

**MTS IRG Meeting - Hamburg, Germany**

**22nd September 2016**

|  |  |
| --- | --- |
| **IRG members in attendance:**  **Austria** | **Apologies:** |
| Stefan Kovacevic, Austria  Andreas Lueger, Austria  Andreas Zeundel, Austria  **Germany**  Jorg Krey  Ingo Graeff  Peter Niebuhr  **Italy**  Michael Prantl  Pasquale Solazzo  Norbert Pfeifer  **Netherlands**  Piet Machielse  **Norway**  Endre Sandvik  Marit Rystad  Stine Engebretsen  **Portugal**  Antonio Marques  Angela Valenca  Paulo Freitas  **Spain**  Juan Carlos Medina  Gema Garcia Riestra  Gabriel Redondo Torres  **UK**  Kevin Mackway-Jones  Janet Marsden  **Observing**  **Austria**  Susanne Greber-Platzer  Gustav Fischmeister  **Portugal**  Diogo Bruno  **UK**  Stephanie Allmark | **Brazil**  Maria do Carmos Rausch  Welfane Cordeiro  **Portugal**  Claudio Ferreira Alves  **UK**  Sue Wieteska  Jill Windle  Dale Morgan (Wiley) |

1. **Intro/housekeeping**
   1. Introductions from Jorg and Kevin to the 2016 IRG meeting in Hamburg
2. **Review of minutes and actions - Spain 2015**
   1. Kevin presented and reviewed the minutes from the IRG meeting in Spain and the following actions which were carried over;
   2. Vignettes for new neuroligical defecit: This was an action point from the IRG meeting in Manchester in 2014 and Spain 2015; vignettes from Germany would be shared between UK, Norway and Portugal in order to agree a research/study protocol into the assessment of new neurological deficit. The ethics committee in Germany have denied access to any vignettes due to sharing of patient information, even with patient identifiable information removed. This has now been removed as an action point, however it was felt there was still some value to this idea, therefore Germany and Austria agreed to write their own vignettes for review and discussion.
   3. An obstetric task and finishgroup has now been developed and is accessable to members through the MTS website. Members are currently enrolled from Brazil and Portugal, therefore if anyone else would be interested in becoming a member of this group could they please contact [sallmark@alsg.org](mailto:sallmark@alsg.org) It was discussed whether maternity should have their own specialised MTS for those countries with Maternity Emergency Departments, however as many countries do not have specific maternity ED’s it was felt it was better to keep the charts generalised.
   4. Paediatric and OBGYN forums are now set up on the MTS website – IRG advised how to register if they wish to take part in any of these forums. Anyone wanting further information should contact [sallmark@alsg.org](mailto:sallmark@alsg.org)
   5. Norway completed their review of the electronic version of the MTS TTA however they have been advised that with the recent review of charts and discrimators there will be further changes that will need to take place.
   6. Development of the website – this is still under development but should hopefully be completed by the end of the year.
   7. Review of changes to charts and discriminators discussed later in the conference.
3. **Updates from IRGs**
   1. Part of Germany has requested to use TTA to aid in the dispatch of ambulances
   2. Spain are currently translating the MTS 3e however they are having problems with the rights – this will be taken up with Wiley.
   3. Portugal presented their Azores study to their government and it has been decided that MTS TTA will be implemented across Portugal in 2016.
   4. Austria are looking to develop an electronic solution for TTA within the next 12 months.
   5. Review of Annual Reports
   6. Norway have evaluated the use of MTS TTA and have come across problems with patients presenting with dizziness as there appears to be no discriminator that accounts for these patients and they are currently managed with the Unwell adult chart. There were discussions around how to distinguish between vertigo, syncope and neurological symptoms with patients presenting with dizziness and there were suggestions for a separate chart or discriminator to help with this. Germany will develop a presentational chart for consideration then implement with the vignettes to evaluate the effectiveness. They will also carry out a retrospective evaluation using the proposed chart to compare outcomes.
   7. It was decided that a Task and Finish group should be implemented to look at dizziness as a presentation. Austria will develop 10-15 hypothetical vignettes to send to IRG members which they can test their current and proposed charts and evaluate the outcomes (both 3e and TTA). Contributions of vignettes are welcome from other IRGs. Live triages using the proposed chart will not be undertaken until the results of any evaluations are completed but IRGs can do a retrospective evaluation of cases.
   8. It was suggested that prior to implementing any new charts/discriminators, an evaluation of current practice should be undertaken to ensure staff are correctly using the current charts and if there is a need for any changes. Italy commented that MTS is not curently being used correctly to identify stroke patients and Norway advised that all IRGs should work to ensure nurses and telephone triage clinicians are using MTS correctly due to the difficulties in prioritising patients following assessment. JM advised that it is essential that nurses and the clinicians utilising MTS be involved with any research or evaluations taking place.
4. **Sepsis presentations**
   1. **Presentation 1: M. Woelk and M. Mengal** – Looked at MTS triage outcomes in patients diagnosed with sepsis with a comparison of SIRS criteria and MTS discriminators. There were no equivalent MTS discriminators for QSOFA indicators. Retrospective analysis of patients diagnosed with septic shock and their MTS priority on arrival to the Emergency Department.

