Triage Procedure

1. Purpose

The purpose of this procedure is to outline the principles and process for triage in WA Country Health Service (WACHS) emergency departments.

Triage is an essential function underpinning the delivery of care in all Emergency Departments (EDs), where any number of people with a range of conditions may present at the same time. Effective triage systems share the following important features[1]:

- a single-entry point for all incoming patients so that all patients are subjected to the same process to determine clinical urgency
- a physical environment that is suitable for undertaking a brief assessment. It needs to include easy access to patients which balances clinical, safety and administrative requirements, and the availability of first aid equipment and hand-washing facilities
- an organised patient processing system that enables flow of patient information from point of triage through to ED assessment, treatment and disposition
- timely data on ED activity levels, including systems for notifying the department of incoming patients from ambulance and other emergency services.

Triage decision-making is an inherently complex and dynamic process. Decisions are made within a time-sensitive environment, with limited information, for patients who generally do not have a medical diagnosis.[1]

Due to the multifaceted nature of the triage role, nurses are required to possess specialised knowledge as well as experience with a wide range of illness and injuries.[1] Nurses should refer to the WACHS Mandatory Training Catalogue for more information about triage training.

WACHS uses the Australasian Triage Scale (ATS) categories for triage. Refer to Appendix A: Australasian Triage Scale Categories for more information.

Out of scope
This procedure aims to standardise the practice at triage. It is not a training manual. Staff can refer to the WACHS Mandatory Training Catalogue for more information about triage training and pre-requisites. Staff can refer to the WACHS endorsed Emergency Triage Education Kit.

2. Procedure

This procedure must be read in conjunction with the Patient Assessment and Management in the Emergency Department Policy.

Triage is undertaken by trained staff. Refer to Section 3 Roles and Responsibilities.
The recommended triage method is outlined in Appendix B.

A guide to ATS descriptors is outlined in the Appendix D: Triage Clinical Descriptor Guide

In the absence of an on-site triage nurse at the time of presentation, consider assistance via local escalation processes, which may include triage assistance from the WACHS Command Centre's Emergency Telehealth Service (ETS).

Staff are to be aware of the Aishwarya's CARE Call process; communicate this information to the patient and their family/carer; and respond appropriately to any calls of concern.

2.1 Triage – primary survey

The primary survey process:

- For sites with:
  - an on-site triage nurse – triage is to be the patient's first point of contact with the ED regardless of mode of arrival
  - an off-site triage nurse – refer to Appendix E: Off-Site Triage Nurse Process.
- Safety hazards are to be considered immediately when the patient presents to triage.
- Rapid survey of Airway, Breathing, Circulation, Disability and Exposure (ABCDE), general appearance, chief complaint and limited history is to occur and should generally take no more than two to five minutes with a balanced aim of speed and thoroughness being the essence[3]. This method is outlined in Appendix B: Recommended Triage Method.
- Effective communication is essential in obtaining accurate information and therefore making an accurate assessment of the patient.[1]
- The most urgent and high-risk clinical features determine the ATS category, with consideration of mechanism of injury and co-morbidities. Relief of pain is a legitimate reason for a higher ATS category.
- Triage does not require comprehensive physiological observations. Palpation of pulses can ascertain quality and rate of heart rate, condition of skin (cool, dry etc.).
- Commence nurse-initiated care activities i.e., first-aid, pain relief, or escalation of care as indicated.
- The triage assessment and ATS category allocated is recorded on the MR1 WACHS Emergency Department Notes. All documentation is to comply with the Documentation Clinical Practice Standard.

2.2 Off-site triage nurse process

In the absence of an on-site triage nurse, the following process applies:

- The nurse is to be the patient's first point of contact in the ED.
- Patients are to have a primary survey completed immediately on arrival by the nurse.
- Immediate life threats or concerns are to be escalated as per local protocols (i.e., urgent Emergency Telehealth Service referral).
- All other patients to be referred to an identified off-site triage resource immediately (e.g. local escalation, Emergency Telehealth Service).
- Refer to Appendix E: Off-Site Triage Nurse Process.

2.3 Safety at triage[2]

It is essential that all EDs plan for the potential risk of aggressive behaviour of patients or their relatives at triage. There must be a safe and non-threatening physical environment, which is as private as possible whilst not exposing staff to risk. Where the safety of staff and/or other patients is under threat, staff and patient safety should take priority and an appropriate security response should take place prior to clinical assessment and treatment. Refer to local Emergency Response Procedures – Code Black.

For de-escalation information refer to the De-escalation Techniques Information Resource.

Patients of concern, including those who may be at risk of self-harm or suicide, should have strategies put in place to enhance safety and reduce risk, such as being in line of sight and/or increased visual observations. Please see the Patient Assessment and Management in the Emergency Department Policy and the Mental Health Care in Emergency Departments and General Wards Policy.

