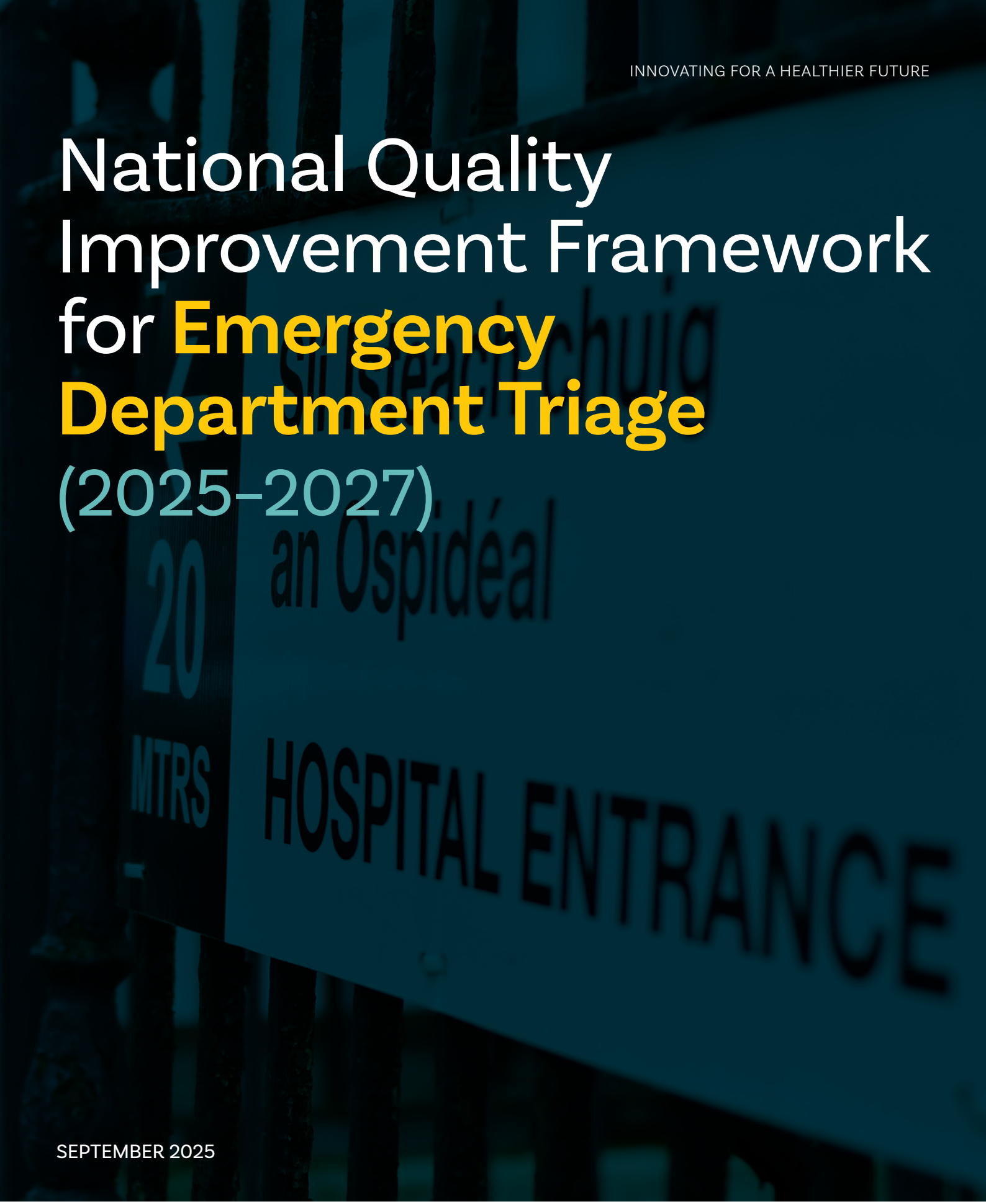
INNOVATING FOR A HEALTHIER FUTURE

National Quality Improvement Framework for Emergency Department Triage (2025–2027)



SEPTEMBER 2025

RCSI
EMERGENCY MEDICINE
HSE

Contents

Foreword

Emergency Departments (EDs) across Ireland are facing ongoing challenges including high levels of attendances, aging populations and increasing complexity of presentations. Maintaining high quality, safe patient care within this environment is a key priority for the health service.

The findings from the Report of Former Chief Justice Mr. Justice Frank Clarke (Clarke Report) identified key themes for improving patient safety. These included the importance of patient flow / escalation management, the ongoing monitoring of patients to identify deterioration, sepsis management and supporting the implementation and oversight of the Framework for Safe Nurse Staffing and Skill Mix. Three recommendations also made specific reference to the need to review and optimise the use of triage within our EDs.

Through the work completed by the Clarke Report Implementation governance structures in conjunction with the Emergency Medicine Programme (EMP) and other key stakeholders, the National Quality Improvement Framework for Emergency Department Triage (2025–2027) has been developed. The implementation of this framework will facilitate expedited identification and management of the most acutely unwell patients to optimise the flow of patients through the ED. The improvement initiatives outlined as part of this framework will be implemented across each Health Region and their impact will be overseen through the mandated monitoring and management of triage key performance indications (KPIs) through Unscheduled Emergency Care governance structures.

Meeting the current and future challenges of unscheduled and emergency care is multi-faceted and ever-evolving. I wish to acknowledge the ongoing hard work and dedication of our health service personnel and the wide-ranging stakeholder consultation that contributed to the development of this framework. I welcome its publication and the anticipated contribution to improving patient safety and quality of care.

