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Inter-rater and intrarater reliability of the South African Triage Scale in low-resource settings of Haiti and Afghanistan

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ABSTRACT

Objective The South African Triage Scale (SATS) has demonstrated good validity in the EDs of Médecins Sans Frontières (MSF)-supported sites in Afghanistan and Haiti; however, corresponding reliability in these settings has not yet been reported on. This study set out to assess the inter-rater and intrarater reliability of the SATS in four MSF-supported EDs in Afghanistan and Haiti (two trauma-only EDs and two mixed (including both medical and trauma cases) EDs).

Methods Under classroom conditions between December 2013 and February 2014, ED nurses at each site assigned triage ratings to a set of context-specific vignettes (written case reports of ED patients). Inter-rater reliability was assessed by comparing triage ratings among nurses; intrarater reliability was assessed by asking the nurses to retriage 10 random vignettes from the original set and comparing these duplicate ratings. Inter-rater reliability was calculated using the unweighted kappa, linearly weighted kappa and quadratically weighted kappa (QWK) statistics, and the intraclass correlation coefficient (ICC). Intrarater reliability was calculated according to the percentage of exact agreement and the percentage of agreement allowing for one level of discrepancy in triage ratings. The correlation between years of nursing experience and reliability of the SATS was assessed based on comparison of ICCs and the respective 95% CIs.

Results A total of 67 nurses agreed to participate in the study: In Afghanistan there were 19 nurses from Kunduz Trauma Centre and nine from Ahmed Shah Baba; in Haiti, there were 20 nurses from Martissant Emergency Centre and 19 from Tabarre Surgical and Trauma Centre. Inter-rater agreement was moderate across all sites (ICC range: 0.50–0.60; QWK range: 0.50–0.59) apart from the trauma ED in Haiti where it was moderate to substantial (ICC: 0.58; QWK: 0.61). Intrarater agreement was similar across the four sites (68%–74% exact agreement); when allowing for a one-level discrepancy in triage ratings, intrarater reliability was near perfect across all sites (96%–99%). No significant correlation was found between years of nursing experience and reliability.

Conclusion The SATS has moderate reliability in different EDs in Afghanistan and Haiti. These findings, together with concurrent findings showing that the SATS has good validity in the same settings, provide evidence to suggest that SATS is suitable in trauma-only and mixed EDs in low-resource settings.

Key messages

What is already known on this subject

► There are few triage scales designed specifically for use in low/middle-income countries (LMIC); the South African Triage Scale (SATS) is one of them and has been shown to have good validity in such settings. The inter-rater reliability of SATS in South Africa has been reported as moderate to substantial, with intrarater reliability ranging from 80% to 86%. Its performance across a spectrum of different LMIC settings, mainly non-sub-Saharan African and trauma-only settings, has not been adequately evaluated.

What this study adds

► In this cross-sectional study using case vignettes, ED nurses in Afghanistan and Haiti assigned triage ratings using the SATS. Inter-rater reliability was moderate and intrarater reliability for exact agreement ranged from 68% to 74%. Added to evidence showing good validity of this scale, this suggests the SATS could be suitable for low-resource settings.

INTRODUCTION

Triage has a central role in emergency care systems: prioritising patients based on acuity improves effective use of resources, and ultimately patient outcomes.¹ A number of different scales exist for in-hospital use, but most of these have been developed for and evaluated in high-resource settings.^{2,3} Context-appropriate triage tools for low/middle-income countries (LMIC) are very uncommon.⁴ Among the few tools that have been contextually modified, validated and implemented in various settings is the South African Triage Scale (SATS), which was developed for in-hospital EDs.⁵ The SATS has been assessed extensively in South Africa and implemented in several settings,^{6–8} but further assessment of its performance in low-resource settings, particularly non-sub-Saharan settings, is still needed.^{4,9}

For a triage scale to be effective, it needs to demonstrate good validity (ie, an acuity rating assigned using the scale must closely reflect a patient's true acuity) and a high degree of reliability



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Table 1 Characteristics of the study sites in Afghanistan and Haiti

	Ahmad Shah Baba	Kunduz Trauma Centre	Martissant Emergency Centre	Tabarre Surgical and Trauma Centre
Country	Afghanistan	Afghanistan	Haiti	Haiti
Location	Kabul City, district 12	Kunduz Province	Port-au-Prince, Martissant district	Port-au-Prince, Tabarre district
Estimated catchment population	219 000	1 000 000	1 200 000	1 000 000
Level of MSF support	Partnership with Ministry of Health	MSF only	MSF only	MSF only
Services offered	OPD ED Maternity IPD: surgery, internal medicine, paediatric	OPD ED IPD trauma care: surgery, orthopaedic ICU, physiotherapy	ED only	OPD ED IPD visceral and trauma care: surgery, orthopaedic ICU, physiotherapy
Type of ED cases	Mixed	Trauma only	Mixed	Visceral surgery and trauma
ED caseload (per month)*	4715	1848	4919	793
Introduction of the SATS	2011	2011	2013	2012

*Mean cases seen per month during 2014.