2.4 Time to treatment

The time to treatment described for each ATS Category refers to the maximum time a patient in that category should wait for assessment and treatment. In the more urgent categories, assessment and treatment should occur simultaneously.[2]
Ideally, patients should be seen well within the recommended maximum times. Implicit in the ATS descriptors is the assumption that the clinical outcome may be affected by delays to assessment and treatment beyond the recommended times.[3]

Where assessment and treatment has not occurred within the recommended ATS category timeframes, refer to the Patient Assessment and Management in the Emergency Department Policy.

2.5 Immediately following allocation of ATS category

Consider / assess:

- risk factors associated with the location of patient while they wait for assessment
- the need to relocate the patient for their or others safety
- the need for an appropriate staff member to stay with the patient whilst awaiting assessment, including the need for visual observations in mental health patients, as outlined in Appendix C: General Management Principles – ATS 1 to 5
- the need for Medical Officer or Nurse Practitioner notifications, further outlined in the Patient Assessment and Management in the Emergency Department Policy
- ensure all documentation is complete
- ensure patients are commenced on the appropriate Observation and Response Chart. All pregnant women over 20 weeks that are triaged must be commenced on a MR140B WACHS Maternal Observation & Response Chart (M-ORC).

3. Roles and Responsibilities

All health care professionals are to work within their scope of practice appropriate to their level of training and responsibility and the scope of their professional registration as documented by the Australian Health Practitioner Regulation Agency.

Nurse managers
For sites which roster two nurses per shift, nurse managers must ensure that triage is within the scope of one of those nurses, where possible. A staff member who is yet to achieve the elements of the WACHS Triage mandatory training requirements must seek guidance from either an onsite nurse who has achieved these elements, through the WACHS Command Centre Emergency Telehealth Service (ETS) and / or through regional escalation pathways.
Registered nurses and nurse practitioners - training and assessment requirements
Those performing Triage (including those in ETS) are required to meet the triage requirements outlined in the WACHS Mandatory Training Catalogue.

- once only requirements:
  - Triage: Theory (NEDT EL2)
  - Triage: Assessment (NEDT 003)
- annual requirements:
  - Triage Continuous Professional Development Declaration (NEDT EL1)
  - Advanced Life Support: Theory (REALH EL2 & REP EL2)
  - Paediatric Advanced Life Support Assessment (REP 003)
  - Adult Advanced Life Support Assessment (REALH 003)
- triage competency facilitators:
  - must have met the requirements outlined in the Triage Competency Facilitators Declaration (NEDT EL4) – annually.
- recognition of prior learning
  - a process for Triage Recognition of Prior Learning is available for Triage: Theory (NEDT EL2) and Triage: Assessment (NEDT 003).
  - refer to the WACHS Resuscitation Education and Competency Assessment Policy for information about the RPL process for Advanced Life Support.

Note: In the event that a staff member's annual compliance with the above has expired, they are able to continue in the triage role, as per their own scope of practice decision making. Staff must take actions to address their mandatory compliance in this time.

Enrolled nurses
An enrolled nurse **must immediately notify** an appropriate triage registered nurse (including ETS) or nurse practitioner on the patient's arrival. An enrolled nurse may be the first person to document an initial assessment of the patient. The registered nurse or nurse practitioner is then required to attend the patient to complete a triage assessment.

All staff are required to work within policies and guidelines to make sure that WACHS is a safe, equitable and positive place to be.

4. Monitoring and Evaluation

4.1 Monitoring

Monitoring of compliance with this document is the responsibility of Regional Nursing and Midwifery Directors and Regional Medical Directors.

Compliance, performance and evaluation is monitored through site, regional and central level governance processes including:

- WACHS Emergency Department Recognising and Responding to Acute Deterioration (RRAD) audit (includes review of triage processes)
- Review indicators within the Health Service Performance Report (HSPR):
  - Percentage of emergency department patients seen within recommended times by triage category
  - WA Emergency Access Target (WEAT)
  - Review of clinical incident data

4.2 Evaluation

The Executive Director Nursing and Midwifery Services is responsible for ensuring that evaluation of this procedure is completed 5 yearly or sooner if indicated. Policy expert/s or leader in best practice will be asked to provide an opinion of WACHS capacity in meeting legislation, regulation, recommendations, strategies or framework obligations.

5. Compliance

Failure to comply with this procedure may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Integrity Policy Framework issued pursuant to Section 26 of the *Health Services Act 2016* and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies and procedures is mandatory.

