DEDER GENERAL HOSPITAL

EMERGRNCY TRIAGE PROTOCOL

Triage Early Warning Score (TEWS)								
ADULT TRIAGE SCORE								
	3	2	1	0	1	2	3	
Mobility				Walking	With Help	Stretcher/Immobile		Mobility
RR		Less than 9		9-14	15-20	21-29	more than 29	RR
HR		Less than 41	41-50	51-100	101-110	111-129	more than 129	HR
SBP	Less than 71	71-80	81-100	101-199		more than 199		SBP
Temp		Less than 35		35-38.4		38.5 or more		Temp
AVPU				Alert	Reacts to Voice	Reacts to Pain	Unresponsive	AVPU
Trauma				No	Yes			Trauma
Pain				No pain	1—3/10	4—7/10	≥ 7/10	Pain

PREPARED BY: HSQU

JULY 2016 E.C

DEDER, EASTERN ETHIOPIA

PROTOCOL APPROVAL SHEET

NAME OF PROTOCOL: EMERGENCY TRIAGE PROTOCOL

PREPARRED BY			
S/N	**NAME**	**RESPONSIBILITY**	**SIGN**
1	Abdi Tofik (BSc, MPH)	Health Service Quality Director (HSQD)	
2	Abdella Aliyi (BSc MW)	HSQ Officer and Reform f/person	
3	Redwan Sharafuddin (BSc Pharm)	HSQ Officer	

APROVED BY			
S/N	**NAME**	**RESPONSIBILITY**	**SIGN**
1	Nureddin Yigezu (BSc, MPH)	Chief Executive Officer (CEO)	
2	Dr. Derese Gosa (MD)	Medical Director	
3	Dr. Isak Abdi (MD, G/Surgeon)	OR Director & SaLTS Team leader	

THIS PROTOCOL IS EFFECTIVE FROM JULY 2016 E.C TO JUNE 2018 E.C

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Introduction

Triage

- The term “Triage” comes from the French word “Trier” meaning to “sort” or “choose. It is a method of ranking sick or injured people according to the severity of their sickness or injury in order to ensure that medical and nursing staff facilities are used most efficiently.
- In triage, patients with the greatest need are helped first.

Types of Triage

A. Patient to triage:

When a patient appears relatively stable and is able to mobilize him/herself to the designated triage area. This will be the type of triage used in most of the cases.

B. Triage to patient

Here the patient is usually unstable. The patient is unable to mobilize him/herself to the designated triage area and should be referred directly to the resuscitation room. Triage should be performed at the bedside and documented in retrospect. This type of triage is used in critical patients.

Triaging involves

- ☞ Controlling the flow of patients through the emergency department
- ☞ Rapidly gather sufficient information to determine triage acuity
- ☞ Provide first aid or send directly for resuscitation

Benefits of triage

- ☞ Speed up the delivery of critical treatment timely for patients with life and limb threatening conditions
- ☞ Ensure that all people requiring emergency care are appropriately categorized according to their clinical condition
- ☞ Improve patient flow
- ☞ Improve patient satisfaction
- ☞ Decrease the patient's overall length of stay
- ☞ Facilitate streaming of less urgent patients

Organization and sequence of emergency patient

Evaluation (triage)

- The triage nurse should be available at the triage area all the time, organize his/her working area with necessary supplies (emergency drugs, basic airway and splinting equipment, BVM, oxygen with administrative devices, infection prevention materials etc). He/she needs to be attentive to pick up the critical patient on arrival.
- All unconscious patients should be evaluated for ABCD before any history and taking vital sign
- Critical patients transferred immediately to the resuscitation area while the triage nurses can do their triage documentation at bed side
- Whenever critical patient or injured patient is evaluated, complete undressing is important to minimize pitfall
- During assessment / triage of critical patients, conduct primary assessment: ABCD, vital signs, short history about the course of illness or mechanism of injury

- After the evaluation, score the patient's condition using the Triage Early warning Score (TEWS) **(table 1)**
- Then add your findings and categorize the patient according to the Emergent Severity Index (ESI) **(table 2)**
- According to the color code, distribute patients to the respective treatment/assessment area

Clinical Activities of Triage

Quick look for two or more patients' assessment at triage office

- All arriving patients receive a "quick look" to determine ABCD stability and "Sick"
- Emergent patients go immediately to the treatment area
- The rest are prioritized for the more thorough triage history and assessment
- Use the simplest method to see the stability of ABC in primary survey by using

30 - 2 - CAN DO methods

- ☞ If an adult patients' respiration is less than 30 **(RR < 30)**
- ☞ Knows their name and where they are **(2)**
- ☞ Follow verbal command (**CAN DO)**

All of these indicate the patients may have adequate initial oxygenation And perfusion

Conduct the appropriate focused history and physical examination

- Triage physical assessment
- General appearance

- ABC stability
- Focused P/E
- Pain assessment

Triage history should include

- Chief complaint
- Pain assessment
- Medications
- Allergies
- Past medical history

Investigations at triage

- Finger prick RBS

Treatment

- Follow the triage protocol
- Secure iv line, start fluid, oxygen administration as indicated
- Medication administration as indicated

Communication

For seriously injured/critically ill patient

- When communicating with the receiving area a brief verbal communication should be made with the treating team.
- Patient should be accompanied by triage officer to resuscitation area.

