

**EMERGENCY  
TRIAGE  
EDUCATION  
KIT**



TRIAGE QUICK REFERENCE GUIDE

[**www.health.gov.au**](http://www.health.gov.au/)

# Recommended Triage Method

|  |  |
| --- | --- |
| **2** | **Assess the following:** |
| * **Chief complaint • Disability** * **General Appearance • Environment** * **Airway • Limited History** * **Breathing • Co-morbidities** * **Circulation** | |

|  |  |
| --- | --- |
| **1** | **Patient presents for triage ~ Safety hazards are considered above all** |
|  |

Triage Method

**Yes**

**No**

|  |  |
| --- | --- |
| **2** | **Quick Evaluation ~ Is patient stable?** |
|  | |

|  |  |
| --- | --- |
| **3** | **Differentiate predictors of poor outcome from other** |
| **data collected during the triage assessment** | |

|  |  |
| --- | --- |
| **4** | **Identify patients who have evidence of or are at** |
| **high risk of physiological instability** | |

|  |  |
| --- | --- |
| **5** | **Assign an appropriate ATS category in re-** |
| **sponse to clinical assessment data** | |

|  |  |
| --- | --- |
| **6** | **Allocate staff to patient, including brief** |
| **handover to allocated staff member/s** | |

|  |  |
| --- | --- |
| **7** | **ED model of care proceeds** |
|  |

ATS Categories

# ATS categories for treatment acuity and performance thresholds

|  |  |  |
| --- | --- | --- |
| **ATS category** | **Treatment acuity (maximum waiting time)** | **Performance indicator (%)** |
| 1 | Immediate | 100 |
| 2 | 10 minutes | 80 |
| 3 | 30 minutes | 75 |
| 4 | 60 minutes | 70 |
| 5 | 120 minutes | 70 |

Assessment of Pain

# Validated Methods for quantitative assessment of pain

**Visual analogue scale: 100 mm line**

(Nelson, Cohen, Lander, et al, 2004) Use a 100 mm line as shown below.

|  |  |
| --- | --- |
| 0 | 10 |
| No pain | Severe pain |
| Ask the patient to mark their level of pain on the line. |  |

# Application of a triage category

Descriptive terms to guide acuity for the ATS and validated methods for quantitative assessment of pain

|  |  |
| --- | --- |
| **Descriptor** | **ATS category** |
| Very severe | 2 |
| Moderately severe | 3 |
| Moderate | 4 |
| Minimal | 5 |

Reference: Australasian College of Emergency Medicine

# Abbey Pain Scale

**For measurement of pain in people who cannot verbalise**

**How to use scale:** While observing the patients, score questions 1 to 6 Add scores for 1 – 6 and record here Total Pain Score

**Q1.Vocalisation** Now tick the box that matches the

|  |  |  |  |
| --- | --- | --- | --- |
| 0–2 | 3–7 | 8–13 | 14+ |
| No pain | Mild | Moderate | Severe |

eg: whimpering, groaning, crying Total Pain Score

Absent 0 Mild 1 Moderate 2 Severe 3

|  |  |  |
| --- | --- | --- |
| Chronic | Acute | Acute on Chronic |

**Q2. Facial expression**

eg: looking tense, frowning, grimacing, looking frightened Absent 0 Mild 1 Moderate 2 Severe 3

**Q3. Change in body language**

eg: fidgeting, rocking, guarding part of body, withdrawn Absent 0 Mild 1 Moderate 2 Severe 3

**Q4. Behavioural change**

eg: increased confusion, refusting to eat, alteration in usual patterns Absent 0 Mild 1 Moderate 2 Severe 3

**Q5. Physiological change**

eg: temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor

Absent 0 Mild 1 Moderate 2 Severe 3

**Q6. Physical changes**

eg: skin tears, pressure areas, arthritis, contractures, previous injuries Absent 0 Mild 1 Moderate 2 Severe 3

Finally, tick the box which matches the type of pain

Pain Scale – Abbey

Reference: Jennifer Abbey, Neil Piller,AnitaDe Bellis,Adrian Esterman, Deborah Parker, Lynne Giles and Belinda Lowcay (2004) The Abbey pain scale: a 1-minute numerical indicator for people with end-stage dementia, *International Journal of Palliative Nursing***,** Vol 10, No 1.pp 6-13.