Dr. Colm Henry

Chief Clinical Officer, Health Service Executive, Ireland

List of Abbreviations

AFIS	Acute Floor Information System
AMU	Acute Medical Unit
AMAU	Acute Medial Assessment Unit
ASAU	Acute Surgical Assessment Unit
BIU	Business Intelligence Unit
CCF	Congestive Cardiac Failure
CCO	Chief Clinical Officer
COPD	Chronic Obstructive Pulmonary Disease
CEMEWS	Children's Emergency Medicine Early Warning Score
DoH	Department of Health
ECG	Electrocardiogram
ED	Emergency Department
EHR	Electronic Healthcare Record
EM	Emergency Medicine
EMEWS	Emergency Medicine Early Warning System
EMP	Emergency Medicine Programme
ENT	Ear, Nose and Throat
FFD	Frailty at the Front Door
GP	General Practitioner
GIRFT	Getting It Right First Time
HCA	Health Care Assistant
HSCP	Health and Social Care Professional
HSTOP	Hospital Specialist Teams for Older People
HSE	Health Service Executive
IHI	Institute for Healthcare Improvement
ICT	Information and Communications Technology
ICTS	Information and Communications Technology System
IPC	Infection Prevention and Control
iPMS	National Integrated Patient Management System
IT	Information Technology
IU	Injury Unit
IV	Intravenous
KPI	Key Performance Indicator
MDT	Multi-Disciplinary Team
MTS	Manchester Triage System
NCCA	National Centre for Clinical Audit
NHS	National Health Service
OT	Occupational Therapy
PAU	Paediatric Assessment Unit
PDSA	Plan-Do-Study-Act
POC	Point-of-Care
QIP	Quality Improvement Programme
RAT	Rapid Assessment and Treatment
REO	Regional Executive Officer
RN	Registered Nurse
SIFT	Senior Intervention Following Triage
SMART	Specific, Measurable, Achievable, Relevant, and Time-bound
SOP	Standard Operating Procedure
SSKIN	Skin integrity principles: Skin assessment, Surface, Keep moving, Incontinence, Nutrition
SUS	System Usability Scale
SVUH	St Vincent's University Hospital
SWAT	Swift Assessment and Treatment

Executive Summary

The National Emergency Department Triage Quality Improvement Programme (Triage QIP) is a system-wide initiative developed in response to issues identified by frontline staff, working groups established by the Emergency Medicine Programme, and the findings of the Report of former Chief Justice Mr Frank Clarke SC.

These issues include excessive waiting times for triage, scope creep within triage, inconsistent streaming practices, and the lack of coordinated post-triage care. The QIP sets out a strategy to restore triage to its core function of prioritisation of relative clinical urgency for patients undergoing triage, while building the supporting infrastructure required to deliver diagnostics, therapeutic interventions and other appropriate assessments as soon as possible after triage.

This document provides a comprehensive framework for local, regional, and national implementation of the Triage QIP. It outlines actionable deliverables—such as the introduction of a "Just Triage" policy, establishment of post-triage care zones and deployment of digital self-registration—and defines roles, responsibilities, and timelines across all levels of the healthcare system. The QIP also introduces a tiered action framework (Must Do, Should Do, Could Do) to guide Emergency Departments in phased and prioritised implementation.

Through improved governance, standardisation, and multidisciplinary care, this programme aims to support safer, faster and more equitable delivery of emergency care across Ireland through a set of clearly defined initiatives. Central to this is the return of triage to its core purpose.

This document outlines the key deliverables of the Triage QIP and explains how these will be achieved at the local, regional, and national levels.

1. Introduction

The Triage Quality Improvement Framework has been developed to support the roll out of standardised quality improvement initiatives for the triage process across Emergency Departments (EDs) in Ireland. It has been developed in response to the challenges faced by EDs in the provision of consistent, high-quality care to patients and in meeting triage-related KPIs. High level analysis of data provided by the Emergency Medicine Programme (EMP) showed that 93% of acute hospitals did not meet the 'Time to Triage' KPI (average <15 minutes from time of registration to triage) between January-October 2024.

An appetite for change has been expressed by ED staff during recent EMP site visits, the Triage Quality Improvement Sprint held by the EMP in March 2025 and in other emergency care fora. The Triage Quality Improvement Framework will also address recommendations from the report of former Chief Justice Mr Frank Clarke SC. Given the recent establishment of the 6 HSE Health Regions, it is vital to implement these changes in a nationally guided, standardised way to ensure equity of access to high-quality emergency care for all patients across Ireland.

The initiatives prioritised within the Framework have been developed from the 'It's About Time' (2022) document, international best practice and examples of the application of these initiatives within the Irish healthcare system. The initiatives have been prioritised by EMP and other subject matter experts, based on potential impact and ease of implementation.

The Framework identifies elements of care that are classified as 'must haves', 'should haves' and 'could haves'. 'Must haves' are standards that are essential and the minimum standard with which all EDs should comply. The introduction of 'should haves' represents an ED progressing to align their care to best practice standards. 'Could haves' are elements that, whilst not required, may assist EDs in improving patient experience.

2. Quality Improvement Initiatives in the Triage Process

2.1 Pre-Triage

Objectives:

- Minimise time to triage
- Identify opportunities for early diversion or streaming of patients presenting to ED to equally or more appropriate settings to meet their care needs.

2.1.1. Introduction

A quality improvement focus on the pre-triage process will expedite the flow of patients to triage, reduce the number of patients being triaged unnecessarily and reduce waiting time for registration and from registration to triage.

