TRIAGE AND OBSERVATION IN THE EMERGENCY CENTRE

AIM

To ensure the best outcome for the patients who present to the Emergency Centre at KEMH.

TRIAGE

Emergency triage is a unique practice that deals with unstable, undiagnosed patients presenting to an emergency centre / department. The process of triage involves the application of high level assessment skills and theoretical knowledge, to assess a patient and make a decision about the degree of urgency to see a treating clinician. It is important that the level of urgency assigned is appropriate and reflective of individual presentations.

KEY POINTS

1. All patients presenting to the Emergency centre at KEMH will be assessed and triaged by a registered nurse/midwife or nurse practitioner with demonstrated competency.

2. Registered nurses/midwives undertaking the role of triage nurse shall provide evidence of triage competence assessment by
   - Completion of an emergency nursing course programme, inclusive of the practice of triage, or
   - Evidence of appropriate competency attainment from a previous hospital verified through the skills recognition process
   - Graduate nurses/midwives may triage patients presenting to EC, but only under the direct supervision of the shift co-ordinator

3. All patients shall be assessed on arrival according to the Australasian Triage Scale (ATS).

4. The triage assessment and ATS category shall be recorded on the MR 021. The most urgent clinical feature determines the ATS category, with consideration of the mechanism of injury and co-morbidities. Once a high-risk feature is identified, a response equal to the urgency shall be initiated.

5. The triage nurse is responsible for ensuring that the documentation of all episodes of care at triage is timely, accurate and comprehensive.
6. Any patient that re-presents with the same condition within 24-48 hours is to be referred to a senior medical officer for review (except patients representing for booked EPAS appointments who have no change in their clinical status).

7. All patients who present to the emergency centre should be triaged on arrival. Where the patient is requested by hospital staff to return to the emergency centre following initial assessment, intervention or discharge for wound review or dressings or an EPAS appointment, they would be triaged as a category 5, unless there have been changes that indicate another category.

TRIAGE NURSE ROLES AND RESPONSIBILITIES

- Undertake initial patient assessment and allocate the ATS category. This should include vital signs to estimate urgency.
- Initiate appropriate nursing intervention to improve patient outcomes and secure the safety of patients and staff.
- Ensure reassessment and management of the patients who remain in the waiting room commensurate with their condition and time frames determined by the ATS category including 30 minutely documentation of their condition while in the waiting room.
- Act as a liaison for members of the public and other health care professionals.
- Provide patient and public education where appropriate.

THE AUSTRALASIAN TRIAGE SCALE

<table>
<thead>
<tr>
<th>ATS Category</th>
<th>Treatment Acuity (Maximum waiting time)</th>
<th>Performance Indicator Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATS 1</td>
<td>Immediate</td>
<td>100%</td>
</tr>
<tr>
<td>ATS 2</td>
<td>10 minutes</td>
<td>80%</td>
</tr>
<tr>
<td>ATS 3</td>
<td>30 minutes</td>
<td>75%</td>
</tr>
<tr>
<td>ATS 4</td>
<td>60 minutes</td>
<td>70%</td>
</tr>
<tr>
<td>ATS 5</td>
<td>120 minutes</td>
<td>70%</td>
</tr>
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OBSERVATIONS IN THE EMERGENCY CENTRE

- All patients who present to the emergency centre shall have a full set of vital signs performed according to their triage category, within 30 minutes (with the exclusion of EPAS patients and other follow-up patients e.g. Postnatal women).

- Vital signs include:
  - Respiratory rate
  - Oxygen saturation
  - Blood pressure
  - Pulse
  - Temperature
  - Conscious state
  - Pain score
  - Blood glucose level (if appropriate)
  - PV loss
  - Glasgow coma scale (when appropriate)

- A urinalysis and pregnancy test (if applicable) shall be performed as soon as practicable following triage.

- Category 1 and 2 patients shall be moved directly into the emergency centre clinical area prior to their observations being performed.

- Category 3, 4 and 5 patients may have their initial observations performed in the waiting area. Checking of PV loss should occur in the clinical area of EC.

- All patients presenting to Emergency Centre with abnormal bleeding should have a speculum/vaginal examination (See clinical guideline Vaginal Examinations) to assess the cervix and cause for the bleeding. If the medical officer is unable to visually assess the cervix then the Registrar, Senior Registrar or Consultants must be contacted to complete the vaginal examination.

FREQUENCY OF OBSERVATIONS

- Observations shall be performed as frequently as determined by the patient’s clinical status.

- All patients admitted to a ward shall have a full set of observations performed and documented on the MR 285.01 Observation chart prior to the actual transfer. This will ensure that the patient’s condition is satisfactory and also assist in determining what level of escort is appropriate.
  
  - A Registered Nurse/Midwife shall escort all patients with vital signs in the Yellow and Orange/Increased Surveillance and Senior Nurse/Midwife Review section of the observation chart, or when staff are worried about the patient but they do not fit the criteria
  
  - A Medical Officer and Registered Nurse/Midwife should escort all patients that have vital signs in the Red/Medical Review section of the observation chart
An Anaesthetist / anaesthetic registrar and anaesthetic technician should escort patient’s that are unstable and have triggered a Code Blue (Purple Area) of the observation chart. Also see Transfer of a critically unwell patient and records to an ICU at another Hospital.

If a woman has required a vaginal/speculum examination due to vaginal bleeding, under no circumstances should she be discharged from the Emergency Centre without this assessment being carried out and the result document in the patient medical record- MR 021/022.