# FLACC Behavioural Pain Scale

|  |  |  |  |
| --- | --- | --- | --- |
|  | **0** | **1** | **2** |
| **Face** | No particular expression or smile | Occassional grimace or frown, withdrawn, disinterested | Frequent to constant quivering chin, clenched jaw |
| **Legs** | Normal position or relaxed | Uneasy, restless, tense | Kicking, or legs drawn up |
| **Activity** | Lying quietly, normal position, moves easily | Squirming, shifting, back and forth, tense | Arched, rigid or jerking |
| **Cry** | No cry (awake or asleep) | Moans or whimpers; occasional complaint | Crying steadily, screams, sobs, frequent complaints |
| **Consolability** | Content, relaxed | Reassured by touching, hugging or being talked to, distractible | Diffcult to console or comfort |

**Instructions**

**Patients who are awake:**

* Observe for at least 2-5 minutes.
* Observe legs and body uncovered.
* Reposition patient or observe activity, assess body for tenseness and tone.
* Initiate consoling interventions if needed.

**Patients who are asleep:**

* Observe for at least 5 minutes or longer.
* Observe body and legs uncovered.
* If possible reposition the patient.
* Touch the body and assess for tenseness and tone.

Each category is scored on the 0-2 scale which results in a total score of 0-10 **Assessment of Behavioral Score:**

**0** = Relaxed and comfortable

**1-3** = Mild discomfort

**4-6** = Moderate pain

**7-10** = Severe discomfort/pain

Pain Scale – FLACC

Reference: Merkel S,Voepel-Lewis T, Shayevitz JR, et al: *The FLACC: A behavioural scale for scoring postoperative pain in young children*. Pediatric Nursing 1997; 23:293-797 Printed with permission © 2002,The Regents of the University of Michigan

Pain Scale – Wong-Baker

# Wong-Baker FACES Pain rating scale

**Developed for young patients to communicate how much pain they are feeling.**



**0 1 2 3 4 5**

**NO HURT HURTS HURTS HURTS HURTS HURTS LITTLE BIT LITTLE EVEN WHOLE WORST**

**MORE MORE LOT**

**Instructions**

Explain to the child that each face is for a person who feels happy because he has no pain (hurt) or sad because he has some or a lot of pain.

**Face 0** is very happy because he doesn’t hurt at all.

**Face 1** hurts just a little bit.

**Face 2** hurts a little more.

**Face 3** hurts even more.

**Face 4** hurts a whole lot more.

**Face 5** hurts as much as you can imagine, although you do not have to be crying to feel this bad. Ask the child to choose the face that best describes how he/she is feeling.

Reference: Hockenberry MJ,Wilson D,Winkelstein ML: *Wong’s Essentials of Pediatric Nursing,* ed. 7, St. Louis, 2005, p. 1259. Used with permission. Copyright, Mosby.

Obstetrics

# The ABCs of obstetrics

|  |  |  |
| --- | --- | --- |
| **Urgency** | **Urgency Indicator** | **Reason for caution** |
| Airway | * Any potential compromise * Increased nasal congestion | * Often diffcult intubations due to:   + increased patient size   + diffculty with patient positioning   + different induction agents required * Increased vascularity of nose and airways causes diffculty in breathing |
| Breathing | * Asthma | * Progesterone may be responsible for increased drive to breathe * One third of pregnant asthmatic women experience a deterioration in their condition |
| Circulation | * Palpitations * Headache * Sudden drop in BP * Symptoms of pulmonary embolus | * Progesterone causes widespread vasodilatation * Oestrogen may contribute to increases in blood volume * Diastolic BP – 6–17mmHg * BP lowest during second trimester * Cardiac output (CO) – by 30–50% * Hyperdynamic fow * High volume and dynamic fow may cause cerebral heamorrhage, especially subarachnoid haemorrhage (SAH) during pregnancy * Sudden and serious deterioration of their condition * Changes in coagulation system associated with pregnancy |