KEY INITIATIVES INCLUDE:

Digitally Enabled Self-Registration

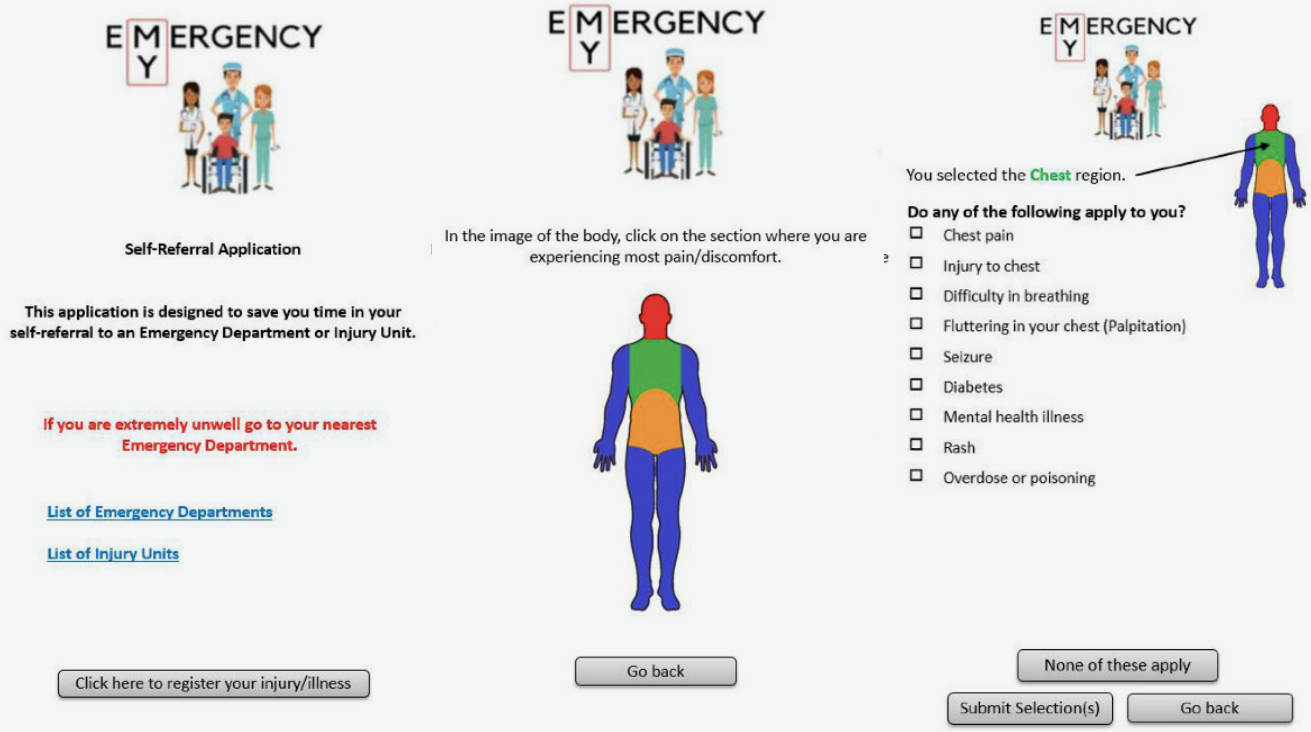
Currently, registration is performed by clerical staff—a process that takes several minutes for each patient. During busy periods, this can results in long queues for registration.

The introduction of digitally enabled self-registration offers a significant opportunity to improve patient experience in EDs. Enabling people to self-register or pre-register could significantly reduce waiting times from arrival to triage.

Patients who self-register will activate their registration upon arrival at the ED, bypassing queues and enabling clerical staff to focus on those who require additional support. This approach reduces delays, improves patient privacy and flow while reducing inaccuracies (administration, spelling errors etc).

Promoting Self-Registration in the Emergency Department: MyEmergency

A Digital Innovation for Smarter Care



In response to the increasing demand for emergency services and prolonged waiting times, a digital self-registration system was developed as part of a project to streamline the intake process for patients with non-urgent needs. Co-designed with patients, this system empowered individuals to assess their symptoms through a guided triage interface that highlights red flag indicators requiring immediate care. If no red flags are present, users proceeded to a self-registration screen where they input demographic and clinical information, selecting their preferred ED or Injury Unit (IU).

The innovation allowed ED clinical staff to receive real-time referrals via a dashboard, enabling early review and potential redirection to more appropriate care settings, such as General Practitioners (GPs) or alternate units. This it is hoped, not only reduces unnecessary ED visits but enhances clinical efficiency by prioritising truly urgent cases.

In trials, the system reduced self-registration time to a median of 4.18 minutes—halving the time of traditional methods. User satisfaction was high, with 94.6% of participants believing it shortened their ED journey and expressing willingness to use it again. With an excellent System Usability Scale (SUS) score of 80.5, the pilot project supports wider implementation. This initiative demonstrates the potential of digital solutions to improve access, patient flow, and resource allocation across Ireland's emergency care facilities.

Streaming

Streaming is a rapid, low-touch clinical assessment designed to identify patients who can be safely directed to an alternative lower-acuity pathway of care without formal triage. It is particularly suitable for healthy individuals without significant comorbidities who have a straightforward issue—such as an uncomplicated limb injury—who may be more appropriately managed in an IU or through an Ambulatory Emergency Care pathway.

Streaming may also apply to patients who have already been clinically assessed by their GP and referred directly to Acute Medical Assessment Unit (AMAU). These patients can be streamed directly to the appropriate specialty service.

Streaming involves a brief clinical interaction—typically asking about the presenting complaint and identifying any red flags or comorbidities—to inform the next steps. It reduces waiting times for triage, limits duplication of assessments and decreases clinical risk.

For streaming to be safe and effective, it should be:

- Undertaken by trained clinical staff, typically a nurse.
- Be performed in a dedicated space with adequate privacy.
- Backed by clear protocols and governance structures.
- Ideally integrated with other rapid assessment processes such as Infection Prevention and Control (IPC) screening, though operational challenges may limit this in practice.

Pre-triage Streaming

St Lukes Hospital Kilkenny

Since its implementation, the pre-triage streaming of patients with a GP referral letter at St. Luke's General Hospital Kilkenny has significantly improved patient flow and efficiency. Patients presenting with appropriate conditions are directed straight to the IU, Acute Medical Unit (AMU), or Paediatric Assessment Unit (PAU)—ensuring they are seen in the right place, at the right time, by the right team.