6. References

1. Australian Government: Department of Health and Ageing. Emergency Triage Education Kit. Canberra ACT: Commonwealth of Australia; 2009 [cited 27 July 2022]
2. Australasian College for Emergency Medicine (ACEM) [Internet] Guidelines on the Implementation of the Australasian Triage Scale in Emergency Departments. Melbourne Australia; 2016 [Cited 27 July 2022]
3. Australasian College for Emergency Medicine (ACEM) [Internet] Triage; Melbourne Australia [Accessed 27 July 2022]
4. Australasian College for Emergency Medicine (ACEM) [Internet] Quality Standards for Emergency Departments and other Hospital-Based Emergency Care Services (1st edition); Melbourne Australia; 2015 [Accessed 27 July 2022]

7. Definitions

Term	Definition
Triage	A triage system is the basic structure in which all incoming patients are categorised into groups using a standard urgency rating scale or structure[1]
Urgency	Urgency is determined according to the patient's clinical condition and is used to 'determine the speed of intervention that is necessary to achieve an optimal outcome'. Urgency is independent of the severity or complexity of an illness or injury[1]

8. Document Summary

Coverage	WACHS wide
Audience	All nurses working in WACHS Emergency Departments
Records Management	Non Clinical: Corporate Recordkeeping Compliance Policy Clinical: Health Record Management Policy
Related Legislation	• *Carers Recognition Act 2004* (WA) • *Children and Community Services Act 2004* (WA) • *Guardianship and Administration Act 1990* (WA) • *Health Practitioner Regulation National Law (WA) Act 2010* • *Medicines and Poisons Act 2014* (WA) • Medicines and Poisons Regulations 2016 (WA) • *Mental Health Act 2014* (WA)
Related Mandatory Policies / Frameworks	• Clinical Governance, Safety and Quality • Clinical Handover Policy – MP 0095/18
Related WACHS Policy Documents	• Clinical observations and Assessments Clinical Practice Standard (physiological (vital signs), neurovascular, neurological and fluid balance) • Consumer and Carer Engagement Policy • Documentation Clinical Practice Standard • Management and Review of "Did Not Wait" Patients that Present to Emergency Services Policy • Mental Health Care in Emergency Departments and General Wards Policy • Patient Assessment and Management in the Emergency Department Policy • Recognising and Responding to Acute Deterioration (RRAD) Policy • Recognising and Responding to Acute Deterioration (RRAD) Procedure • Resuscitation Education and Competency Assessment Policy • WebPAS Child at Risk Alert Procedure
Other Related Documents	• WACHS De-escalation Techniques Information Resource • CAHS Guidelines for Protecting Children 2020
Related Forms	• MR1 WACHS Emergency Department Notes • MR140A Adult Observation and Response Chart (A-ORC) • MR140B Maternal Observation and Response Chart (M-ORC) • MR140C Additional Maternal Observation Chart • MR140D Paediatric Observation and Response Chart (N-ORC) • MR140E Paediatric Acute Recognition and Response Observation Tool (PARROT) – Age less than 3 months

	• MR140F Paediatric Acute Recognition and Response Observation Tool (PARROT) – 3-12 months • MR140G Paediatric Acute Recognition and Response Observation Tool (PARROT) – 1-4 years • MR140H Paediatric Acute Recognition and Response Observation Tool (PARROT) – 5-11 years • MR140I Paediatric Acute Recognition and Response Observation Tool (PARROT) – 12 years and above
Related Training Packages	• Emergency Triage Education Kit. Courses via MyLearning: • Triage: Theory (NEDT EL2) • Triage: Assessment (NEDT 003) • Triage Continuous Professional Development Declaration (NEDT EL1) • Advanced Life Support: Theory (REALH EL2 & REP EL2) • Paediatric Advanced Life Support Assessment (REP 003) • Adult Advanced Life Support Assessment (REALH 003) • Triage Competency Facilitators Declaration (NEDT EL4)
Aboriginal Health Impact Statement Declaration (ISD)	ISD Record ID: 2134
National Safety and Quality Health Service (NSQHS) Standards	2.01, 5.04, 6.01, 8.01, 8.04, 8.05, 8.08, 8.09 and 8.10
Aged Care Quality Standards	1, 2, 3, 5 and 8
National Standards for Mental Health Services	10.3, 10.4 and 10.5
National Standards for Disability Services	1, 5, and 6

9. Document Control

Version	Published date	Current from	Summary of changes
1.00	15/09/2023	15/09/2023	New procedure
1.01	02/01/2024	15/09/2023	Minor amendments to Registered nurses and nurse practitioners - training and assessment requirements and Related Training Packages sections: • Triage: Theory (NEDT EL2). • Triage Competency Facilitators Declaration (NEDT EL4).
1.02	19/03/2024	15/09/2023	Minor amendments to formatting.

10. Approval

Policy Owner	Executive Director Nursing and Midwifery Services
Co-approver	Executive Director Clinical Excellence
Contact	WACHS Coordinator of Nursing
Business Unit	Nursing and Midwifery
EDRMS #	ED-CO-16-73455

This document can be made available in alternative formats on request.

