Triage
Introduction

• **Triage** is the French word for sort.

• **Triage** is a process by which patients are prioritized and classified according to type and urgency of their conditions.

• First used in World War I in battlefields in determining treatment priorities.
Importance of Triage

• Ensure that the critically ill or injured patients receive medical attention before less ill or injured patients

• Establishes acuity based on set guidelines

• Helps inform the resources required [e.g. type of treatment room required]
Importance of Triage

• Ensures smooth flow of patients.

• Alleviates the anxieties of the patient and that of the caregiver knowing that they are in the system

• Identifies reassessment frequency.
Importance of Triage

• Can improve lines of communication.

• Monitor waiting time.

• Provides an opportunity for surveillance of predictable conditions and ensures appropriate action is taken e.g. isolating contagious patients
Fundamentals of Triage

• Not first come first served

• Patients acuity assessed and categorised using set criteria

• Set timelines for patient assessment based on acuity
Fundamentals of Triage

• Treatment initiated in a timely manner for the seriously ill/injured patients

• Dynamic process
Triage Requirements

• A trained triage nurse

• A private room to ensure confidentiality.

• A desk and two chairs.

• A monitor to take vital signs (BP, PR, SPO$_2$, T$^0$C), blood sugar machine

• Patients record chart
Components of Triage

• Identify the patient using 2 names, D.O.B, registration number.

• Take a **SAMPLE History**
  – **S** - Signs and symptoms
  – **A** - Allergies
  – **M** - Medication (current medication the patient is on)
  – **P** - Past medical history, Pregnancy history (LMP)
  – **L** - Last meal
  – **E** - Events [what has brought the patient to hospital]
Components of Triage

• Take vital signs (BP, PR, SPO$_2$, T$^\circ$C, RBS) including the pain score
• Assign triage level
• Give appropriate health education.
• Document on patient record chart
Triage Documentation

File Number: ...........................................  Date: ...........................................  Arrival Time: ...........................................

Patient Name: .................................................................................................  Age: ...........................................  Gender: ...........................................

Mode of Arrival:  Walking □  Stretcher □  Wheelchair □  Carried □

Triage Level:  Resuscitation □  Emergent □  Urgent □  Less Urgent □  Non Emergent □

Vital Signs:  BP ........mmHg  PR ....../min  RR......./min  Temp......°C  Spo₂......%  AVPU ......  RBS .......mmol/L  Pain Score: ........

SAMPLE HISTORY

Signs & Symptoms: ...........................................................................................

Allergies .............................................................................................................

Medication ...........................................................................................................

Past Medical History ..............................................  Last Menstrual Period...........................

Last meal...........................................................................................................

Events leading to illness/injury ...........................................................................

Triage Nurse Name and Signature ........................................................................

EMERGENCY MEDICINE KENYA FOUNDATION
emergencymedicinekenya.org
Canadian Triage and Acuity Scale (CTAS) is a criteria that was developed in Canada for the emergency department and later rolled out to the prehospital care due to its success and efficiency.
It’s a tool that categorizes patients care according to the type and severity of their presenting signs and symptoms.
Using CTAS

<table>
<thead>
<tr>
<th>Level</th>
<th>Category</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>Resuscitation</td>
<td>Immediate</td>
</tr>
<tr>
<td>Level 2</td>
<td>Emergent</td>
<td>Within 15 minutes</td>
</tr>
<tr>
<td>Level 3</td>
<td>Urgent</td>
<td>Within 30 minutes</td>
</tr>
<tr>
<td>Level 4</td>
<td>Less Urgent</td>
<td>Within 1 hour</td>
</tr>
<tr>
<td>Level 5</td>
<td>Not Urgent</td>
<td>Within 2 hours</td>
</tr>
</tbody>
</table>
Considerations in CTAS

• Triage category should be based on an individuals need for care and not affected by ED workload, financial incentives or organizational systems.

• All patients should be allocated a triage category according to their objective clinical urgency.
## ADULT TRIAGE CRITERIA

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LEVEL I: RESUSCITATION

Conditions that are life or limb threatening (or with imminent risk of deterioration) needing immediate aggressive intervention.

