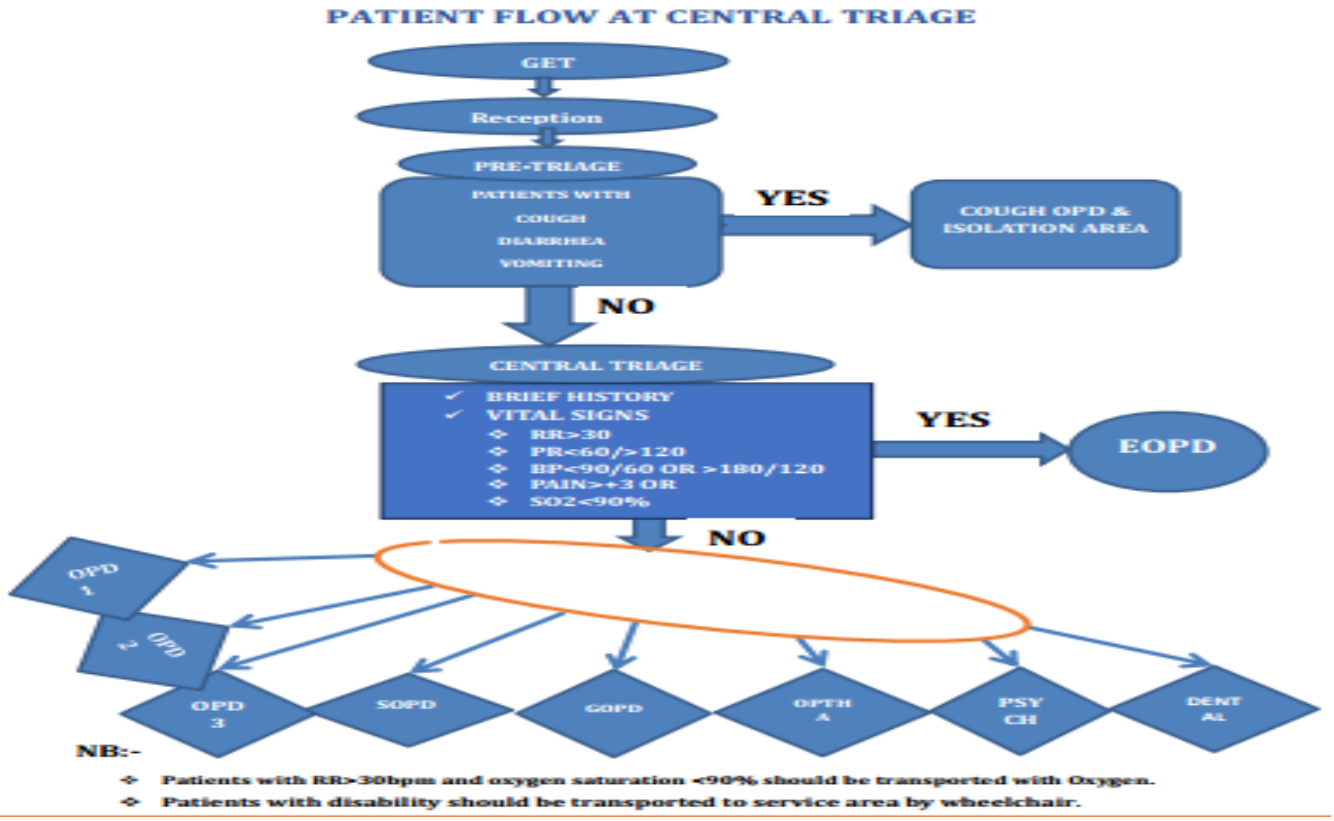
DEDER GENERAL HOSPITAL

CENTRAL TRIAGE PROTOCOL



PREPARED BY: HSQU

JULY 2016 E.C

DEDER, EASTERN ETHIOPIA

PROTOCOL APPROVAL SHEET

NAME OF PROTOCOL: TRIAGE PROTOCOL

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

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INTRODUCTION

Hospitals have always played an indispensable role in the prevention, diagnosis, treatment, and management of diseases in a given community. Among these are scheduled access for non-admitted patients to assessment, diagnosis, follow-up, and treatment of healthcare conditions. Such service needs sorting and sending patients/clients to specific service area. Such service is known as out Triage service.

Central Triage Pathway

The central triage is the first point of patient contact in outpatient services. The central triage infrastructure should include a waiting area with adequate seats, registration and clinical assessment areas.