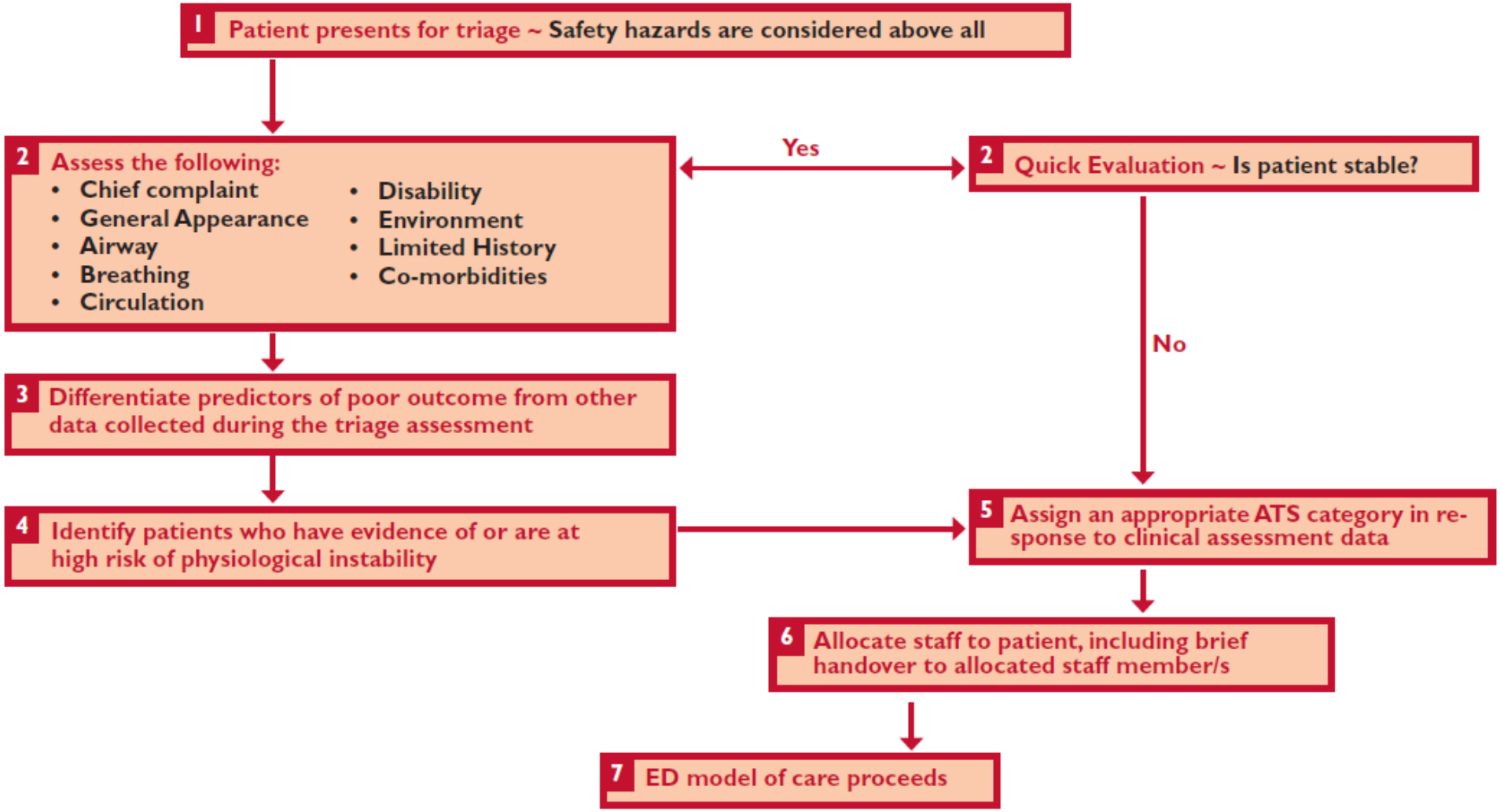
Appendix A: Australasian triage scale categories

The time allocated to each ATS category describes the maximum time a patient can safely wait for medical assessment and treatment

ATS	DESCRIPTION OF CATEGORY	RESPONSE Key Performance Indicator	National Target Times
1	Immediately life-threatening - Conditions that are threats to life (or imminent risk of deterioration) and require immediate aggressive treatment.	**Immediate -** Simultaneous assessment and treatment	100%
2	Imminently life-threatening condition or deteriorating so rapidly that there is the potential of threat to life/foetus/organ system failure or important time-critical intervention e.g. antidote, thrombolysis, or human practice mandates the relief of very severe discomfort/pain or distress.	**Within 10 minutes** - Assessment and treatment	80%
3	Potentially life-threatening – may progress to life or limb threatening, or may lead to significant morbidity, or potential for adverse outcome or time-critical treatment.	**Within 30 minutes -** Assessment and treatment	75%
4	Potentially serious condition – may deteriorate, or possible adverse outcome or time-critical treatment; Symptoms moderate or prolonged or situational urgency or significant complexity or severity likely to require complex work-up and consultation and/or inpatient management.	**Within 60 minutes** - Assessment and treatment start	70%
5	Less urgent - the patient's condition is chronic or minor enough that symptoms or clinical outcome will not be significantly affected if assessment and treatment are delayed or clinic-administrative problems e.g. request for prescription only; results review; medical certificate.	**Within 120 minutes** - Assessment and treatment start	70%

Source: Australasian College of Emergency Medicine (ACEM) 2015

Appendix B: Recommended triage method



Source: Triage Quick Reference Guide (2013) Australian Department of Health and Ageing

Appendix C: General management principles – ATS 1 to 5

Note: This guide is not exhaustive; advice is to be sought for any other concern relating to safety of a patient.