This approach eliminates unnecessary duplication of assessment, reduces pressure on ED triage, and maximises the use of co-located specialist units. For example, patients with minor injuries referred by their GP bypass ED reception and triage entirely, attending the IU directly. Similarly, medical and paediatric cases are streamed appropriately based on clinical need and referral information.

Staff report smoother workflows, better utilisation of resources, and—critically—no safety concerns have been identified since the pathway's inception. The system supports rapid, direct access to specialist care and maintains high patient safety standards, while providing a more efficient, patient-centred experience. Overall, this initiative reflects a collaborative commitment to smart streaming and safe, timely care.

2.1.2 Pre-Triage Must Have/Should Have/Could Have

ID/No.	Description	Rationale	Dependencies	Action Owner
Must Have				
PT1	Streaming at registration	Prevents unnecessary triage, faster redirection to suitable care (e.g. Injury Unit, AMAU, surgical day ward, ENT clinic)	SOPs that link local and regional infrastructure to allow streaming from reception.	Local/Regional
Should Have				
PT2	Public & GP Awareness Campaign	Clarifies what happens in ED, sets realistic expectations	HSE/DOH collaboration, media strategy	National- HSE Comms
PT3	Self-Registration	Reduces queues, improves privacy, allows for multilingual input	EHR procurement, EHR vendor & associated toolset procured	Emergency Medicine Programme
PT4	Pre-registration for patients arriving by ambulance with certain defined conditions e.g. stroke, trauma	Ensures rapid access to diagnostics and to interventions	Administration, fidelity of prehospital information, defined merging process for those with temporary name	Local
Could Have				
PT5	Clinician-staffed virtual streaming hubs at regional level	Diversion of patients to most ap-propriate pathway, access point for advice for community providers	Staffing, mapping regional versus national needs.	Regional

2.2 Triage

Objectives:

- Deliver rapid, safe clinical prioritisation
- Clarify scope of triage
- Alleviate triage burden

2.2.1 Introduction

Triage

Triage is a system of clinical risk management used in EDs to safely prioritise patients when demand exceeds capacity. Its primary function is to ensure that the sickest patients are identified and treated first. In Ireland, this is typically carried out by experienced nurses using validated systems such as the Manchester Triage System and the Irish Children's Triage System.

However, due to long waiting times and persistent overcrowding, the triage process has evolved beyond its original purpose. In many EDs, triage has expanded to other non-triage tasks such as providing analgesia, administering medication, initiating investigations, care planning, and screening have been incorporated into triage. This practice significantly increases the time spent in triage and prolongs the time to triage for all patients.

To address this drift from "just triage", the Triage QIP proposes restoring triage to its core function—rapid prioritisation only—by shifting all additional tasks to a well-resourced and standardised Post-Triage Phase of Care.

2.2.2 Triage Must Have/Should Have/Could Have

ID/No.	Description	Rationale	Dependencies	Action Owner
Must Have				
T1	"Just Triage" Policy	Clarifies scope and reduces time to triage. Policy should be that only the actions required by MTS or ICTS are included in triage activity	SOPs, post-triage care bundle availability	Regional responsibility for implementation – acknowledgement that local site-level adaptation required
T2	Mechanism to measure Triage KPI	Triage KPI is time from completion of registration to time to commencement of triage, with target 15 minutes. This is collected in a number of ways nationally compromising data reliability about time taken to triage	Process map for electronic data needs to be clear on each site with capability to reliably measure these time points.	
Should Have				
T3	Pathways for deferred/ scheduled care within local network	Patients with defined conditions should be placed on pathways of care, including deferred care in the ED scheduled care for specialist review or referral to appropriate acute pathways from the ED	Clear governance at local level for pathways.	Local/Regional
Could Have				
T4	HCA to support triage	Takes vitals, reduces RN burden	Staffing and training, HCA skillset	Local/Regional
T5	Triage support from senior clinical decision maker for complex patients and/or for high volume EDs at peak times	This would operate in parallel to triage and allow a number of actions including: A see and treat policy or access to alternative pathways. e.g. SIFT, RAT, SWAT	Staffing, availability senior clinical decision maker	Local/Regional

ID/No.	Description	Rationale	Dependencies	Action Owner
Must Have				
T1	"Just Triage" Policy	Clarifies scope and reduces time to triage. Policy should be that only the actions required by MTS or ICTS are included in triage activity	SOPs, post-triage care bundle availability	Regional responsibility for implementation – acknowledgement that local site-level adaptation required
T2	Mechanism to measure Triage KPI	Triage KPI is time from completion of registration to time to commencement of triage, with target 15 minutes. This is collected in a number of ways nationally compromising data reliability about time taken to triage	Process map for electronic data needs to be clear on each site with capability to reliably measure these time points.	
Should Have				
T3	Pathways for deferred/ scheduled care within local network	Patients with defined conditions should be placed on pathways of care, including deferred care in the ED scheduled care for specialist review or referral to appropriate acute pathways from the ED	Clear governance at local level for pathways.	Local/Regional
Could Have				
T4	HCA to support triage	Takes vitals, reduces RN burden	Staffing and training, HCA skillset	Local/Regional
T5	Triage support from senior clinical decision maker for complex patients and/or for high volume EDs at peak times	This would operate in parallel to triage and allow a number of actions including: A see and treat policy or access to alternative pathways. e.g. SIFT, RAT, SWAT	Staffing, availability senior clinical decision maker	Local/Regional

2.3 Post Triage Phase of Care

Objectives:

- Ensure rapid initiation of care bundles
- Keep triage as "just triage"
- Reduce clinical risk in waiting areas

2.3.1 Introduction

OPTIMISING THE POST-TRIAGE PHASE OF CARE

The Post-Triage Phase of Care refers to the period immediately after triage, when structured assessments and interventions appropriate to the individual patient begin. This phase replaces the traditional consecutive care model with a parallel assessment approach, enabling members of the multidisciplinary team (MDT) to provide interventions appropriate to their skill set without having to wait for the patient to be assessed by a doctor. Simultaneously, this accelerates decision-making—particularly regarding the likelihood of admission—and reduces delays in care. It is critical to maintaining the integrity of a "Just Triage" model by shifting all additional clinical tasks out of triage and into a structured, well-resourced follow-up process.