Patients will be directed to Central Triage from the reception service or Emergency Department. Within Central Triage the patient will undergo a triage assessment and all relevant administrative processes (registration, medical record retrieval, payment etc) will be conducted. The triage assessment will assign each patient to appropriate case team (emergency, ROPD, specialty and sub- specialty clinic or back referral with appropriate counseling.) The patient will then be directed to the relevant case team and his/her medical record will be delivered to the case team by a runner. (Electronic medical recodring are preferred)

Central Triage Activity

The central triage should be open at least an hour before and during regular working hours.

Opening Schedule of central triage

A. MORNING

- 1:00DLT to 5:30 DLT

B. AFTERNOON

- 7:00DLT to 10:30 DLT

NB:

DLT= day local time

All patients should undergo Central Triage using guideline **EXCEPT**:

- Emergency cases (should immediately attend emergency department),
- Laboring mothers (should immediately attend delivery unit),
- Those with an appointment (should immediately go to relevant case team), and
- Private wing patients

The first step in Central Triage activity is aiming in **identifying and treating emergency signs**. The Triage Clinician should identify patients who would be more appropriately treated by the emergency case team and after resuscitation, should transfer these patients to the emergency case team. If a patient does not have an emergency condition, the Triage Clinician should then determine the nature and urgency of the client's medical problem and determine the appropriate service/case team required by the patient. If the service is available the patient should be transferred to the appropriate case team or given an appointment for the next available date while a referral should be arranged to another facility for services not available in the hospital. When scheduling appointments for the same, or a future date, staff should take all relevant patient information into account, including:

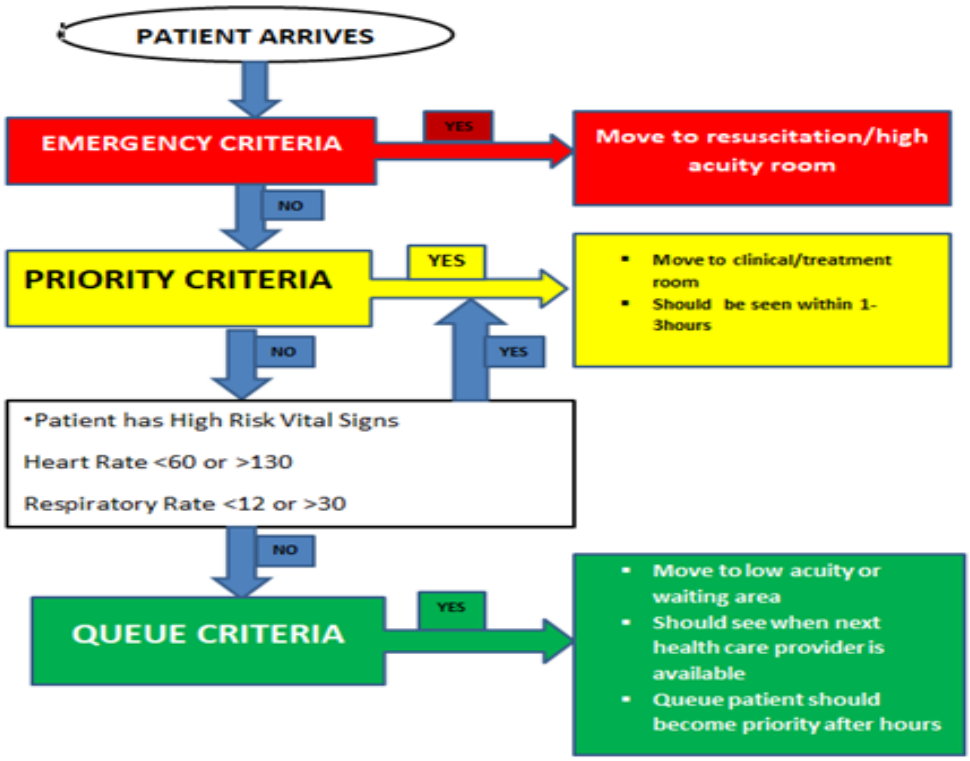
- The severity of the condition
- Geographic/Distance travelled by patient/

- ❖ Financial status of patient (for example financial difficulties that could prevent the patient returning to the hospital at a future date taking into consideration transport and/or hotel costs
- ❖ Social circumstances of patient (for example loss of income due to absence from work, childcare needs of dependent children and etc).