ICU, intensive care unit; IPD, inpatient department; MSF, Médecins Sans Frontières; OPD, outpatient department; SATS, South African Triage Scale.

(ie, it must yield the same triage rating on repeated assessments of the same patient). For any given patient, tools should have high inter-rater (the degree of variability among different nurses) and intrarater (the variability of retriage ratings for one nurse) reliability.

Médecins Sans Frontières (MSF), an international medical humanitarian organisation, provides free medical care to vulnerable populations in many LMIC settings. It operates within constrained resources and serves populations with little health-care access. Since 2011, MSF-Operational Centre Brussels has implemented the SATS in projects where it provides emergency care. The validity of the SATS was recently assessed in the EDs of MSF-supported sites in Afghanistan and Haiti¹⁰ with good results, but corresponding reliability in these sites has yet to be reported on. This is the basis of the current study.

METHODS

Study design

This was a cross-sectional study using a set of ED vignettes (short written clinical case reports of actual ED patients) as a proxy for live patients, in which ED nurses assigned triage ratings using the SATS.

Study setting

The study was conducted at four active MSF project sites between December 2013 and February 2014: two hospitals in Afghanistan (Ahmad Shah Baba (ASB) and Kunduz Trauma Centre (KTC)) and two facilities in Haiti (Martissant Emergency Centre (MT) and Tabarre Surgical and Trauma Centre (TB)). Specific details on these four sites are summarised in [table 1](#).

SATS and its use in the ED

Described in detail elsewhere,¹⁰ the SATS is a four-tiered triage tool which depicts a patient's urgency for care using the following colour codes: priority 1: red—'emergency' (to be seen immediately); priority 2: orange—'very urgent' (to be seen within 10 min); priority 3: yellow—'urgent' (to be seen within 60 min); priority 4: green—'routine' (to be seen within 240 min). The SATS also allocates the colour blue (black was used in the study countries for cultural purposes) to 'dead on arrival' cases.

Study population

The study included all ED nurses at the four study sites who fulfilled the following inclusion criteria: (1) had received training in use of the SATS and (2) agreed to participate in the study. All nurses employed by MSF have a basic nursing degree and are registered with the country nursing authority.

Study protocol

Under classroom conditions, all nurses who agreed to participate in the study were asked to use the SATS to triage a set of vignettes and assign one of the following four categories to each vignette: 'emergency', 'very urgent', 'urgent' and 'routine'. Each set comprised between 28 and 30 vignettes generated from information extracted from randomly selected patient files of real ED cases who had presented at the study centres between June and December 2013. Each vignette included information on patient gender, age, presenting complaint, mode of arrival to the ED and vital signs. All clinical information in the triage paperwork was copied into the vignettes including information from additional investigations such as blood glucose and haemoglobin levels (see [box 1](#) for an example of a vignette).

Professionals translated the vignettes from English into the relevant local languages. Local bilingual doctors ratified the translations to ensure correct medical terminology.

Under classroom conditions, all nurses who agreed to participate in the study assigned one of four SATS categories to the set of reference vignettes.

Data analysis

Inter-rater reliability was measured by comparing the triage ratings assigned for each of the vignettes by different nurses at each

Box 1 Example of a vignette used to assess the South African Triage Scale (SATS) in Afghanistan and Haiti, 2013

A 17-year-old boy presents with abdominal pain, loose motion and vomiting since this morning. He says he ate something last night that did not agree with his stomach and since this morning has not been feeling well. At triage, you find an alert boy with moderate abdominal pain. No signs of dehydration are present.

BP: 120/80; HR: 109; RR: 16; temperature: 36°C

Table 2 Nurses' response rate at each study site in Afghanistan and Haiti, 2013

Study site	Nurses invited to participate (n)	Nurses agreeing to participate (n)	Response rate (%)
KTC (Afghanistan)	21	19	90
ASB (Afghanistan)	9	9	100
MT (Haiti)	21	20	95
TB (Haiti)	20	19	95

ASB, Ahmad Shah Baba; KTC, Kunduz Trauma Centre; MT, Martissant Emergency Centre; TB, Tabarre Surgical and Trauma Centre.

study site. Intrarater reliability was measured by asking nurses to retriage 10 random vignettes from the original set 1–10 days later (depending on their availability), and comparing these duplicate ratings.