During this phase, a range of targeted interventions can be initiated, including:

1. Care Bundles and Early Intervention

Standardised care bundles should be initiated for common clinical presentations such as:

- Sepsis, Vomiting, Bronchiolitis, Asthma, Chronic Obstructive Pulmonary Disease (COPD), Syncope, Falls, Delirium, Seizures, Chest pain, Hip fractures, Major trauma etc.
- These bundles follow nationally agreed protocols and may include delegated drug prescribing approved at Health Regions level. Their initiation in the post triage phase expedites treatment and reduces duplication.

2. Clinical Screening and Diagnostics

Key screening and early interventions for individual patients should begin as soon as they enter the post-triage zone. *Examples of this include:*

- **Clinical Screening** for conditions such as frailty, delirium, domestic violence, or transmissible infections
- **Emergency Medicine Early Warning Score (EMEWS)** monitoring for early detection of clinical deterioration (Children's post triage monitoring via the Childrens EMEWS once available would also be initiated in this space.
- **Early Diagnostic**s delivered by Health Care Assistant (HCAs) with extended scope of practice, or by other support staff (e.g. Multitask attendants, EM technicians, Phlebotomists), with senior decision maker oversight
- Use of tools such as pain assessments, falls, Intravenous (IV) cannula bundles, skin integrity (SSKIN), urinary catheter care bundles.

3. Parallel Assessment by the Multidisciplinary Team

Parallel involvement of health and social care professionals (HSCPs) for particular patients supports early identification of complex needs and appropriate pathways. *This includes:*

- Mental health professionals (using the Post-Triage Mental Health Triage Tool)
- Physiotherapists, occupational therapists, and social workers
- Alcohol liaison teams
- Frailty at the Front Door (FFD) teams or Hospital Specialist Teams for Older People (HSTOP), where available

4. Frailty Screening

Frailty screening is a key element of post-triage care, especially in older adults. It should be regarded as everyone's responsibility and embedded in ED culture. Screening tools help identify patients at risk, guiding timely referral to embedded frailty teams or triggering follow-up with community-based services if available and appropriate for the individual patient.

- **Parallel Assessment** by Health and Social Care Professionals (HSCPs) such as physiotherapists, social workers, or mental health clinicians and relevant medical specialties.
- **Referral Bundles**, designed to efficiently direct patients to the most appropriate service, reducing duplication and delays.

This coordinated, multidisciplinary approach ensures timely care delivery, enhances patient flow, and preserves the triage function as a rapid, prioritisation-only step in the emergency care pathway

Pitstop: A Rapid Assessment Model

Pitstop was a front-door rapid assessment model piloted in the ED at St. Vincent's University Hospital (SVUH). It was designed to expedite care for acutely unwell patients who did not meet the threshold for resuscitation but required urgent assessment and intervention. The model facilitated early clinical assessments—including vital signs, Electrocardiogram (ECGs), bloods, and IV access—immediately on arrival, often before a team was available. This approach supported faster clinical decision-making, earlier interventions (such as antibiotics for sepsis), and improved overall patient flow. Once stabilised and worked up, patients were transferred to their assigned nursing team.

The pilot was well received by staff. Doctors reported that patients arrived at their care areas already assessed and partially worked up, enabling quicker diagnoses and fewer delays. Nurses and HCAs highlighted reduced waiting times, faster access to analgesia, and fewer interruptions to team workflows, as Pitstop allowed them to continue their tasks without having to pause for initial assessments. Paramedics also valued the streamlined handover process and quicker turnaround during busy periods.

Audit data confirmed Pitstop's impact, showing significantly reduced times to assessment, ECG, and blood tests compared to out-of-hours care. Time to antibiotics was also improved.

Although the pilot has concluded, staff expressed strong support for reinstating, with suggestions including 24/7 operation, and additional Pitstop bays. Despite some logistical challenges, the model was widely regarded as a high-value innovation that improved safety, efficiency, and patient-centred care

2.3.2 Post-Triage Must Have/Should Have/Could Have

ID/No.	Description	Rationale	Dependencies	Action Owner
Must Have				
PTJ1	Implement EMEWS*	Enables early identification and escalation of care for deteriorating patients at triage; supports timely intervention and improves patient outcomes.	Staff training; Staff availability; escalation pathways aligned to EMEWS protocols.	Local / Regional
PTJ2	Dedicated Post-Triage Clinical workflow	Provides clear plan for how initiation of tests/care is commenced in an ED	Identify location where nursing/post triage assessment occurs	Local / Regional
PTJ3	Identified nurse to provide care, initiate treatment/bundles of care	Consistency of approach, clear role delineation on shift, clarity of responsibility	Workforce availability, clinical governance	Local/ Regional
PTJ4	Referral & care bundles for common presentations (sepsis, asthma, COPD, CCF, vomiting, febrile illness, frailty, falls, hip fractures)	Allows initiation of national guidelines at an early stage in patient journey and in a reliable way.	Clear clinical governance	Local
PTJ5	Post-Triage MDT Parallel Assessment	Allows physio, OT, mental health, social care to start care early, identify additional needs	Workforce availability, governance	Local
Should Have				
PTJ6	Dedicated Post-Triage Clinical Zone	For higher volume sites* Provides safe holding area with capacity to initiate tests/care	Physical space, infrastructure available, equipment	Local
PTJ7	HCA support to maintain flow and ensure timely implementation of elements of care	For higher volume sites* Ensure early approach to comprehensive nursing assessment, initiation of investigations and preparation for further investigations (place in gown for radiography etc.)	Workforce availability, governance, HCA skill set	Local
PTJ8	Early initiation of investigations	POC testing and phlebotomy in post-triage zone, use of agreed radiology pathways	Workforce availability, balance with Green EM and sustainability objectives	Local
Could Have				
PTJ9	Senior Decision-Maker available at peak times in Post-Triage Area	For higher volume sites* Expedites diagnosis, treatment, and discharge	Consultant staffing model	Local/ Regional