The criteria by which a patient is given **priority** for treatment should be written and visible to patients and staff to ensure **transparency in the process.**

- If the patient can receive services on the **same day he/she** will complete all necessary registration and payment requirements in medical record management unit and then be directed to the relevant outpatient case team.
- If the appointment is scheduled for a future date, the patient will complete all necessary registration and payment requirements in medical record management unit, given an appointment card and advised to report to the appropriate case team on the date of their appointment, without undergoing Central Triage again.
- Triage team will register patients not seen on the same day and report to the outpatient department leader for future improvement purposes.
- The hospital should have a clear management system for isolating patients with communicable diseases like patients having chronic cough and suspected of TB. The hospital should also have a separate waiting area for children and adults.
- The hospital central triage service should be started an hour before the regular OPD working hours to ensure efficient and smooth flow of patients

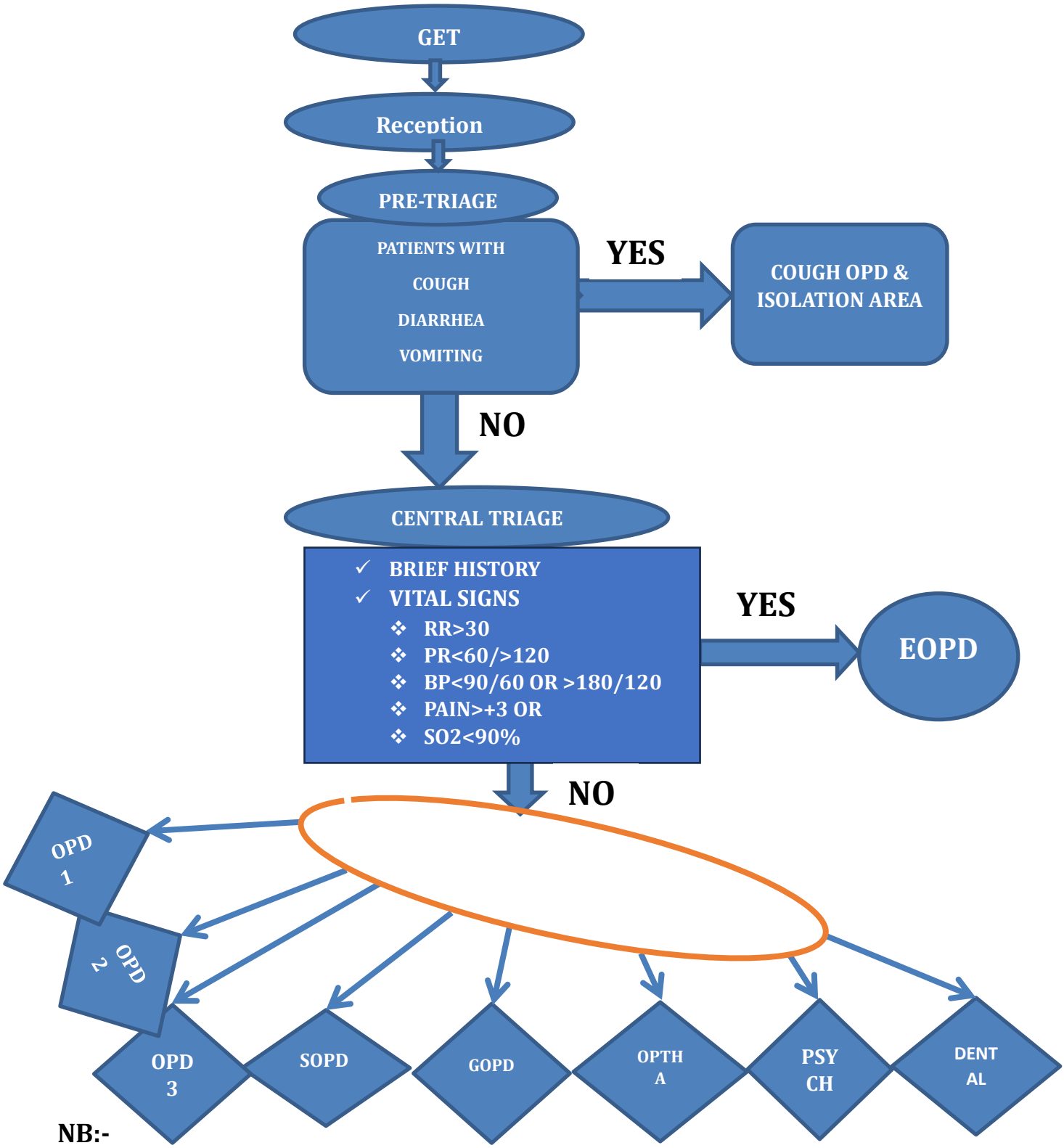
Figure 1. Summary of triage flow and timelines of care



