Australian Government

Department of Health and Ageing

EMERGENCY TRIAGE EDUCATION KIT

TRIAGE QUICK REFERENCE GUIDE

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Recommended Triage Method

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

2 Assess the following:

- Chief complaint
- General Appearance
- Airway
- Breathing
- Circulation
- Disability
- Environment
- Limited History
- Co-morbidities

Yes

2 Quick Evaluation ~ Is patient stable?

No

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 response 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 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

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.

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

Q1. Vocalisation
eg: whimpering, groaning, crying

Absent 0 Mild 1 Moderate 2 Severe 3

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eg: fidgeting, rocking, guarding part of body, withdrawn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

Add scores for 1 – 6 and record here → Total Pain Score

Now tick the box that matches the Total Pain Score →

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

Finally, tick the box which matches the type of pain →

Chronic	Acute	Acute on Chronic

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	Difficult 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

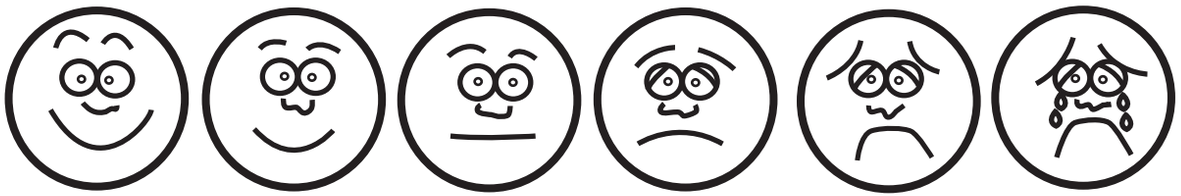
Assessment of Behavioral Score:

0 = Relaxed and comfortable
1-3 = Mild discomfort
4-6 = Moderate pain
7-10 = Severe discomfort/pain

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

Wong-Baker FACES Pain rating scale

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



0
NO HURT

1
HURTS LITTLE BIT

2
HURTS LITTLE MORE

3
HURTS EVEN MORE

4
HURTS WHOLE LOT

5
HURTS WORST

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.

The ABCs of obstetrics

Urgency	Urgency Indicator	Reason for caution
Airway	• Any potential compromise • Increased nasal congestion	• Often difficult intubations due to: – increased patient size – difficulty with patient positioning – different induction agents required • Increased vascularity of nose and airways causes difficulty 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 flow • High volume and dynamic flow 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 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 refill <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 Significant 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 – significant tachycardia – capillary refill >4 secs.	Moderate hemodynamic compromise, e.g. – weak/thready brachial pulse – skin pale, cool, – moderate tachycardia – capillary refill 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 refill.	Moderate neurovascular compromise, e.g. – pulse present – cool – sensation – movement – ↓capillary refill.	Mild neurovascular compromise, e.g. – pulse present – normal/↓sensation – normal/↓movement – normal capillary refill.	No neurovascular compromise

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 for serious illness or injury

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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.

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 – flash burns – foreign body	• Normal vision • Mild eye pain, e.g. – blunt eye injury – flash burns – foreign body	• Normal vision • No eye pain

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 Scale[1] 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 definition 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 Scale[1] 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 definition 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
	Australasian Triage Scale[1] 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 definition 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 Scale[1] 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 definition 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 **Australasian Triage Scale[1] 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 definition below) **Action** – Discuss with mental health triage – Refer to treating team if case-managed

Management Definitions[2]
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
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