**The ABCs of obstetrics (continued)**

**Points to remember**

* + Hyperdynamic physiological changes occur as early as 6–8 weeks gestation.
  + An assessment of urgency must be made on the basis of both the woman and the foetus.
  + An elevated BP is an ominous sign: the higher the BP the more urgent the review.
  + At 20 weeks the weight of the uterus compresses the inferior vena cava if the woman is lying on her back – a compromise to foetal wellbeing.
  + The risk of many conditions is higher in pregnant women than non-pregnant women of childbearing age. These conditions include:
    - cerebral haemorrhage or cerebral thrombosis
    - severe pneumonia
    - atrial arrythmias
    - venous thrombosis
    - cholelithiasis
    - pyelonephritis
    - spontaneous arterial dissections, e.g. splenic and subclavian dissections, with no previous medical history.
  + Domestic violence is more prevalent during pregnancy. This can mean increased complications for mother and adverse neonatal outcomes.
  + In the setting of trauma, maternal signs may remain stable even when loss of one-third of blood volume may have occurred.
  + The best initial treatment for the foetus is the optimum resuscitation of the mother.

# Assessment of dehydration levels in infants

|  |  |  |  |
| --- | --- | --- | --- |
| **Signs** | **Severity** | | |
| **Mild** | **Moderate** | **Severe** |
| General condition | Thirsty, restless, agitated | Thirsty, restless, irritable | Withdrawn, somnolent or comatose; rapid deep breathing |
| Pulse | Normal | Rapid, weak | Rapid, weak |
| Anterior fontanelle | Normal | Sunken | Very sunken |
| Eyes | Normal | Sunken | Very sunken |
| Tears | Present | Absent | Absent |
| Mucous membranes | Slightly dry | Dry | Dry |
| Skin turgor | Normal | Decreased | Decreased with tenting |
| Urine | Normal | Reduced, concentrated | None for several hours |
| Weight loss | 4–5% | 6–9% | >10% |

Source: Health Information for International Travel. Chapter 8:Traveling Safely with Infants and Children. USA: Centers for Disease Control and Prevention [Online] 2005 [Cited 2007 March 24].

Paediatric – Dehydration

PPD

# Paediatric physiological discriminators (PPD)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Category 1 Immediate** | **Category 2 Emergency**  **Within 10 minutes** | **Category 3 Urgent**  **Within 30 minutes** | **Category 4 Semi urgent**  **Within 60 minutes** | **Category 5 Non urgent**  **Within 120 minutes** |
| Airway | Obstructed  Partially obstructed with severe respiratory distress | Patent  Partially obstructed with moderate respiratory distress | Patent  Partially obstructed with mild respiratory distress | Patent | Patent |
| Breathing | Absent respiration or hypoventilation | Respiration present | Respiration present | Respiration present | Respiration present |
| Circulation  s/s dehydration LOC/activity cap refll <2 sec dry oral mucosa sunken eyes tissue turgor absent tears  deep respirations thready/weak pulse tachycardia  urine output | Severe respiratory distress, e.g.   * severe use accessory muscles * severe retraction * acute cyanosis. | Moderate respiratory distress, e.g.   * moderate use accessory muscles * moderate retraction * skin pale. | Mild respiratory distress, e.g.   * mild use accessory muscles * mild retraction * skin pink. | No respiratory distress – no use accessory  muscles  – no retraction. | No respiratory distress – no use accessory  muscles  – no retraction. |
| Absent circulation Signifcant bradycardia,  e.g. HR <60 in an infant | Circulation present | Circulation present | Circulation present | Circulation present |
| Severe haemodynamic compromise, e.g.   * absent peripheral pulses * skin pale, cold, moist, mottled * signifcant tachycardia * capillary refll >4 secs. | Moderate hemodynamic compromise, e.g.   * weak/thready brachial pulse * skin pale, cool, * moderate tachycardia * capillary refll 2–4 secs. | Mild haemodynamic compromise, e.g.   * palpable peripheral pulses * skin pale, warm * mild tachycardia. | No haemodynamic compromise, e.g.   * palpable peripheral pulses * skin pink, warm, dry. | No haemodynamic compromise, e.g.   * palpable peripheral pulses * skin pink, warm, dry. |
| Uncontrolled hemorrhage | >6 s/s dehydration | 3–6 s/s dehydration | <3 s/s dehydration | No s/s dehydration |