In accordance with the Guidelines for Reporting Reliability and Agreement Studies (GRRAS), inter-rater reliability was assessed using the unweighted kappa (UWK), linearly weighted kappa (LWK) and quadratically weighted kappa (QWK) statistics, as well as the intraclass correlation coefficient (ICC).¹¹ UWK and LWK point estimates were assessed and included as per GRRAS guidelines, but in keeping with triage literature we only interpreted QWK and ICC point estimates using the Landis and Koch classification system: 0.0–0.20—slight agreement; 0.21–0.40—fair agreement; 0.41–0.60—moderate agreement; 0.61–0.80—substantial agreement; 0.81–1.00—almost perfect agreement.¹² In triage reliability studies, UWK and LWK can be ignored. QWK and ICC yield almost identical results hence either one could be used based on ease of calculation.¹²

Intrarater reliability was assessed by calculating both the percentage of exact agreement and the percentage of agreement allowing for one level of discrepancy in triage ratings. 95% CIs were calculated for all measures.

In addition, we assessed whether there was any correlation between years of nursing experience (ie, years of being a qualified nurse) and the ICC based on comparison of the 95% CIs and use of bootstrapping.

RESULTS

Study population

Table 2 shows the sample size at each study site. The response rate ranged from 90% in KTC to 100% in ASB.

Reliability of nurse triage ratings

Table 3 summarises the different reliability measures calculated to assess inter-rater and intrarater reliability across the four study sites. Inter-rater agreement was moderate across all sites, apart from TB where it was moderate to substantial. Trauma-only facilities (KTC and TB) yielded very similar results (ICC: 0.60 and 0.58 and QWK: 0.59 and 0.61, respectively) whereas among the mixed settings (ASB and MT), there was a wider variability in results (ICC: 0.50 and 0.59 and QWK: 0.50 and 0.59, respectively).

Intrarater agreement was similar across the four sites, ranging from 68% exact agreement in ASB to 74% in MT. When allowing for a one-level discrepancy in triage ratings, intrarater reliability was near perfect across all sites ranging from 96% in TB and ASB to 99% in KTC.

Table 4 shows the correlation between years of nursing experience and ICC across the four sites. The mean years of nursing experience were similar across all sites ranging (6.3–7.1 years). The ICC for nurses with 5 or more years of nursing experience appeared to be higher than for those with less than 5 years of experience, but 95% CIs overlapped (even after applying a bootstrapping technique) indicating no statistical significant difference.

DISCUSSION

Our study shows that the SATS has moderate inter-rater and intrarater reliability when used by nurses in trauma-only and mixed ED settings in Afghanistan and Haiti. This is evidenced to suggest that the SATS could be suitable for use in low-resource settings. Further reliability studies in low-resource settings are needed to confirm these findings.

The main strengths of this study are its multisite nature, the high response rate of participants and the fact that the vignettes reflected real ED cases seen in each specific setting. In previous studies assessing the SATS in contexts outside of South Africa, the vignettes used were based on South African ED cases, not ED cases specific to the study setting.^{8,9}

Limitations

There were a number of study limitations. First, using paper-based vignettes as a proxy for real ED cases has the inherent limitation of not mimicking real life.⁹ Although conducting consecutive live triage assessments on a single patient at one point in time and at multiple points in time is not feasible or practical,¹³ use of paper-based vignettes assessed under

Table 3 Inter-rater and intrarater reliability measures for the SATS in Afghanistan and Haiti, 2013

Inter-rater reliability measures	Ahmad Shah Baba	Kunduz Trauma Centre	Martissant Emergency Centre	Tabarre Surgical and Trauma Centre
Point estimates (95% CI)				
ICC	0.50 (0.37 to 0.66)	0.60 (0.48 to 0.74)	0.59 (0.46 to 0.73)	0.58 (0.44 to 0.73)
QWK	0.50 (0.37 to 0.66)	0.59 (0.22 to 0.77)	0.59 (0.32 to 0.78)	0.61 (0.32 to 0.79)
LWK	0.44 (0.16 to 0.69)	0.46 (0.21 to 0.66)	0.50 (0.27 to 0.70)	0.48 (0.23 to 0.68)
UWK	0.40 (0.26 to 0.53)	0.33 (0.23 to 0.41)	0.41 (0.31 to 0.48)	0.35 (0.23 to 0.47)
Level of agreement*				
ICC	Moderate	Moderate	Moderate	Moderate
QWK	Moderate	Moderate	Moderate	Substantial
Intrarater reliability measures, % (min-max)				
Mean exact agreement	68 (40–90)	71 (40–100)	74 (40–90)	73 (50–90)
Mean agreement with one-degree discrepancy	96 (80–100)	99 (90–100)	97 (60–100)	96 (70–100)

*According to the Landis and Koch criteria.¹¹

ICC, intraclass correlation coefficient; LWK, linearly weighted kappa; QWK, quadratically weighted kappa; SATS, South African Triage Scale; UWK, unweighted kappa.

