

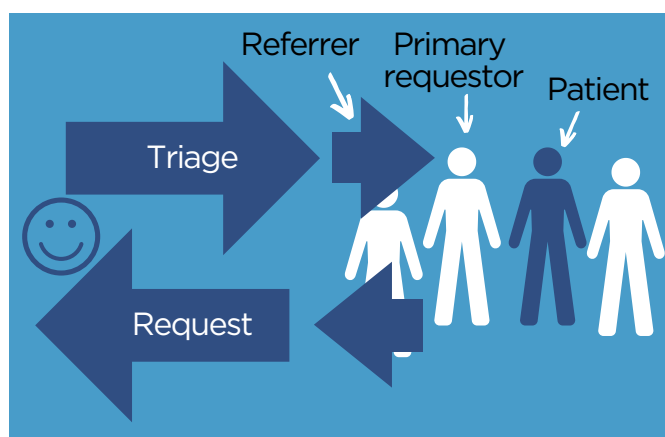
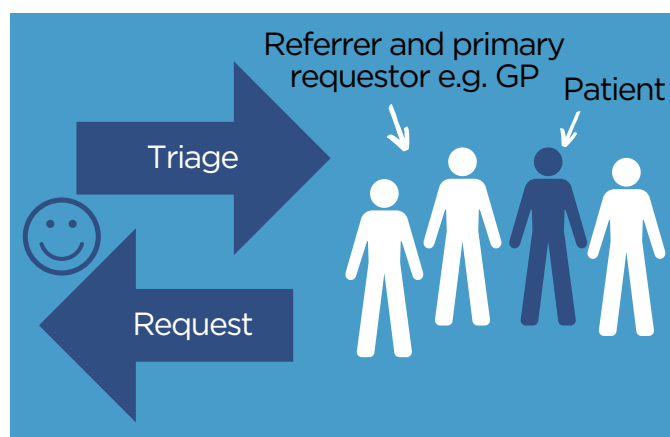


## Who's Bothered, Part Two

### Duty and Decision (9)

The previous blog noted that the first task in triage is to identify the 'primary requestor'. This is the person most proximal to the identified patient who is concerned about the possible impact or is noticing impact in the patient. Although this is often the identified patient, it is not always. This blog explores triage when the bothered person is not the patient.

It can be helpful to map the pattern of concern across the patient's circle of support. This can help to identify the person or people who are nearest to them who are concerned about impact or who are already noticing impact in the patient. If triage is not currently focussed on these people, the conversation should move to them and then come back to the referrer. Two scenarios are considered below.



In the first scenario, the primary referrer is a professional who has noticed foreseeable harm or current impact in an identified patient. However, the patient does not share this concern. For instance, a practitioner may be concerned that the patient has limited insight into the potential impact on their wellbeing of their lifestyle or that they are not motivated to self-manage a health condition. In this situation the 'so what' aspect of triage needs to focus on how concerned the practitioner is and why. The intention being: (1) to develop an understanding of the bothered person's perception of harm and/or foreseeable harm for the identified patient; (2) to empathetically tune into the needs of the primary requestor and to their experience, irrespective of the patient's needs; and, (3) to try and understand the disparity between their level of concern and that of the patient.

A second scenario would be where the requestor is passing on another person's concerns, but these are not those of the identified patient. For example, a family member may have reported to their GP that they are bothered about a relative's health, but the identified patient does not share these concerns. In this situation the triager might start by moving to focus on the referrer. They learn from them that the primary requestor is a family member. They might then decide to move to focus on how concerned the family member is and why.

Mapping concern across the circle of support also helps to identify disparity or congruence in the concern being expressed by different people. This is important because a key task in triage is to judge how accurate the

bothered person's concern is as an indicator of risk. For instance, hypervigilance or emotional dysregulation might contribute to someone "over-reacting" to their perceptions of risk, which in turn could lead to poor triage decisions. These in turn can lead to avoidable harm arising from services becoming over involved. For instance, by leading to dependency, reduced autonomy, restricted liberty, and other people missing out on the opportunity for support. In contrast, under-vigilant people tend not to ask for help putting them at risk.

The last in this series of blogs explores other reasons why a practitioner might elect to stay on the outside of a person's circle of support. This blog outlines their duty in each of these circumstances.