ATS 1

ATS Category	General (adult and paediatric) Considerations	Mental Health Considerations
1	Action: • Continuous cardiac monitoring, SpO_2 • MET call activation • Transfer the patient to the resuscitation area immediately • Alert the resuscitation nurse and medical staff immediately for commencement of immediate simultaneous assessment and treatment • Activate local emergency response protocols (If not on site immediately contact ETS/ RRC/RFDS for assistance/advice). Consider: • Alerting Theatre, Radiology, and Pathology for emergency intervention • Alerting ambulance service / RFDS / APTC for emergency transfer dependent on local service capacity.	Supervision: • Continuous visual surveillance (1:1 ratio) Action: • Alert medical staff immediately, for prompt assessment for consideration of referral under the *Mental Health Act 2014.* • Alert mental health team / RuralLink (Free call 1800 552 002, TTY 1800 720 101), or MH ETS as appropriate to day, time and site. • Provide safe environment for patient or others as outlined in the WACHS Patient Assessment and Management in the Emergency Department Policy. • Alert senior nurse to prepare for personnel to assist with any required emergency psychiatric treatment. Consider: • Calling an emergency Code Black for assistance, as per local procedure, if required • Calling police +/- security/additional staff if staff or patient safety is compromised • Intoxication by drugs and alcohol may cause escalation in behaviour that requires management

ATS 2

ATS Category	General (adult and paediatric) Considerations	Mental Health Considerations
2	Action: • Transfer the patient to the resuscitation / treatment area immediately • Continuous cardiac monitoring, SpO_2 • Triage nurse to weigh child/infant • Alert an RN for commencement of immediate simultaneous assessment and treatment • Alert medical staff immediately for commencement of assessment and treatment • Activate local emergency response protocols. (If not on site immediately contact ETS / APTC / RFDS for assistance/advice) Consider: • Alerting theatre for emergency intervention. • Alerting ambulance service/RFDS/APTC for emergency transfer dependent on local service capacity.	Supervision: • Continuous visual surveillance (direct visual observation at all times) Action: • Alert medical staff immediately, for prompt assessment for consideration of referral under the *Mental Health Act*. • Alert mental health team / RuralLink (Free call 1800 552 002, TTY 1800 720 101), or MH ETS as appropriate to day, time and site. • Provide safe environment for patient or others as outlined in the WACHS Patient Assessment and Management in the Emergency Department Policy. • Use defusing techniques (oral medication, time in quieter area) • Alert senior nurse to prepare for personnel to assist with any required emergency psychiatric treatment • Prompt assessment for patient recommended. Consider: • If de-escalation techniques ineffective, escalate care • Police +/- security/ additional staff until patient sedated • Intoxication by drugs and alcohol may cause escalation in behaviour that requires management.

ATS 3

ATS Category	General (adult and paediatric) Considerations	Mental Health Considerations
3	Action: • Transfer the patient to the treatment area as appropriate • Triage nurse to weigh child/infant. • Commence first aid and comfort measures (ice for pain and swelling, sling for arm) • Handover patient to a nurse or MO/ETS for consideration of assessment and treatment • If patient able to remain in waiting room, triage nurse to observe patient and perform physiological observations and document at 30 minute intervals.	Supervision: • Close observation (regular observation at a maximum of 10 minute intervals). • Do not leave in the waiting room without support person Action: • Alert mental health team / RuralLink (Free call 1800 552 002, TTY 1800 720 101), or MH ETS as appropriate to day, time and site. • Ensure safe environment for patient and others as outlined in the WACHS Patient Assessment and Management in the Emergency Department Policy. Consider: • Clinical escalation if evidence of increasing behavioural disturbance, such as restlessness, intrusiveness, agitation, aggressiveness, increasing distress or threats of harm to self or others • Alert nurse coordinator / security that patient is in the department, for code black preparedness • Intoxication by drugs and alcohol may cause escalation in behaviour that requires management.