Recommendations: To add discriminators to the MTS which can more accurately pick up on QSOFA indicators which should be added to the top 5 presentational charts which are used to identify patients with sepsis: Unwell adult; Collapsed adult; Shortness of breath; Urinary problems and Abdominal pain.

Requested presentation to be circulated to the IRG members however this was declined by the authors as they are waiting to publish their findings and did not want to share prior to publication.

* 1. **Presentation 2: I. Graeff –** Also compared the MTS outcomes and priorities of patients diagnosed with sepsis, severe sepsis and sepsis with circulation dysfunction. Results of the study showed that MTS was poor at identifying patients with sepsis with only 15.3% of patients identified as an orange priority. Severe sepsis, and sepsis with organ dysfunction was better identified with 40.2% and 50% identified as orange priority, however the recognition by MTS of patients diagnosed with sepsis was poor overall.
  2. Discussion around the use of SIRS criteria and the sensitivity of this in triage resulting in the over-triage of a high number of patients. It was identified that QSOFA may work better in triage to more accurately recognise patients with sepsis. There was the consideration of hypotension and new confusion as discriminators to identify patients at risk of sepsis, which was later changed to the addition on ‘Signs of sepsis’. Should this new discriminator be included to identify patients at risk of sepsis, Ingo was asked to model the effects of the new discriminator into his research to see how this would affect the sensitivity and specificity of the MTS.

1. **IRG Annual reports presented by each country**
   1. The annual reports were presented by a representative from each IRG, giving a brief overview of their progress from the past 12 months and any new developments. Any countries that have not submitted their annual report, can they please submit to sallmark@alsg.org as soon as possible for inclusion on the website.
   2. Austria report presented by Stefan Kovacevic
   3. UK report presented by Janet Marsden
   4. Italian report presented by Michael Prantl – 5 scale triage is now law in Italy therefore looking to expand the MTS
   5. Netherlands report presented by Piet Machielse – 60% Emergency Departments in Holland now utilizing MTS. Ambulance Service use AMPDS for primary triage however TTA is not currently used in Ambulance Service. Some GPs are currently using MTS TTA. They are currently rolling out the 3rd Edition, this is being translated now.
   6. Norway report presented by Endre Sandvik – Introduction of TTA has resulted in a reduction in ED attendances as most outcomes are in the Green priority.
   7. Portugal report presented by Angela Valenca – MTS is mandatory in all public hospitals as are extended yearly audits which are mandatory by law. Internal monthly audits are also mandatory by the hospital’s own staff.
   8. Spain report presented by Gabriel Redondo Torres – Approximately 70-75 hospitals using MTS 1st Edition. 3rd Edition only just translated and is only used in 1 hospital at present. IT solution for 3rd Edition is currently being looked at. Canaries and Extremadura are also interested in the implementation of the MTS.
   9. German report presented by Jorg Krey
   10. Brazil – No IRG members in attendance therefore annual report circulated.
   11. Can everyone please check their names and email addresses of all members to ensure correct, and if there is anyone missing from the IRG list could they please let [sallmark@alsg.org](mailto:sallmark@alsg.org) know
2. **Discussions**
   1. Changes to 3e circulated for information and review. The removal of Hot baby in the Unwell newborn chart was discussed as without this discriminator, unwell newborns with a high temperature would not be picked up in the Orange priority. This was taken on board by the MTG and will not now be removed.

Concerns raised by Germany that they had issues with the directing of triage practitioners to the Unwell newborn chart in some of the presentational charts such as abdominal pain and worried parent. It was advised that as the Unwell newborn is a specific chart, this should be used for all patients under 28 days where appropriate, however any concerns should be raised via the paediatric forum.

There was some concern expressed regarding the need to update software solutions in line with MTS updates. It was decided that changes would be divided into ‘Safety changes’ which should be implemented immediately and ‘General changes’ which could be implemented at the time of each individual countries edition changes.