**Paediatric physiological discriminators (continued)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Category 1 Immediate** | **Category 2 Emergency**  **Within 10 minutes** | **Category 3 Urgent**  **Within 30 minutes** | **Category 4 Semi urgent**  **Within 60 minutes** | **Category 5 Non urgent Within**  **120 minutes** |
| Disability | GCS<8 | GCS 9–12  Severe decrease in activity, e.g.   * no eye contact, * decreased muscle tone. | GCS >13  Moderate decrease in activity, e.g.   * lethargic * eye contact when disturbed. | Normal GCS or no acute change to usual GCS.  Mild decrease in activity, e.g.   * quiet but eye contact * interacts with parents. | Normal GCS or no acute change to usual GCS.  No alteration to activity, e.g.   * playing * smiling. |
|  |  | Severe pain, e.g.   * patient/parents report severe pain * skin, pale, cool * alteration in vital signs * requests analgesia. | Moderate pain, e.g. – patient/parents  report moderate pain   * skin, pale, warm * alteration in vital signs * requests analgesia. | Mild pain, e.g.   * patient/parents report mild pain * skin, pink, warm * no alteration in vital signs * requests analgesia. | No or mild pain, e.g. – patient/parents  report mild pain   * skin, pink, warm * no alteration in vital signs * declines analgesia. |
|  |  | Severe neurovascular compromise, e.g.   * pulseless * cold * nil sensation * nil movement * capillary refll. | Moderate neurovascular compromise, e.g.   * pulse present * cool * sensation * movement * capillary refll. | Mild neurovascular compromise, e.g.   * pulse present * normal/ sensation * normal/ movement * normal capillary refll. | No neurovascular compromise |

APP

# Summary of adult physiological predictors (APP) for the ATS

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Category 1 immediate** | **Category 2**  **10 minutes** | **Category 3**  **30 minutes** | **Category 4**  **60 minutes** | **Category 5**  **120 minutes** |
| Airway | Obstructed/partially obstructed | Patent | Patent | Patent | Patent |
| Breathing | Severe respiratory distress/absent respiration/ hypoventilation | Moderate respiratory distress | Mild respiratory distress | No respiratory distress | No respiratory distress |
| Circulation | Severe haemodynamic compromise/absent circulation  Uncontrolled haemorrhage | Moderate haemodynamic compromise | Mild haemodynamic compromise | No haemodynamic compromise | No haemodynamic compromise |
| Disability | GCS <9 | GCS 9–12 | GCS >12 | Normal GCS | Normal GCS |

**Risk factors for serious illness or injury**

These should be considered in the light of history of events and physiological data. Multiple risk factors = increased risk of serious injury.

The presence of one or more risk factors may result in allocation of triage category of higher acuity.

Developed by a project team for the ‘Consistency in Triage Project’ (2001). Contributors: Emergency Nurses Association,Triage Working Party and Royal Children’s Hospital emergency nursing staff.

Risk factors

# Risk factors for serious illness or injury

These should be considered in the light of history of events and physiological data. Multiple risk factors = increased risk of serious injury.