ATS 4

ATS Category	General (adult and paediatric) Considerations	Mental Health Considerations
4	Action: • Patient may wait in the waiting room, advise patient may not to drink or eat anything until assessed (presentation dependent) • Triage nurse to weigh child/infant • Commence first aid and comfort measures e.g. ice for pain and swelling, elevation of swollen limb, clean dressing and patient applied pressure • Handover patient to a nurse or MO/ETS for prioritisation of assessment and treatment • If patient appropriate to remain in waiting room, triage nurse to observe the patient and perform physiological observations and document at hourly intervals.	Supervision: • Intermittent observation (regular observation at a maximum of 30 minute intervals) Action: • Discuss with mental health team / RuralLink (Free call 1800 552 002, TTY 1800 720 101), or MH ETS as appropriate to day, time and site. • Referral information and emergency crisis contact details must be provided to consumer prior to discharge. Consider: • Clinical escalation if evidence of increasing behavioural disturbance, such as restlessness, intrusiveness, agitation, aggressiveness, increasing distress • Referral for follow-up with community mental health team on discharge / admission • Intoxication by drugs and alcohol may cause escalation in behaviour that requires management.

ATS 5

ATS Category	General (adult and paediatric) Considerations	Mental Health Considerations
5	Action: • Patient may wait in the waiting room, advise patient may not to drink or eat anything until assessed (presentation dependent) • Triage nurse to weigh child/infant • Commence first aid and comfort measures e.g. ice for pain and swelling, elevation of swollen limb, clean dressing and patient applied pressure • Handover patient to nurse or MO/ETS for prioritisation of assessment and treatment • If patient appropriate to remain in waiting room, triage nurse to observe the patient and perform physiological observations and document at two hourly intervals observe the patient.	Supervision: • General observation (routine waiting room check at a maximum of 1 hour intervals). Action: • Discuss with mental health team / RuralLink (Free call 1800 552 002, TTY 1800 720 101), or MH ETS appropriate to day, time and site. • Refer to treating team if case-managed • Referral information and emergency crisis contact details must be provided to consumer prior to discharge.

Appendix D: Triage clinical descriptors guide

Note: This guide is not exhaustive; advice is to be sought for any other concern relating to safety of a patient. The list is based on guidelines from the Emergency Triage Education Kit (ETEK), the ETEK Triage Quick Reference Guide, and the ACEM Guidelines on the Implementation of the Australasian Triage Scale in Emergency Departments.

Airway and Breathing

		Category 1 (immediate)	Category 2 (10 minutes)	Category 3 (30 minutes)	Category 4 (60 minutes)	Category 5 (120 minutes)
AIRWAY	ALL PATIENTS	Immediate risk to airway: • Completely or partially obstructed • Severe stridor • Threatened airway (swelling / facial burns) or airway management required	• Potential airway risk • Partially obstructed with moderate respiratory distress	• Patent • Able to verbalise	• Patent • Foreign body aspiration with no respiratory distress	• Patent
BREATHING	ADULTS	Extreme respiratory distress: • Absent respiration/ respiratory arrest	Severe respiratory distress	Moderate respiratory distress	Mild or no respiratory distress • Chest injury without rib pain or respiratory distress • Difficulty swallowing, no respiratory distress	No respiratory distress

For additional information on paediatric patients please refer to Emergency Triage Education Kit – Chapter 8: Paediatric Triage.

Breathing (continued)

		Category 1 (immediate)	Category 2 (10 minutes)	Category 3 (30 minutes)	Category 4 (60 minutes)	Category 5 (120 minutes)
BREATHING	PAEDIATRIC	Extreme respiratory distress: • Absent respiration • Hypoventilation • Severe respiratory distress e.g. severe use accessory muscle, severe retraction, acute cyanosis	Severe respiratory distress: • Moderate use accessory muscles, moderate retraction, skin pale	Mild-moderate respiratory distress: • Mild use accessory muscles, mild retraction, skin pink	No respiratory distress	No respiratory distress

For additional information on paediatric patients please refer to Emergency Triage Education Kit – Chapter 8: Paediatric Triage.

Circulation

		Category 1 (immediate)	Category 2 (10 minutes)	Category 3 (30 minutes)	Category 4 (60 minutes)	Category 5 (120 minutes)
CIRCULATION	ADULTS	• Severe circulatory compromise • Absent circulation/Cardiac arrest • Uncontrolled haemorrhage	• Moderate circulatory compromise • Clammy, mottled skin, skin pale, cool, poor perfusion • Severe blood loss • Chest pain of suspected cardiovascular origin • Fever 38° C+ with signs of lethargy (any age) • Suspected sepsis (haemo-dynamically unstable) • Febrile neutropenia-immunosuppressed, oncology or steroid therapy	• Mild circulatory compromise • Palpable peripheral pulses, skin pale, warm • Moderately severe blood loss – any cause • Persistent vomiting or diarrhoea with signs of dehydration	• No circulatory compromise • Skin pink and warm, no alteration in vital signs • Vomiting or diarrhoea without dehydration	• No circulatory compromise

Circulation (continued)