MTG to contact Wiley to ensure that Wiley keep in contact with countries and keep them informed of software solutions progress and ensure each IRG is aware of the content of the software solutions. Need discussions around the responsibilities of IT solutions companies to sign contracts to say they will update any ‘Safety changes’ as and when they are introduced.

* 1. Changes to MTS TTA circulated for review. No comments or suggestions from changes document.
  2. Discussed as to whether the TTA should have separate representation at the IRG or whether it should be a joint representation with countries that have TTA joining in the allocated 3 spaces for IRG members. It was decided that the IRG should be mixed for those countries that have both MTS and TTA.
  3. Send completed changes to Andreas, Austria along with contact details for Dale @ Wiley for licensing
  4. Ensure changes are uploaded onto website as soon as all changes confirmed with safety changes highlighted in red. Amend change process to include General and Safety changes.

1. **Presentation from Diogo Bruno ‘Obs and Gynae triage in OBGYN Emergency Maternity units in Portugal’.** 
   1. Recommendations to remove ‘absence of foetal movements in patients <20 weeks pregnant’ as there would not be the need for this discriminator. Discussion around whether the discriminator should also include the reduction of foetal movements, not just an absence. OBGYN forum to decide on what the definition of reduction should be.
      1. **This was discussed at the MTG meeting and it was agreed that should not be <20 weeks. Discriminator and definition will be sent out with other updates.**
   2. Consider removing abdominal pain as a discriminator in PV bleeding as this would be covered by general pain discriminators. **MTG response:** This will be discussed in the next MTG meeting in October.
      1. **It was decided at the MTG that this discriminator would remain in the PV bleeding chart.**
   3. Remove ‘Possibly pregnant’ as almost all patients triaged as Yellow or Orange anyway in the Maternity ED so is not necessary. **MTG response:** In a maternity ED this might not be necessary as patients presenting here would all be pregnant or possibly pregnant, however this would still be required for patients presenting at General EDs.
   4. Discussion around the need for a separate obstetric MTS chart or whether obstetric discriminators should be included in general charts – Portugal is awaiting a ministerial decision on triage systems in maternity services. The consensus from IRGs was that a separate chart should not be developed, but obstetric discriminators should be included in the general charts as not everywhere has their own maternity Emergency Departments or specialist nurses, therefore obstetric presentations should be able to be easily identified using general MTS. However it was decided that a specialist chart may be developed, possibly in an online format for use in specialist departments. OBGYN Task and Finish group to be set up to develop MTS specialist chart.
   5. Invite any new members to the OBGYN forum.
   6. Diogo to circulate presentation to IRG.
2. **QSOFA and New confusion**
   1. SIRS criteria felt to be too sensitive for triage – QSOFA allows sepsis criteria to be picked up without overloading resources from over-triage. One suggestion was to include hypotension and acute confusion as discriminators in Orange (would not need respiratory rate as well as any one of the QSOFA indicators would still give an Orange priority and only 2 out of the 3 needed for idnetification of QSOFA risk). There were concerns as to the increased time this may take in triage to measure observations if hypotension were to be included in MTS charts as it was felt that by adding hypotension, all patients entering triage would then require a blood pressure to be taken. It was reinforced by the MTG that the presence of a discriminator for observations does not mean this has to be done for all patients, only those where it is clinically relevant to do so.
   2. It was also discussed as to whether hypotension was required as this should be identified in patients when looking at the definition for shock. Requested that the definition needs the addition of <90 or <100mmHg in the dictionary. The addition of the discriminator ‘New confusion’ was also discussed; both will be discussed at the next MTG meeting.
      1. **It was decided following discussion at the MTG meeting that the values for hypotension would not be included in the definition, as clinical judgement should be used depending on the patients age and presentation. ‘New confusion will be added as new discriminator, definition and chart placement will be circulated once confirmed at the next MTG meeting in December.**
   3. It was suggested that rather than having separate discriminators to determine a patient at risk of sepsis, one discriminator ‘Signs of sepsis’ could be added to Orange, whereby any suspicion of sepsis would lead the triage nurse to whatever sepsis screening tool they are currently using. This could also be added to TTA whereas the inclusion of observations could not. This will be discussed at the next MTG meeting in October and any changes will be circulated to the IRG.
      1. **The new discriminator ‘Possible sepsis’ will be introduced. Included charts and definition will be sent out as soon as confirmed in December.**
3. **AOB**
   1. Request to remove the word ‘adult’ from the ‘Collapsed adult’ chart, as patients under the age of 16 (18 in some countries) who have collapsed are currently not assessed using this chart as it is restricted to adults only.
      1. **This was agreed. The chart will now be called ‘Collapse’**
   2. Request to include ‘Moderate pain’ as a discriminator in TTA – this will be discussed at the next MTG meeting.
      1. **It was not felt that the inclusion of Moderate pain was required due to the difficulties in assessing pain with telephone triage, and that if the patient outcome is Later and there is clinical concern due to pain, the clinician would request a higher priority anyway.**
   3. Requests for meetings/teleconferences with Wiley – please can anyone wishing to arrange a teleconference with Dale or Sue from Wiley, please contact [dale.morgan@wiley.com](mailto:dale.morgan@wiley.com) or [sue.mattingley@wiley.com](mailto:sue.mattingley@wiley.com) and please also copy in [SWieteska@alsg.org](mailto:SWieteska@alsg.org).
4. **Venue IRG 2017**
   1. It was agreed that the IRG meeting in 2017 will be held in Manchester in October. Requests made for after the second week in October due to holidays and prior commitments to other conferences.
      1. **The 2017 IRG conference will be held in Manchester on the 12th and 13th October 2017. Venue to be decided.**
   2. Kevin and Jorg closed the meeting, thanking everyone for their input to a very constructive IRG meeting.