Triage Acuity Level/ Category

ESI - is a five-level triage algorithm that categorizes ER patients by evaluating both patient acuity and resource needs

Acuity is determined by the stability of **vital functions and the potential threat to life or limb**

Triage Scale(TS) or Emergency Severity Index (ESI)

1. **ESI 1- (Red)** Immediately life threatening ---- → Disposition → Resuscitation
   - ✓ EG. ABCD unstable patients, Respiratory, facial, neck, chest injuries, severe hemorrhage, neck injuries, shock, coma with signs of airway obstruction, severe respiratory distress, convulsions, chest pain with unstable VS,

2. **ESI 2 – (ORange)** potentially life threatening → to resuscitation **WITHIN 10-15 mins**
   - ✓ If care is not given within 10 minutes (pending respiratory failure, altered consciousness without airway obstruction, moderate trauma with stable vital signs, such patients require frequent re-triage until they are seen by the physician and they are the second priority following the red if any deterioration appears they may be re-categorized accordingly

3. **ESI 3 (Yellow)** less urgent potentially serious, could be delayed up **to 60 minutes → waiting area**
   - ✓ These patients require re-triaging, reassurance and some applicable investigations such as: EKG, RBS, for diabetic and hypertensive pts, pregnancy test, Urine analysis, pregnancy test, Hct, and Blood group, for young ladies… (Such investigations can be supported by hospital protocol depending the hospitals standard)
   - ✓ Eg. Injuries to the lower genitourinary tract, splinted fractures, soft tissue lesions, they also require re- triaging until they are assessed by the physician and if any deterioration appears they might be re-categorized accordingly

4. **ESI 4 (green)** non-urgent, can be delayed up to 240 minutes and can be sent to nearby health institution, regular OPDs, after counseling or 1st aid is given

5. **ESI 5 (BlaCK/Blue)** Dead **ON** arrival

TEWS ESI

≥7	Red
5-6	Orange
3-4	Yellow
0-2	Green

Table1: TEWS (Triage Early Warning Score)

ADULT TRIAGE SCORE								
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over 12 years / taller than 150cm								

Severity Index (ESI)

Colour	Red	ORange	YellOw	gReen	Blue
TEWS	7 or more	5-6	3-4	0-2	DEAD
Target time to treat	Immediate	Less than 10 mins	Less than 60 mins	Less than 240 mins	
Mechanism of injury		High energy transfer			
Presentation		Shortness of breath- acute		ALL OTHER PATIENTS	
		Coughing blood			
		Chest pain			
		Hemorrhage- uncontrolled	Hemorrhage- controlled		
	Seizure-current	Seizure postictal			
		Focal neurology-acute			
		Levelofconsciousness reduced			
		Psychosis/Aggression			
		Threatened limb			
		Dislocation-other joint	Dislocation-finger or toe		
		Fracture-compound	Fracture-closed		
	Burn-face/inhalation	Burn over 20%	Burns-other		
		Burn - electrical			
		Burn - circumferential			
		Burn - chemical			
		Poisoning/Overdose	Abdominal pain		
	Hypoglycaemia-glucose less than 3	Diabetic-glucoseover 11 & ketonuria	Diabetic-glucose over 17 (no ketonuria)		
		Vomiting-fresh blood	Vomiting persistent		
		Pregnancy & abdominaltraumaor pain	Pregnancy & trauma		
			Pregnancy & PV bleed		
Pain		Severe	Moderate	Mild	DEAD
	Senior Healthcare Professional's Discretion				

TriageScale(TS)oremergentSeverityIndex(eSI)

ESI 1- (Red) Immediately life threatening ---- → Disposition → Resuscitation

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Eg. Injuries to the lower genitourinary tract, splinted fractures, soft tissue lesions, they also require re- triaging until they are assessed by the physician and if any deterioration appears they might be re-categorized accordingly

ESI 4 (green) non-urgent, can be delayed up to 240 minutes and can be sent to nearby health institution, regular OPDs, after counseling or 1st aid is given

ESI 5 (BlaCK/Blue) Dead ON arrival

example:
Patient with help — scores 1
Respiratory rate = 18 — scores 1
Heart rate = 118 — scores 2,
BP = 208/112 — scores 2
Temperature = 36.5 — scores 0
Patient Alert — scores 0
No Trauma — Scores 0
Total = 6 = Orange