		Category 1 (immediate)	Category 2 (10 minutes)	Category 3 (30 minutes)	Category 4 (60 minutes)	Category 5 (120 minutes)
CIRCULATION Paediatric signs and symptoms (s/s) of dehydration: - ↓LOC/activity - Cap refill> 2 secs - Dry mucous membranes - Absent tears - Sunken eyes/ fontanelles - ↓Tissue turgor - Deep respirations - Thready/weak pulse - Tachycardia - ↓Urine output / <4 wet nappies in 24hrs - Weight loss >4-5%	PAEDIATRIC	• Severely shocked child • Absent circulation • Significant bradycardia (e.g. <60 in an infant) • Severe haemodynamic compromise (absent peripheral pulses, skin pale, cold, mottled, significant tachycardia for age range; capillary refill >4 seconds, very sunken fontanel) • Uncontrolled haemorrhage	• Moderate circulatory compromise: • Greater than 6 s/s of dehydration • Skin pale, cool, moderate tachycardia for age range, capillary refill 2-4 seconds, sunken fontanel, decreased skin turgor) • Fever with signs of lethargy/ increased irritability (any age) • Any neonate or corrected preterm age < 28 days • Age < 3 months and febrile (38.0°C) • Age < 5 years, febrile (38.5°C) and with signs of lethargy or increased irritability or rash or co-morbidities • Suspected sepsis (haemo-dynamically unstable)	• Mild circulatory compromise: • 3-6 s/s of dehydration • Palpable peripheral pulses, skin pale, warm, slightly dry mucous membranes • Mild tachycardia as for age range	• No circulatory compromise • Less than 3 s/s of dehydration • Palpable peripheral pulses, skin pink warm and dry for age range)	• No circulatory compromise • No s/s of dehydration

For additional information on paediatric patients please refer to Emergency Triage Education Kit – Chapter 8: Paediatric Triage.

Disability

		Category 1 (immediate)	Category 2 (10 minutes)	Category 3 (30 minutes)	Category 4 (60 minutes)	Category 5 (120 minutes)
DISABILITY	ADULTS	• AVPU- Unresponsive • GCS <9 (less than 9) • Ongoing/prolonged seizure • Pupils: fixed and dilated (Indication of possible drug overdose or head trauma) • IV drug overdose and unresponsive or hypoventilation	• AVPU- responds to pain only • GCS 9 – 12 • Drowsy, decreased responsiveness of any cause • Sudden severe headache with altered GCS • BSL <3 • Suspected DKA • Suspected provisional diagnoses (acute stroke, meningococcemia) • Significant sedative or other toxic ingestion • Significant or dangerous envenomation	• AVPU- responds to voice • GCS > 12 (greater than 12) • Sudden severe headache with normal GCS • Head injury with short loss of consciousness, now alert • Seizure, now alert • Suspected stroke	• Normal GCS or no acute change to usual GCS • AVPU - Alert • Minor head injury, no loss of consciousness	• Normal GCS
	PAEDIATRIC	• AVPU- Unresponsive • GCS <8 (less than 8) • Ongoing / prolonged seizure	• GCS 9 – 12 • Severe decreases in activity (no eye contact, decreased muscle tone) • Significant sedative or other toxic ingestion • Significant / dangerous envenomation	• GCS ≥13 (greater than or equal to 13) • Moderate decrease in activity (lethargic, eye contact when disturbed)	• Normal GCS or no acute change in usual GCS • Mild decrease in activity (quiet but eye contact, interacts with parents)	• Normal GCS • No alteration to activity (playing, smiling)

For additional information on paediatric patients please refer to Emergency Triage Education Kit – Chapter 8: Paediatric Triage.

Pain

		Category 1 (immediate)	Category 2 (10 minutes)	Category 3 (30 minutes)	Category 4 (60 minutes)	Category 5 (120 minutes)
PAIN	ALL PATIENTS		• Very severe pain requiring analgesia, affecting physical capacity emotions and or behaviour. Including possible: cardiac cause, acute myocardial infarction, AMI, PE, aortic dissection, pulmonary embolus, aortic dissection, ruptured abdominal aortic aneurysm, testicular torsion, ectopic pregnancy, ischaemic leg, ischaemic gut, renal colic, dislocated hip or shoulder	• Moderate severe pain requiring analgesia • Chest pain, likely non-cardiac • Abdominal pain without high risk features of moderate-severe pain or patient age >65 years	• Moderate pain some risk features and/or requiring analgesia • Non-specific abdominal pain	• Minimal pain

For additional information on paediatric patients please refer to Emergency Triage Education Kit – Chapter 8: Paediatric Triage.

