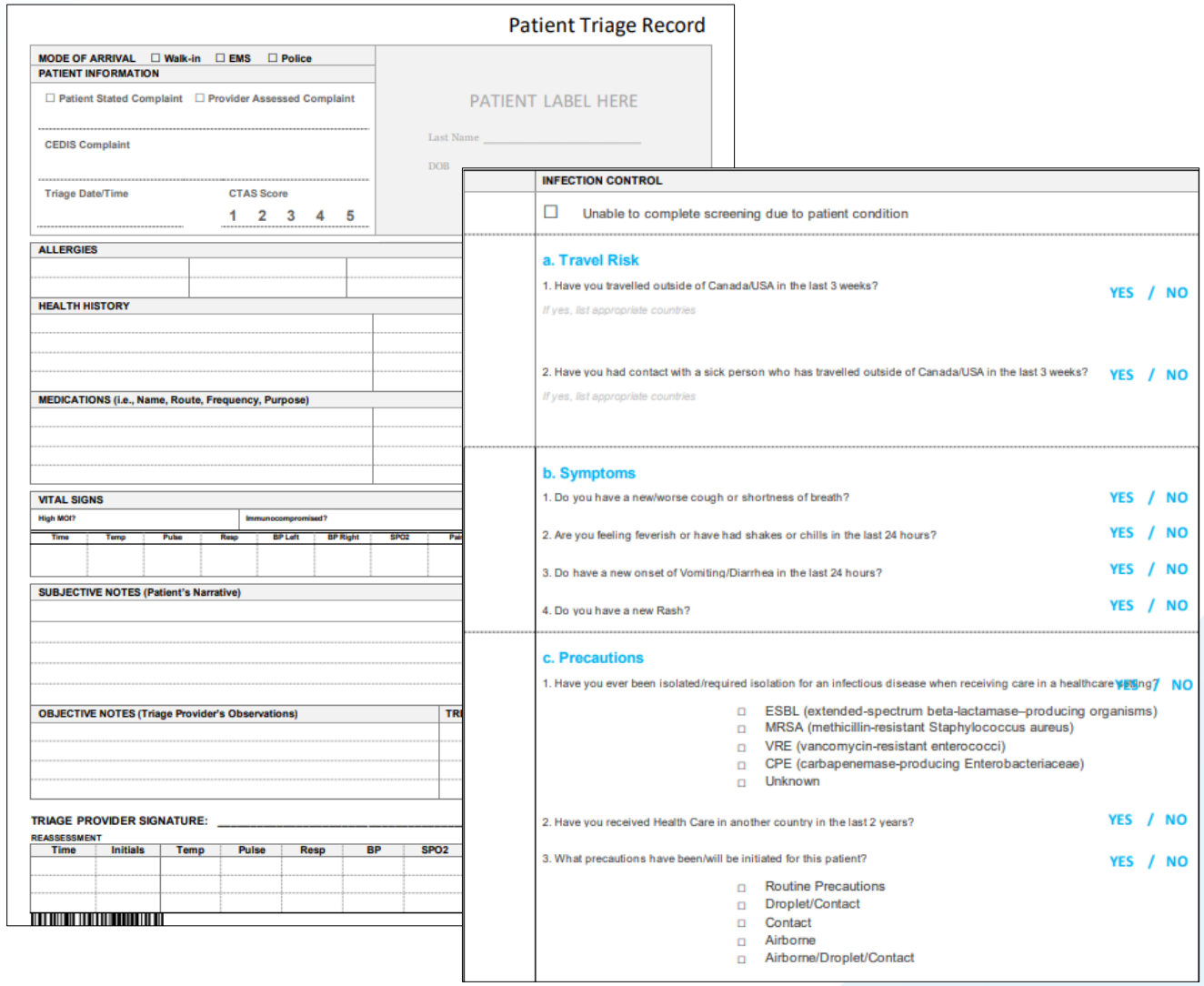
Downtime Contingency

- If your Hospital Help Desk confirms eCTAS or your HIS is down, start your downtime protocols
- Downtime protocols will vary based on each facility's unique workflow and configuration
- Switch to paper triage if it is part of your downtime protocol **or** stay logged in and continue to use eCTAS
- If you stay logged in, data that you entered will sync and update patient queues when connectivity is restored
- Check **eCTAS Status Page** for downtime recovery:



Note: Hospitals eCTAS Leads may leverage and **post** Quick Reference Poster located on the ATC Information Site.

eCTAS Backup Triage Assessment Form



Patient Triage Record

MODE OF ARRIVAL ☐ Walk-in ☐ EMS ☐ Police

PATIENT INFORMATION

☐ Patient Stated Complaint ☐ Provider Assessed Complaint

CEDIS Complaint

Triage Date/Time

CTAS Score 1 2 3 4 5

PATIENT LABEL HERE

Last Name

DOB

ALLERGIES

HEALTH HISTORY

MEDICATIONS (i.e., Name, Route, Frequency, Purpose)

VITAL SIGNS

High MOI? Immunocompromised?

Time | Temp | Pulse | Resp | BP Left | BP Right | SPO2

SUBJECTIVE NOTES (Patient's Narrative)

OBJECTIVE NOTES (Triage Provider's Observations)

TRIAGE PROVIDER SIGNATURE:

REASSESSMENT

Time | Initials | Temp | Pulse | Resp | BP | SPO2

INFECTION CONTROL

☐ Unable to complete screening due to patient condition

a. Travel Risk

1. Have you travelled outside of Canada/USA in the last 3 weeks? YES / NO

If yes, list appropriate countries

2. Have you had contact with a sick person who has travelled outside of Canada/USA in the last 3 weeks? YES / NO

If yes, list appropriate countries

b. Symptoms

1. Do you have a new/worse cough or shortness of breath? YES / NO

2. Are you feeling feverish or have had shakes or chills in the last 24 hours? YES / NO

3. Do have a new onset of Vomiting/Diarrhea in the last 24 hours? YES / NO

4. Do you have a new Rash? YES / NO

c. Precautions

1. Have you ever been isolated/required isolation for an infectious disease when receiving care in a healthcare setting? YES / NO

- ☐ ESBL (extended-spectrum beta-lactamase–producing organisms)
- ☐ MRSA (methicillin-resistant Staphylococcus aureus)
- ☐ VRE (vancomycin-resistant enterococci)
- ☐ CPE (carbapenemase-producing Enterobacteriaceae)
- ☐ Unknown

2. Have you received Health Care in another country in the last 2 years? YES / NO

3. What precautions have been/will be initiated for this patient? YES / NO

- ☐ Routine Precautions
- ☐ Droplet/Contact
- ☐ Contact
- ☐ Airborne
- ☐ Airborne/Droplet/Contact

- During eCTAS downtimes, Ontario Health recommends using the 2-page paper eCTAS Backup Triage Assessment Form
- Available in the eCTAS Online Help
- No special access required
- Hospitals have the option to use their own form

Clinical Documentation Errors

- Hospitals must establish clear processes for correcting clinical documentation errors that occur within the correct patient record.
- Guidance on handling Clinical Documentation Errors can be found in the Online Help
  - For example: If you receive patients in an HIS (e.g., Meditech/Expanse), clinical documentation errors (allergies, meds, med history, notes, vital signs) must be corrected in your HIS
- If your clinical documentation error involves a potential privacy breach, or a patient triaged under incorrect identifiers, refer to the processes for reporting privacy breaches, and reporting a visit triaged under incorrect patient

Mark Record as Triaged in Error

Nurses should mark a patient record as triaged in error when:

- A Triage Nurse submits a triage assessment under an incorrect patient name (i.e. the Triage Nurse entered triage information for Patient A under Patient B)
- A Triage Nurse accidentally logs into the incorrect site and begins triaging patients