** Note: Children's Emergency Medicine Early Warning Score (CEMEWS) is also in development*

3. Audit and Measurement

3.1 Purpose of Audit in the QIP

A core element of this QIP is the consistent measurement and monitoring of triage performance to ensure safety, equity, efficiency, and system accountability across all EDs in Ireland.

The audit framework is designed to:

- Provide real-time visibility of triage and flow challenges
- Enable early intervention when standards are not being met
- Drive continuous quality improvement at local, regional, and national levels
- Support data-informed resource planning and staffing models
- Foster a culture of clinical governance, transparency, and shared learning

KPIs should be monitored at least weekly in each ED, with monthly reporting to Health Regions. National visibility of these should also be present via BIU to inform service planning and performance review.

3.2 Key Performance Indicators (KPIs)

KPI	Definition	Why It Matters		Demonstration
Implement EMEWS*	Enables early identification and escalation of care for deteriorating patients at triage; supports timely intervention and improves patient outcomes.	Enables early identification and escalation of care for deteriorating patients at triage; supports timely intervention and improves patient outcomes.	Must	Regular Audit
Mean and variance of triage duration	Measures the average time to complete triage per patient, with variation range	Helps assess workflow efficiency and identifies issues like scope creep or delays due to documentation or tech limitations	Must	Reportable daily - BIU
% of patients streamed before triage	Tracks effectiveness of pre-triage streaming/navigation hubs	A high percentage reflects successful early redirection to appropriate services, reducing ED congestion	Should	Regular Audit
% of patients diverted to a non-ED care pathway	Includes redirection to AMAU, ASAU, IU, GP out-of-hours, virtual care, etc.	Indicates system capacity to provide care in the most appropriate setting and manage demand safely	Should	Regular Audit
% of patients beginning post-triage care within 30 minutes of triage	Tracks initiation of diagnostics, care bundles or MDT input after triage	Ensures timely escalation or intervention, especially for moderate-acuity patients at risk of deterioration	Should	Regular Audit
Staff satisfaction and burnout metrics	Captured through standardised staff surveys	Serves as an early warning for workforce sustainability, especially in high-pressure areas like triage and post-triage	Could	Staff Survey

4. Implementation Plan

4.1 Local Implementation Plan

4.1.1 Objectives

- Reduce queuing for registration and time to triage.
- Restore clarity of scope of triage.
- Enable post-triage care initiation within 30 minutes.

4.1.2 Roles & Responsibilities

- ED Clinical Lead: Oversight of local implementation and weekly tacking of KPI performance
- Triage QIP Lead: Lead PDSA cycles, data collection, staff engagement.
- ED Admin Lead: Implement self-registration tools and support IT changes.
- HSCPs: Support parallel assessments in post-triage zones.

4.1.3 Timeline

- Q4 2025: Appoint QI leads; start weekly audits.
- Q4 2025: Reconfigure triage/post-triage spaces.
- Q2 2026: Begin delivery of care bundles and MDT support post-triage.

4.1.4 Monitoring & Evaluation

- Weekly KPI monitoring (% triaged <15 mins, mean and variance of triage duration).
- Monthly review by ED operational group.
- Continuous PDSA cycles for iterative improvement.

4.2 Regional Implementation Plan (REO/ Health Regions)

4.2.1 Objectives

- Enable streaming and re-direction at scale.
- Build regional infrastructure for care bundles, frailty, and mental health.
- Coordinate data collection standardisation across EDs.

4.2.2 Roles & Responsibilities

- Coordinate triage QIP activities across all Emergency Departments in the region
- Establish the necessary pathways to support the implementation of assigned actions.
- Oversight of each hospital's KPI performance through reporting cycle.

4.2.3 Timeline

- Q4 2025: Define regional SOPs for streaming and care bundles.

4.2.4 Monitoring & Evaluation

- Monthly KPI dashboard reports from EDs.
- Quarterly regional review meetings.
- Gap analysis across sites to support delivery.

4.3 National Implementation Plan (HSE)

4.3.1 Objectives

- Set national policy and clinical governance standards related to triage QIP
- Support equitable and phased rollout of QIP nationally.
- Oversee data reporting and communications plan.

4.3.2 Roles & Responsibilities

- **EMP National Lead:** QIP programme design, support and stakeholder engagement.
- **EMP: Work with relevant** HSE functions to deliver national registration and triage data platforms.
- **HSE Communications:** Coordinate national awareness campaigns.
- **Clinical Advisory Group EMP:** Maintain national standards for care bundles and triage.

4.3.3 Timeline

- Q3 2025: Publish national "Just Triage" Triage guidance and toolkit.
- Q1 2026: Launch national communications
- TBC: Self-registration rollout
- Q2 2026: Conduct first national KPI benchmarking review.

4.3.4 Monitoring & Evaluation

- National KPI dashboard published quarterly.
- Clinical Advisory Group EMP: to review policy, reported critical incidents and lessons learned.