The presence of one or more risk factors may result in allocation of triage category of higher acuity.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Mechanism of injury, e.g.   * penetrating injury * fall >2 – height * MCA >60 kph * MBA/cyclist > 30 kph * pedestrian * ejection/rollover * prolonged extrication (>30 minutes) * death same car occupant * explosion. | Co morbidities, e.g. Hx prematurity   * respiratory disease * cardiovascular disease * renal disease * carcinoma * diabetes * substance abuse * immuno-compromised * congenital disease * complex medical Hx. | Age <3 months and   * febrile * acute change to feeding pattern * acute change to sleeping pattern   Victims of violence, e.g.   * child at risk * sexual assault * neglect. | Historical variables, e.g. events preceding presentation to ED   * apnoeic/cyanotic episode * seizure activity * decreased intake * decreased output * red current jelly stool * bile stained vomiting. Parental concern. | Other, e.g.   * rash * actual/potential effects of drugs/alcohol * chemical exposure * envenomation * immersion * alteration in body temperature. |

OEP

# Summary of ophthalmic emergency predictors (OEP) for the ATS

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Category 1 Immediate** | **Category 2**  **10 minutes** | **Category 3**  **30 minutes** | **Category 4**  **60 minutes** | **Category 5**  **120 minutes** |
|  | * Penetrating eye injury * Chemical injury * Sudden loss of vision with or without injury * Sudden onset severe eye pain | * Sudden abnormal vision with or without injury * Moderate eye pain, e.g.   + blunt eye injury   + fash burns   + foreign body | * Normal vision * Mild eye pain, e.g.   + blunt eye injury   + fash burns   + foreign body | * Normal vision * No eye pain |

MH Triage tool

# Mental health triage tool

|  |  |  |  |
| --- | --- | --- | --- |
| **Triage code – Treatment acuity** | **Description** | **Typical presentation** | **General management principles\*** |
| **1 – Immediate** | **Deﬁnite danger to life (self or others) Australasian Triage Scale1 states:**  – Severe behavioural disorder with immediate threat of dangerous violence | **Observed**   * Violent behaviour * Possession of weapon * Self-destruction in ED * 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)   * Recent violent behaviour | **Supervision**  Continuous visual surveillance 1:1 ratio (see defnition below)  **Action**   * Alert ED medical staff immediately * Alert mental health triage or equivalent * Provide safe environment for patient and others * Ensure adequate personnel to provide restraint/detention based on industry standards   **Consider**   * Calling security +/- police if staff or patient safety compromised. May require several staff to contain patient * 1:1 observation * Intoxication by drugs and alcohol may cause an escalation in behaviour that requires management. |

**Mental health triage tool (continued)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Triage code – Treatment acuity** | **Description** | **Typical presentation** | **General management principles\*** |
| **2 – Emergency**  Within 10 minutes | **Probable risk of danger to self or others**  *AND/OR*  **Client is physically restrained in emergency department** *AND/OR*  **Severe behavioural disturbance Australasian Triage Scale1 states:**  Violent or aggressive (if):   * Immediate threat to self or others * Requires or has required restraint * Severe agitation or aggression | **Observed**   * Extreme agitation/restlessness * Physically/verbally aggressive * Confused/unable to cooperate * Hallucinations/delusions/paranoia * Requires restraint/containment * High risk of absconding and not waiting for treatment   **Reported**   * Attempt at self-harm/threat of self-harm * Threat of harm to others * Unable to wait safely | **Supervision**  Continuous visual supervision (see defnition below)  **Action**   * Alert ED medical staff immediately * Alert mental health triage * Provide safe environment for patient and others * Use defusing techniques (oral medication, time in quieter area) * Ensure adequate personnel to provide restraint/detention * Prompt assessment for patient recommended under Section 9 or apprehended under Section 10 of Mental Health Act.   **Consider**   * If defusing techniques ineffective, re-triage to category 1 (see above) * Security in attendance until patient sedated if necessary * Intoxication by drugs and alcohol may cause an escalation in behaviour that requires management |