Table 4 Effect of nurse experience on inter-rater reliability of the SATS

Study site	Nurses agreeing to participate (n)	Mean years of experience	Nurses with <5 years of experience		Nurses with ≥5 years of experience	
			n	ICC	n	ICC
KTC (Afghanistan)	19	6.6	11	0.53 (0.38–0.68)	9	0.67 (0.54–0.79)
ASB (Afghanistan)	8*	7.1	5	0.46 (0.29–0.64)	3	0.55 (0.35–0.74)
MT (Haiti)	20	6.3	11	0.53 (0.38–0.68)	9	0.64 (0.50–0.78)
TB (Haiti)	19	6.3	6	0.70 (0.57–0.83)	13	0.57 (0.43–0.71)

*Information available on eight out of the nine nurses.

ASB, Ahmad Shah Baba; ICC, intraclass correlation coefficient; KTC, Kunduz Trauma Centre; MT, Martissant Emergency Centre; SATS, South African Triage Scale; TB, Tabarre Surgical and Trauma Centre.

classroom conditions may have influenced the relative degree of reliability that was observed. For example, the wording of the vignettes may have been interpreted differently by different nurses. That said, a previous study has shown that there is little difference between the inter-rater reliability measures generated using paper-based cases compared with live cases.¹³ Second, translation of the vignettes from English into the local language may have slightly distorted some of the original information. We tried to limit this by recruiting professional translators with some medical background to carry out the translations in each setting, and having local medical staff back translate.

Originally developed for use in South Africa, the SATS has been assessed extensively in South Africa, and also in Botswana, Malawi and Pakistan with good results.^{4 7 8 14} But the degree to which these findings are applicable to other LMIC settings—particularly those outside of sub-Saharan Africa and those that deal with trauma-only caseloads—has remained unclear. This is what prompted a recent study assessing the validity of the SATS in different EDs in Afghanistan and Haiti.¹⁰ The results of this study were good, but reliability in these settings was still unknown. Reliability of triage across both high-resource and low-resource settings varies greatly. Two articles assessing reliability in South Africa report moderate to substantial reliability with QWK of 0.57 and 0.66, respectively.^{14 15} In Ghana, the SATS showed moderate reliability with QWK of 0.59 and 0.60¹⁶ while studies in Pakistan and Botswana reported substantial to near-perfect results with QWK of 0.77 and 0.87, respectively.^{8 9} In high-resource settings, the Canadian Emergency Department Triage and Acuity Scale (CTAS), a 5-level triage scale, reported a chance corrected kappa of 0.80 and a weighted kappa of 0.77.^{17 18} The Emergency Severity Index (ESI) has reported inter-rater reliability ranging from 0.76 to 0.8 with the Manchester Triage System (MTS) showing a weighted kappa from 0.62 to 0.82.^{2 19 20} No studies were found in low-resource settings for either the CTAS or MTS. The ESI was implemented in Iran but according to Mirhaghi *et al* may not reveal optimal outcomes for LMICs.²¹ Standardisation of reporting reliability is poor with some studies not identifying which weighted kappa statistic was used to calculate reliability, making comparisons between studies difficult.¹¹ The one-two-triage scale, the only other new scale developed in 2015 for low-resource settings, reported a kappa of 0.308 among nurses in Cambodia.²²

The results of our study confirm that the SATS is valid in Haiti and Afghanistan and demonstrates moderate reliability. This latter finding is most certainly a reflection of the relative simplicity of the SATS, both in terms of its construct and application, and supports its value in resource-constrained settings where highly skilled staff are often in short supply.

Reliable use of the SATS did appear to be higher among nurses with 5 or more years of nursing experience, although our results were not statistically significant. The latter however may be related to our relatively small sample size, and thus low statistical power.

This finding is similar to previous research by Göransson *et al* that found no significant difference between nursing experience and reliability of triage when using the Canadian Triage and Acuity Scale.¹⁸

In addition, there may be other factors that influence reliability and which confounded the relationship between years of experience and reliable use of the SATS, for example, how regularly the nurses were working in triage (all the nurses were working on a rotational basis and therefore were not permanently based in the ED).

It would be useful to explore these sorts of factors further in order to establish how they affect reliability and ultimately what could be done to optimise the reliable use of the SATS.

CONCLUSION

In conclusion, our study shows that the SATS is a moderately reliable tool for use in different EDs in Afghanistan and Haiti. These findings, together with concurrent findings showing that the SATS has good validity in the same settings, provide evidence to suggest that SATS is suitable in trauma-only and mixed EDs in low-resource settings.

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Contributors MD, PV, MT, LW and KTS designed, analysed and interpreted the study and data. AQP, WHH and MN were the project leads in Afghanistan. OG and SC were the project leads in Haiti. All authors contributed to the revision of the final article.

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Competing interests None declared.

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