4.4 QIP Methodology

How to Do Quality Improvement Projects (QIPs) in Healthcare: A General Overview

Quality Improvement Projects (QIPs) are structured, data-driven initiatives aimed at enhancing patient care, improving system performance, and fostering a culture of safety and learning. Whether focused on triage in the Emergency Department or other clinical processes, successful QIPs follow a consistent approach grounded in evidence-based improvement science.

Core Principles of Effective QI

- **Patient-centred focus:** QIPs must aim to improve patient outcomes, experiences, and safety. Success is judged from the perspective of those receiving care.
- **Data-driven decision-making:** Use baseline data to identify problems and track progress. Define specific metrics to evaluate success.
- **Frontline-led with leadership support:** Improvement is most effective when driven by the clinical teams closest to the issue, supported by senior management.
- **Continuous, not one-off:** QI should be embedded in the daily rhythm of clinical work, not treated as a stand-alone event.

The QI Process – Step by Step

1. **Define the Problem Clearly**
   - Use available data, audit findings, or staff/patient feedback.
   - Ensure the problem is within your team's influence to change.
2. **Assemble a QI Team**
   - Include a mix of roles (clinicians, nurses, admin, patients if appropriate).
   - Assign clear responsibilities and agree on a governance structure.
3. **Set an Aim**
   - Make it Specific, Measurable, Achievable, Relevant, and Time-bound (SMART).
   - Example: “Reduce the percentage of triage assessments taking longer than 15 minutes from 60% to 30% within 3 months.”
4. **Choose a Methodology**
   - The Model for Improvement and PDSA (Plan-Do-Study-Act) cycles are widely used.
   - Other tools include Lean, Six Sigma, and Clinical Microsystems.
5. **Measure Your Progress**
   - Identify process, outcome, and balancing measures.
   - Collect data regularly and analyse trends over time.
6. **Test and Implement Changes**
   - Start small. Try changes with one team or shift before scaling up.
   - Use PDSA cycles to learn what works.
7. **Review, Adapt, and Sustain**
   - Embed successful changes into practice (e.g., SOPs, training).
   - Share results and learning across the organisation.

Recommended QI Tools & Resources

- The Model for Improvement – Institute for Healthcare Improvement (IHI)
- PDSA Cycle Template – IHI PDSA Worksheet
- Clinical Microsystems Approach – The Dartmouth Institute
- Lean in Healthcare – NHS Improvement Guide to Lean
- HSE National Centre for Clinical Audit (Ireland) – NCCA QI and Audit Resources
- HSE Quality Improvement Team – QI Tools and e-learning

Common Pitfalls to Avoid

- Trying to fix too many things at once.
- Working without a clear aim or defined metrics.
- Not involving the people doing the work.
- Lack of leadership buy-in or protected time.
- Ignoring the need to monitor for unintended consequences.

Quality Improvement is a journey, not a destination. It is most successful when teams embrace small, manageable changes that are guided by data and rooted in a shared purpose to make care better for patients. With the right tools, support, and mindset, any team can lead meaningful improvement.

Conclusion

The Triage QIP represents a critical response to longstanding concerns regarding overcrowding, delayed care, and the expansion of the activities encapsulated in triage in Emergency Departments. It directly addresses recommendations from Former Chief Justice Clarke's review and integrates the insights of multiple clinical working groups convened through the National Emergency Medicine Programme.

By realigning triage to its original purpose, introducing post-triage care zones, enhancing streaming and redirection, and enabling digital tools such as self-registration, this QIP provides a scalable and practical roadmap for transformation.

Sustained Regional leadership supported by ongoing EMP engagement will be essential to drive the implementation of this initiative. The impact of this triage quality improvement framework will be evaluated through the 'must have' KPIs outlined above which will be monitored at Regional and National levels via unscheduled care governance structures on an ongoing basis. This QIP lays the foundation for a high-performing emergency care system built on clarity, consistency, and compassion.

The Triage QIP is a strategic, evidence-informed effort to ensure Ireland's EDs provide safe, timely, and equitable emergency care. By delivering on the key objectives of restoring triage to its core function, building effective post-triage systems, streamlining access via digital tools and regional coordination, this programme is a foundational step toward resilient and high-performing emergency services.

Appendix 1: ED-Level Action Framework

The following framework supports Emergency Departments in implementing the Triage QIP. Actions are categorised by priority:

Must Do (Critical to patient safety and QIP success)	
T1	Implement "Just Triage" policy to restore triage to its core function.
T2	Establish a reliable mechanism to measure and report Triage KPIs (e.g., time to triage from registration).
PT1	Introduce clinical streaming at registration with SOPs enabling safe redirection to AMAU, Injury Units, etc.
PTJ1	Implement EMEWS (Early Warning Score) at triage and post-triage to monitor deterioration.
PTJ2	Define and operationalise a dedicated post-triage clinical workflow.
PTJ3	Ensure each shift has an identified nurse responsible for initiating post-triage care.
PTJ4	Implement referral & care bundles for common conditions (e.g., sepsis, asthma, falls).
KPI	Audit and report core triage KPIs weekly, including: time to triage, triage duration, % triaged <15 minutes.
Governance	Appoint a local ED QIP Lead responsible for audits, PDSA cycles, and engagement.
Should Do (Recommended to optimise care and flow)	
PT4	Enable pre-registration for ambulance arrivals for certain high-acuity presentations (e.g., stroke).
T3	Develop deferred/scheduled care pathways (e.g., local specialty clinics or AMAU).
PTJ5	Implement parallel assessment by MDTs post-triage (HSCPs, mental health, frailty teams).
PTJ6	Create dedicated post-triage clinical zones for larger sites to enable early intervention.
PTJ7	Use HCA support to streamline vitals, positioning, and preparation for diagnostics.
PTJ8	Initiate diagnostics early (e.g., POC testing, phlebotomy, imaging) in post-triage areas.
KPI	Monitor: % of patients streamed before triage, % diverted to non-ED care, post-triage initiation time.
Could Do (Innovative, resource-dependent, future-focused)	
T4	Use HCAs to support triage by taking vitals
T5	Implement senior clinical decision-maker support at triage in high-volume settings (e.g., SIFT, SWAT).
PTJ9	Provide senior decision-maker availability in post-triage zone during peak hours.
Innovation	Pilot virtual waiting room triage or telehealth pre-assessment tools.
Patient Info	Introduce real-time queue visibility (online or onsite) to manage patient expectations.
Workforce	Monitor staff satisfaction and burnout using surveys to inform staffing decisions.