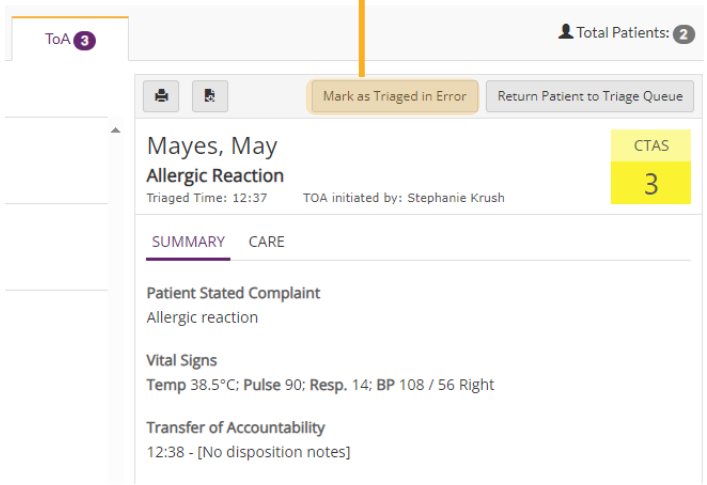
Note: a Nurse can only mark their own triage as triaged in error

Important: If the error constitutes a privacy breach (e.g. a Triage Nurse working at more than one site accidentally logs into the incorrect site and begins triaging patients) notify your Privacy Officer and eCTAS Coordinator immediately and follow the process for reporting privacy breaches.

Mark Record as Triaged in Error

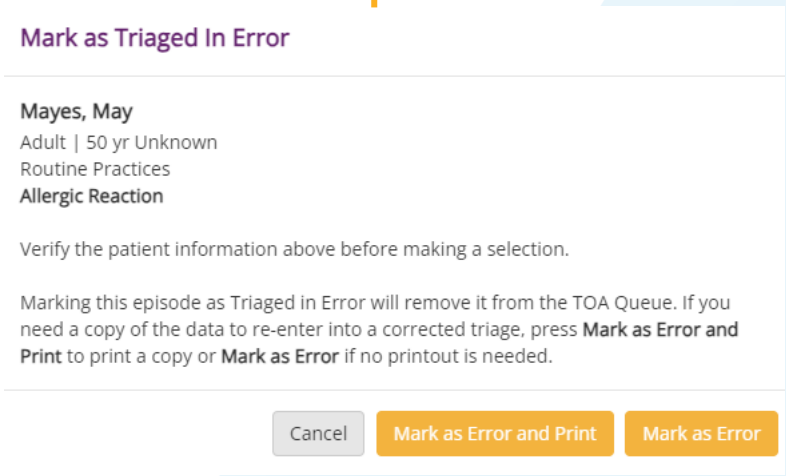
- Nurses can mark episodes as triaged in error from the TOA queue within the Clinical Application

1. Click on the **Mark as Triaged in Error** button

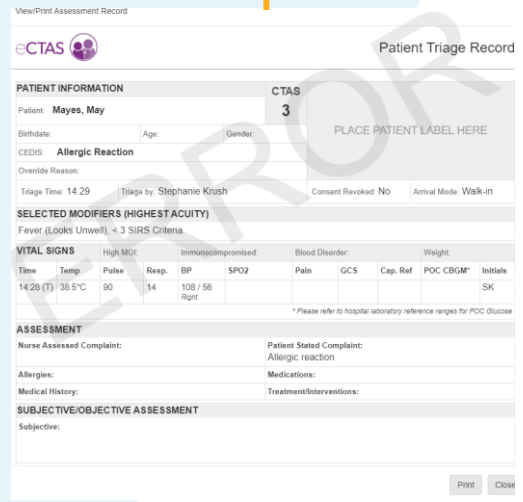


2. A pop-up will appear where the Nurse can:

- Cancel
- Mark as Error and Print
- Mark as Error



Note: If information documented in the record needs to be transcribed into a new triage the Nurse may choose to print the record



Note: Other designated resources can mark a record as triaged in error through the Administration Console. More information can be found on the System Administrator Section under Past Record Lookup within Registration View.