**Mental health triage tool (continued)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Triage code – Treatment acuity** | **Description** | **Typical presentation** | **General management principles\*** |
| **3 – Urgent**  Within 30 minutes | **Possible danger to self or others**   * Moderate behaviour disturbance * Severe distress   **AustralasianTriage Scale1 states:**   * Very distressed, risk of self-harm * Acutely psychotic or thought-disordered * Situational crisis, deliberate self-harm * Agitated/withdrawn | **Observed**   * Agitation/restlessness * Intrusive behaviour * Confused * Ambivalence about treatment * Not likely to wait for treatment   **Reported**   * Suicidal ideation * Situational crisis   **Presence of psychotic symptoms**   * Hallucinations * Delusions * Paranoid ideas * Thought disordered * Bizarre/agitated behaviour   **Presence of mood disturbance**   * Severe symptoms of depression * Withdrawn/uncommunicative and/or anxiety * Elevated or irritable mood | **Supervision**  Close observation (see defnition below)   * Do not leave patient in waiting room without support person   **Action**   * Alert mental health triage * Ensure safe environment for patient and others   **Consider**   * Re-triage if evidence of increasing behavioural disturbance i.e.   + Restlessness   + Intrusiveness   + Agitation   + Aggressiveness   + Increasing distress * Inform security that patient is in department * Intoxication by drugs and alcohol may cause an escalation in behaviour that requires management |

**Mental health triage tool (continued)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Triage code – Treatment acuity** | **Description** | **Typical presentation** | **General management principles\*** |
| **4 – Semi-urgent**  Within 60 minutes | **Moderate distress Australasian Triage Scale1 states:**   * Semi-urgent mental health problem * Under observation and/or no immediate risk to self or others | **Observed**   * No agitation/restlessness * Irritable without aggression * Cooperative * Gives coherent history   **Reported**   * Pre-existing mental health disorder * Symptoms of anxiety or depression without suicidal ideation * Willing to wait | **Supervision**  Intermittent observation (see defnition below)  **Action**  Discuss with mental health triage nurse  **Consider**   * Re-triage if evidence of increasing behavioural disturbance i.e.   + Restlessness   + Intrusiveness   + Agitation   + Aggressiveness   + Increasing distress * Intoxication by drugs and alcohol may cause an escalation in behaviour that requires management |

**Mental health triage tool (continued)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Triage code – Treatment acuity** | **Description** | **Typical presentation** | **General management principles\*** |
| **5 – Non-urgent**  Within 120 minutes | **No danger to self or others**   * No acute distress * No behavioural disturbance   **AustralasianTriage Scale1 states:**   * Known patient with chronic symptoms * Social crisis, clinically well patient | **Observed**   * Cooperative * Communicative and able to engage in developing management plan * Able to discuss concerns * Compliant with instructions   **Reported**   * Known patient with chronic psychotic symptoms * Pre-existing non-acute mental health disorder * Known patient with chronic unexplained somatic symptoms * Request for medication * Minor adverse effect of medication * Financial, social, accommodation, or relationship problems | **Supervision**  General observation (see defnition below)  **Action**   * Discuss with mental health triage * Refer to treating team if case-managed |

**Management Deﬁnitions2**

**Continuous visual surveillance** = person is under direct visual observation at all times **Close observation** = regular observation at a maximum of 10 minute intervals **Intermittent observation** = regular observation at a maximum of 30 minute intervals **General observation** = routine waiting room check at a maximum of 1 hour intervals

\* Management principles may differ according to individual health service protocols and facilities.

1 Australasian College of Emergency Medicine (2000). Guidelines for the implementation of the Australasian Triage Scale (ATS) in Emergency Departments.

2 South Eastern Sydney Area Health Service Mental Health Triage guidelines for Emergency Departments

**Acknowledgements**

NICS acknowledges existing triage tools provided by Barwon Health