EMERGENCY CRITERIA (Tick here if Yes)			
	Unresponsive		Pregnant with Heavy bleeding
	Stridor		Pregnant with Severe abdominal pain
	SpO_2 <90%		Pregnant with Seizures
	Respiratory distress or cyanosis		Pregnant with Severe headache
	Weak pulse or Capillary refill>3 sec		Pregnant with Visual changes
	Heart rate <50 or >150		Pregnant with SBP≥160 or DBP ≥110
	Heavy bleeding		Pregnant with Active labour
	Active convulsions		Pregnant with Trauma
	Hypoglycemia		Age < 2years with Temp <36°C or >39°C
	High-risk trauma*		Child <14 with severe dehydration
	Poisoning or dangerous chemical exposure*		Adult with signs of meningitis
	Threatened limb*		Acute chest or abdominal pain (>50 years old)
	Snake Bite		ECG with acute ischaemia
	Violent or aggressive		Other (state):
PRIORITY CRITERIA (TICK here is Yes)			
	Vomits everything or ongoing diarrhoea (adult)		Severe pain (no Red criteria)
	Unable to feed or drink		Visible acute lime deformity

	Severe Pallor		Open fracture
	On-going bleeding (no emergency criteria)		Suspected dislocation
	Recent fainting		Other trauma/burns (no Red criteria)
	Altered mental status (no emergency criteria)		Sexual assault
	Acute general weakness		Acute tersticular/scrotal pain or priapism
	Acute focal neurology		Unable to pass urine
	Acute visual disturbance		Wheezing (no Red criteria)
	New rash worsening over hours or peeling (no emergency criteria)		Exposure requiring time-sensitive prophylaxis (example: animal bite, needle-stick injury)
	Any infant 8 days to 2 months old		Child below 14 years old with malnutrition
	Child below 14 years old with dehydration		Child below 14 years old with ongoing diarrhoea
	Referral patient (no emergency criteria)		Other, state:
QUEUE CRITERIA (Tick here if Yes)			
	Patient with no Emergency or priority criteria indicated in above tables		

PATIENT FLOW AT CENTRAL TRIAGE



NB:-

- **Patients with RR>30bpm and oxygen saturation <90% should be transported with Oxygen.**
- **Patients with disability should be transported to service area by wheelchair.**

Central Triage Human Resource Requirements

- The Central Triage Case Team consists of both **clinical and non-clinical staff**.
- Triage should be carried out by a **General Practitioner**. However, depending on the availability of human resources, it can be conducted by an **MSc/BSc Nurse**.
- Non-clinical members of the Central Triage case team include
  - ☞ Runners,
  - ☞ Cashiers,
  - ☞ Registrars/ Clerks and
  - ☞ Cleaners.
- The **runners** are responsible to facilitate the registration of patients and to transport patients as needed.
- The Central Triage Case Team should have ready access to the Liaison and Referrals Service.

Central Triage Equipment and Supply Requirements

The central triage should have sufficient equipment and supplies considering patient workload. The following is a list of the minimum items that should be available at central triage:

- Triage room with office furniture
- Examination bed
- Thermometer
- Glucometer
- Adult stethoscope
- Adult sphygmomanometer (automatic or manual)

- Adult weight and height scale
- Resuscitation tools
- Patient monitor with ECG monitoring (for general and tertiary hospitals)
- Pulse oximetry
- Wheelchair
- Stretcher
- Screens, partitions or separate rooms
- Gloves, face masks and other personal protective equipment
- Wall clock
- Microphone/Public address system

TRIAGE EARLY WARNING SCORE (TEWS)

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
over 12 years / taller than 150cm								

SEVERITY INDEX

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	DEAD
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			
		Level of consciousness 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-glucose over 11 & ketonuria	Diabetic-glucose over 17 (no ketonuria)		
		Vomiting-fresh blood	Vomiting persistent		
		Pregnancy & abdominal trauma or pain	Pregnancy & trauma		
			Pregnancy & PV bleed		
Pain		Severe	Moderate	Mild	
	Senior Healthcare Professional's Discretion				