Triage Errors Training Video: Self-directed

Trainers and eCTAS users can access the video via:

- Online Help icon within eCTAS → Training Videos section → ‘Triage Errors Training’ or…
- eCTAS Triage Errors Basic and Complex

Troubleshooting, Downtime & Errors

- ✓ Self-Help
- ✓ ‘Sync Error’ Messages
- ✓ Downtime
- ✓ Clinical Documentation Errors
- ✓ Mark a Record as Triaged in Error

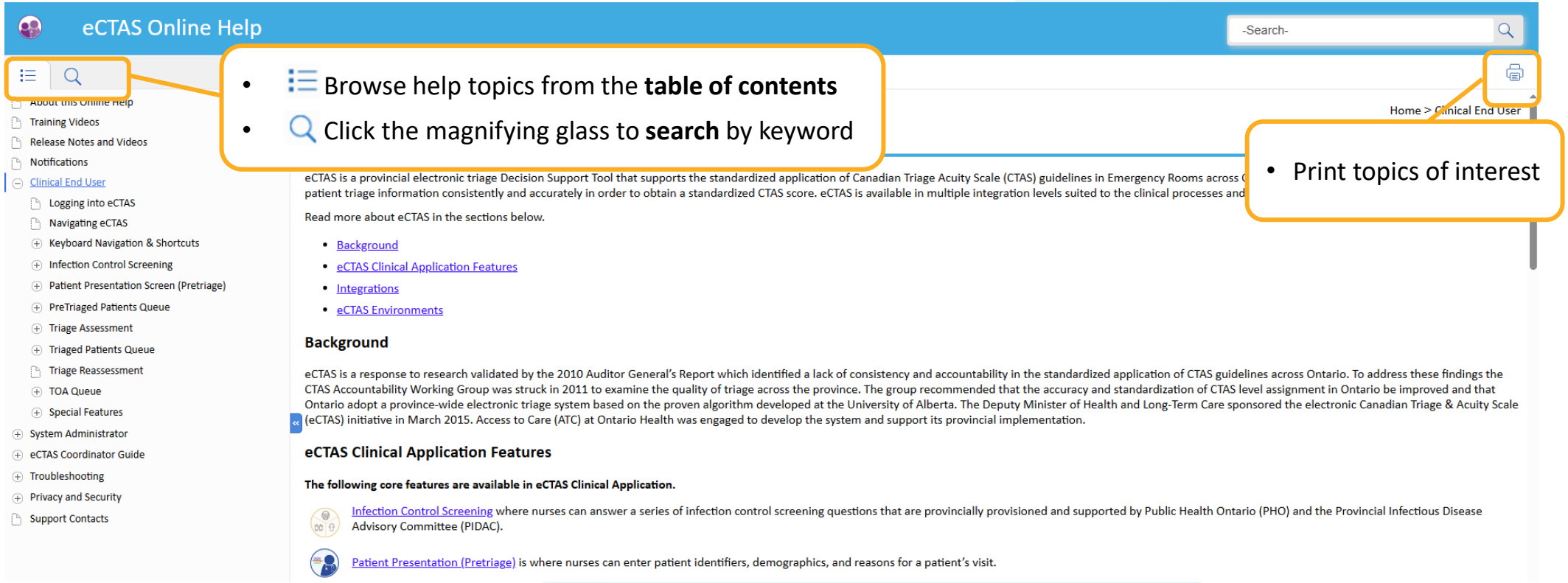
Resources

eCTAS Clinical End User Online Help

DEMO

Click on the question mark icon in the eCTAS Clinical Application

Visit the eCTAS Online Help URL: https://help.accesstocare.on.ca/helpfiles/eCTASOnlineHelp



Questions

We are happy to answer your questions

Thank You