Appendix 2: Summary: National Clinical Audit of Emergency Department Triage (2023)

The HSE National Clinical Audit of Emergency Department Triage Report 2023, conducted jointly by the National Centre for Clinical Audit (NCCA) and the National Emergency Medicine Programme (EMP), provides a comprehensive evaluation of triage performance across Irish Emergency Departments. This audit is central to informing national QI efforts to improve safety, consistency, and efficiency in emergency care triage.

Key Focus Areas and Findings:

1. **Timeliness of Triage (Part I):**
   - National standard: 95% of patients should be triaged within 15 minutes.
   - Actual performance was significantly below this, with only **37%** triaged within 15 minutes during the day and **42%** at night.
   - Wide variability was observed between hospitals (range: 11–85%).
   - Paediatric (0–15) and older (75+) patients had higher timely triage rates than other age groups.
   - Arrival by helicopter or ambulance correlated with higher rates of timely triage.

2. **Acuity and Trending (Part II):**
   - 2022 triage data showed:
     - Category 1: 1%
     - Category 2: 22%
     - Category 3: 52%
     - Categories 4 & 5: 25% combined
   - A significant increase in Category 2 cases over recent years (from 10% to 22%) reflects evolving patient complexity, system pressures, and updates in triage guidance.
   - Monthly trends showed relative stability but noted a slight increase in Category 2 patients from September to December.

3. **Completeness and Accuracy (Part III):**
   - Audit of 2,245 cases assessed adherence to safe triage criteria:
     - Correct flowchart used: 93%
     - Correct discriminator selected: 73%
     - Correct triage category assigned: 81%
     - Pain score recorded where indicated: 64%
   - **Under-triage** occurred in 9% of cases; most\ commonly, Category 3 patients should have been Category 2.
   - **Over-triage** occurred in 10% of cases; predominantly Category 3 patients were assigned Category 2.
   - None of the safety criteria met the 95% audit standard.

4. **ICT and System Considerations:**
   - There are 5 different triage software platforms in use across sites (iPMS most common).
   - Variability in ICT systems and triage system versions was noted (e.g., some EDs using outdated ICTS editions).
   - All EDs reported having a triage-trained nurse assigned.

Recommendations:

- Establish consistent national triage practices, including mandatory pain scoring and routine audit cycles (biannually).
- Standardise SOPs for managing Category 4 and 5 patients to improve flow and reduce overcrowding.
- Strengthen staff training and digital systems to support accurate triage decision-making.
- Improve data capture and sharing with the Business Information Unit for ongoing monitoring.
- Develop a national re-audit cycle and business case for an annual triage audit programme.

BIBLIOGRAPHY

CQC. Patient First: Flow. Available from: https://www.cqc.org.uk/publications/patient-first/flow [Accessed 9 April 2025].
GIRFT (n.d.). Emergency Medicine – Getting It Right First Time.
Available from: https://gettingitrightfirsttime.co.uk/medical_specialties/emergency-medicine/ [Accessed 9 April 2025].

HSE (2012). A strategy to improve safety, quality, access and value in Emergency Medicine in Ireland. Available from: https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/the-national-emergency-medicine-programme.pdf [Accessed 5 March 2025].

HSE Emergency Medicine Programme (2013). *Implementation Guide 4: Overview of the ED Improvement Approach and EMP Implementation.* Dublin: Health Service Executive. Available from: https://emnow.ie/wp-content/uploads/2015/03/1.EMP-IG-4-EMP-Quality-Improvement-Approach-January-2013_1.pdf [Accessed 15 April 2025].

HSE (2017). Developing an Acute Floor Model for Ireland. Dublin: Health Service Executive. Available from: https://emnow.ie/wp-content/uploads/2024/03/006-HSE-Acute-Floor-Report-Published-version-v1-0.pdf [Accessed 7 August 2025].

Health Service Executive (2019). *Acute Floor Information System (AFIS).* Emergency Medicine Programme. Available from: https://emnow.ie/home-page/emp/acute-floor-information-system/ [Accessed 15 April 2025].

HSE: Emergency Medicine Programme (2021). *"It's About Time": Efficient Emergency Department Care in Ireland.* Dublin: HSE. Available from: https://iaem.ie/wp-content/uploads/2024/06/Efficiency-Document-_14th-October-2021.pdf [Accessed 9 April 2025]

HSE (2023). Development of a Framework of Key Metrics with clear triggers and actions to ensure the triage of patients presenting to Emergency Department is in line with best practice. Dublin: HSE. Available from: https://emnow.ie/wp-content/uploads/2024/04/ED-Escalation-Working-Group-Framework-Report-FINAL-November-2023.pdf [Accessed 6 August 2024].

HSE (2023). National Clinical Audit of Emergency Department Triage Report 2023. Dublin: Health Service Executive. Available from: https://assets.hse.ie/media/documents/HSE_National_Clinical_Audit_of_ED_Triage_Report_Final.pdf [Accessed 9 August 2024].

NHS England (n.d.). Urgent and Emergency Care: Acute Patient Flow.
Available from: https://www.england.nhs.uk/long-read/urgent-and-emergency-care-acute-patient-flow/ [Accessed 9 April 2025].

RCSI

EMERGENCY MEDICINE