|  |  |  |  |
| --- | --- | --- | --- |
| **Agenda Item** | **Action** | **Lead** | **Deadline** |
| 2.4 | Send out invite to join OBGYN Task and Finish group (with 2 week deadline for replies) | SA | Completed October |
| 3.5 | Request any missing annual reports | SA | Completed October |
| 3.6 | Germany will develop a presentational chart for consideration then implement with the vignettes (3.6) to evaluate the effectiveness. They will also carry out a retrospective evaluation using the proposed chart to compare outcomes. | JK/IG | July 2017 |
| 3.6 | Set up Dizziness T&F group and send invite to IRG members | SA | December 2016 |
| 3.6 | Germany and Austria will develop 10-15 hypothetical vignettes to send to IRG members which they can test their current and proposed charts and evaluate the outcomes for a potential Dizziness chart | JK/IG  AL | December 2016 |
| 4.3 | If ‘signs of sepsis’ agreed as a new discrimnator request for IG to model the effects of the new discriminator into his Sepsis research to see how this would affect the sensitivity and specificity of the MTS. | IG | July 2017 |
| 5.11 | All IRG members please check your names and email addresses to ensure correct. If there is anyone missing from the IRG list please contact [sallmark@alsg.org](mailto:sallmark@alsg.org) | All IRG | ASAP |
| 6.1 | MTG to contact Wiley to ensure countries are informed of software solutions progress and each IRG is aware of the content of the software solutions. | MTG/Wiley | October 2016 |
| 6.1 | Discussion of responsibilities of IT solutions to implement safety changes as soon as made | MTG/Wiley | October 2016 |
| 6.1 | Hot baby will not be removed from unwell newborn chart | MTG | Completed October 2016 |
| 6.4 | Send completed TTA changes to Andreas, Austria along with contact details for Dale @ Wiley for licensing | SA | As soon as updated |
| 6.5 | Ensure changes are uploaded onto website as soon as all changes confirmed with safety changes highlighted in red. Amend change process to include General and Safety changes. | SA/NH | As soon as updated |
| 7.1 | OBGYN forum to decide on what the definition of reduction should be in the new discriminator ‘Absent or reduced foetal movements’ | OBGYN Forum members | Definition completed October |
| 7.1 | Recommendations to remove ‘absence of foetal movements in patients <20 weeks pregnant’ to be considered at next MTG meeting | MTG | Removed by MTG October |
| 7.2 | Consider removing abdominal pain as a discriminator in PV bleeding as this would be covered by general pain discriminators | MTG | Complete October 2016 |
| 7.4 | OBGYN Task and Finish group to be set up and invite IRG members to join | SA | Completed Oct |
| 7.4 | OBGYN Task and Finish group to develop MTS specialist chart for OBGYN/Maternity | OBGYN T&F group | July 2017 |
| 7.6 | Diogo to circulate presentation to IRG. | DB | November 2016 |
| 8.2 | Request for definition of shock to include either <90 or <100mmHg | MTG | Completed Oct 2016 |
| 8.2 | Consideration of ‘New confusion’ as new discriminator | MTG | December 2016 |
| 8.3 | Signs of sepsis to be considered as a new discriminator | MTG | Completed Oct 2016 |
| 9.1 | Removal of ‘Adult’ from ’Collapsed adult’ to be considered | MTG | Completed October 2016 |
| 9.2 | Moderate pain to be included in TTA to be considered | MTG | Completed October 2016 |
| 10.1 | Arrange date and venue for 2017 IRG Conference | MTG/SW | Completed October 2016 |