Time to doctor: IMMEDIATE

Usual presentations:
1. Cardiac and/or pulmonary arrest
2. Major trauma
3. Shock states
4. Unconscious patients
5. Severe respiratory distress
6. Status epilepticus
7. Acute coronary syndrome / chest pain
8. CVA / stroke
9. DKA / HHS
10. Shock states (Trauma haemorrhagic / septic shock)
   • BP <90/60
   • Temp <360C or >380C
   • PR <60bpm or >100bpm
   • RR <16bpm or >24bpm
11. Hypertensive Emergencies
    • BP >180/110mmHg with blurred vision / vomiting / CVA / confusion
12. GI bleed
13. Severe asthmatic attack
   • SPO2 <90%
   • Single word speech
   • Confusion
   • Silent chest
14. Deranged blood glucose levels
    (<3mmol/l or >18mmol/l with confusion / seizures / diaphoresis)
15. Pregnancy related complications
    • Presenting fetal parts
    • Prolapsed cord
    • Vaginal bleeding (esp. 3rd trimester except show)
    • Absent fetal movements
    • Eclampsia
16. Severe head injury (GCS: 3-8/15)
17. Drug / substance abuse / intoxication with haemodynamic instability
Cardiac Arrest

CPR Video.mp4
Unconscious Patient with a Pulse (C)-ABCDE

(C) - C-Spine Protection (for trauma)
– Manual in-line Stabilisation (MILS) + Blanket Rolls

A - Airway assessment
– Head-Tilt-Chin-Lift
– Jaw Thrust
– Suctioning
– Adjuncts – OPA insertion
Unconscious Patient with a Pulse (C)-ABCDE

B - Breathing

– Look, listen & feel
– Attach SPO$_2$ monitor
– Give oxygen with mask if breathing adequately
– Bag-valve-mask ventilation (1 breath every 6 secs) if not breathing adequately
Unconscious Patient with a Pulse
(C)-ABCDE

C- Circulation

– Stop active bleeding
– Attach cardiac and BP monitor
– IV access (big cannulas, 2 in trauma)
– Blood samples including RBS
– IV Normal Saline or Ringer’s Lactate TKVO
Unconscious Patient with a Pulse (C)-ABCDE

D - Disability
- AVPU
- Correct Hypoglycaemia (RBS < 3.5 mmol/L)
- Consider analgesia

E - Exposure
- Remove all clothing
- Keep patient warm
LEVEL II: EMERGENT

Conditions that are potential threat to life, function or limb, requiring rapid medical intervention.

Time to doctor < 15min

Usual presentations:

1. Altered mental state
2. Head injury (mild / moderate with GCS of 9-15)
3. Neonates
4. Eye pain/ injuries
5. Drug and/or substance overdose / intoxication / withdrawal with stable vitals
6. Asthma (moderate)
7. Anaphylaxis
8. Heavy vaginal bleeding / acute pelvic or lower abdominal pain
9. Sepsis/pyrexia
10. Severe vomiting and/or diarrhoea (haemodynamically unstable)

11. Acute psychosis / extreme agitation
12. Severe abdominal / groin pain / acute abdomen
13. Severe hypertension or hypotension (BP > 180/110 mmHg or < 90/60 mmHg)
14. Abuse / neglect / assault (physical / sexual)
15. Patients on chemotherapy
16. Acute pain - severe (pain score 8-10/10)
17. Seizure disorder
LEVEL III: URGENT

Conditions could potentially progress to a serious problem requiring emergency intervention. May be associated with significant discomfort or affecting ability to function at work or activities of daily living.

Time to doctor < 30min

Usual presentations:
1. Asthma, mild
2. Acute pain - moderate (pain score 4-7/10)
3. Vomiting or diarrhoea with dehydration
4. Dialysis (or transplantation patients)
5. Other diabetic - associated conditions e.g. neuropathy, nephropathy, retinopathy.
LEVEL IV: LESS URGENT

Conditions could potentially progress to a serious problem requiring emergency intervention. May be associated with significant discomfort or affecting ability to function at work or activities of daily living.

Time to doctor ≤ 1 hour

Usual presentations:
1. Minor trauma with soft tissue injuries
2. Headache (pain score 0-3/10)
3. Ear ache
4. Back pain, chronic
5. URTI symptoms with fever
6. Vomiting and/or diarrhea with no signs of dehydration
7. Acute pain - mild
   (pain score 0-3/10)
LEVEL V: NOT URGENT

Problem with or without evidence of deterioration.

**Time to doctor ≤ 2 hours**

Usual Presentations:
1. Sore Throat/URTI without fever
2. Abdominal pain without vomiting
3. Diarrhoea or vomiting alone without dehydration
Important Interventions at Triage

• (C)-ABCDE

• Stop active bleeding

• Nebulisation for acute asthmatic attacks

• ECG for chest pain

• Additional fluids for shock/DKA
Important Interventions at Triage

- Adrenaline 0.3mg IM for anaphylaxis
- Analgesia & Antipyretics
- Anticonvulsants for seizing patient
- Urine PDT for pregnancy
- Fracture and dislocation immobilisation
Important Interventions at Triage

• DO NOT GIVE ORAL ANTIHYPERTENSIVES FOR HIGH BPs

• DO NOT GASTRIC LAVAGE FOR INGESTIONS
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