Neurovascular and trauma

		Category 1 (immediate)	Category 2 (10 minutes)	Category 3 (30 minutes)	Category 4 (60 minutes)	Category 5 (120 minutes)
NEURO-VASCULAR	ALL PATIENTS		• Severe neurovascular compromise; pulseless, cold, nil sensation, nil movement, ↓ cap refill	• Moderate neurovascular compromise; pulse present or acutely absent, cool, ↓ sensation, movement and / or cap refill	• Mild neurovascular compromise; pulse present, normal/ ↓ sensation, movement and/or cap refill • Tight cast- with no neurovascular impairment • Swollen 'hot' joint/s	• No neuro-vascular compromise
TRAUMA		• Major multi trauma	• Major multi trauma (requiring rapid organised response) • Severe localised trauma – major fracture, amputation • Suspected testicular torsion	• Moderate limb injury – deformity, severe laceration, crush injury • Trauma – high risk history with no other high-risk features • Child at risk of abuse/suspected non-accidental injury	• Minor limb trauma – sprained ankle, possible fracture • Uncomplicated laceration requiring investigation or intervention	• Minor wounds – small abrasions, minor lacerations (not requiring suturing)

Major trauma criteria ATS 1 or 2:
- Penetrating injury
- Fall > 3 metres (paediatric fall >1m)
- MCA > 60kph
- MBA / cyclist / pedestrian > 30kph
- Explosion

Ophthalmic

	Category 1 (immediate)	Category 2 (10 minutes)	Category 3 (30 minutes)	Category 4 (60 minutes)	Category 5 (120 minutes)
OPHTHALMIC ALL PATIENTS		• Penetrating eye injury • Chemical Injury (acid or alkali splash to eye) – requiring irrigation • Sudden loss of vision or pain +/- injury • Suspected endophthalmitis post eye procedure (post cataract, post intravitreal injection)	• Sudden abnormal vision with or without injury • Moderate eye pain e.g. blunt eye injury, flash burns, foreign body	• Eye inflammation or foreign body with normal vision	• Low-risk history and now asymptomatic • Minor symptoms of existing stable illness or low risk condition. • Patient requesting medical certificates, prescriptions.

Mental Health

	Category 1 (immediate)	Category 2 (10 minutes)	Category 3 (30 minutes)	Category 4 (60 minutes)	Category 5 (120 minutes)
MENTAL HEALTH ALL PATIENTS If in police custody or on Mental Health Forms consider clinical escalation	**Risk:** Definite danger to life (self or others). Severe behavioural disorder. **Observed:** • Extreme or violent behaviour • Possession of weapon • Self-destruction in ED • Displays extreme agitation or restlessness • Bizarre/disoriented behaviour **Reported:** • Verbal commands to do harm to self or others, that the person is unable to resist (command hallucinations)	**Risk:** Probable risk of danger (self or others) **Observed:** • Severe agitation/ restlessness • Physically/verbally aggressive • Confused/unable to cooperate • Hallucinations/delusions/paranoia • Requires or has required restraint / containment • High risk of absconding and not waiting for treatment **Reported:** • Attempt at self-harm / threat of self-harm • Immediate threat of harm to others • Unable to wait safely	**Risk:** Possible danger to self or others; very distressed; risk of self-harm or has deliberately self-harmed **Observed:** • Agitated/restless • Intrusive behaviour • Thought disordered • Withdrawn/ uncommunicative / ambivalence about treatment • Not likely to wait for treatment • Potentially aggressive • Elevated / irritable mood **Reported:** • Suicidal ideation • Situational crisis Presence of psychotic symptoms: • Hallucinations • Delusions • Paranoid ideas	**Risk:** Under observation and/or no immediate risk to self or others. **Observed:** • No agitation/ restlessness • Irritable without aggression • Cooperative • Patient provides coherent history **Reported:** • Semi urgent mental health problem • Pre-existing mental health disorder • Symptoms of anxiety or depression, without suicidal ideation • Willing to wait	**Risk:** No danger to self or others. No acute distress or behavioural disturbance **Observed:** • Cooperative • Communicative and able to engage in developing management plan • Able to discuss concerns • Compliant with instructions • Request for medication • Minor adverse effect of medication **Reported:** • Pre-existing non-acute mental health disorder with chronic psychotic symptoms, social crisis, clinically well patient

For additional information on mental health patients please refer to Emergency Triage Education Kit – Chapter 5: Mental Health Triage

Appendix E – Off-site triage nurse process

Emergency Telehealth Service (ETS) 1800 422 190

Patient presents to site. On arrival, site nurse completes rapid primary survey (ABCDE) to identify any immediate life threats/concerns

IMMEDIATE LIFE THREATS IDENITIFIED OR OTHER CONCERNS - CALL ETS. PRESS 1.

FOR ALL OTHER PRESENTATIONS PRESS 2

Provide patient's name, DOB, UMRN (where possible) and presenting complaint

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Confirm site VC number with ETS nurse & ensure patient is present and aware that ETS triage nurse will appear on screen

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Commence the primary assessment, including a full set of vital signs

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Site nurse to handover the primary assessment findings to ETS nurse. ETS nurse will triage the patient WITH the site nurse

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ETS nurse will enter the patient directly on to WebPAS and print the MR1 to the site printer. The ETS nurse will then handover patient care on WebPAS to the site nurse *(will require the nurse at site's he number)*

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On-site nurse to fax through copy of MR1 BACK to ETS with a set of observations and any other relevant information, such as ECG