TRIAGE AND OBSERVATION IN EC

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 have primary assessment at triage to rapidly determine threat to life and be allocated an Australasian Triage Scale (ATS) based on risk analysis.

2. Only senior Registered nurses/ midwives shall undertake the role of triage nurse RN Level 1.3 and above. It is not appropriate for triage to be undertaken by an enrolled nurse, midwife (who is not also a registered nurse), or administration staff.

3. The triage assessment is not intended to make a diagnosis.

4. Any adverse signs or symptoms identified throughout the assessment process must be reported to the appropriate staff and escalated as required.

5. 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.

6. The triage nurse is responsible for ensuring that the documentation of all episodes of care at triage is timely, accurate and comprehensive.

7. 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).
8. 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, an EPAS appointment or follow up quantitative βHCG, are not triaged. The episode of care is documented on the MR021 as an outpatient occasion of service.

9. A second person (chaperone) must be present during any intimate physical examinations. See NMHS Chaperone policy.

10. Women presenting with a potential life threatening condition e.g. chest pain, severe haemorrhage or birth is imminent may be assessed initially in the Emergency Centre. Non gynaecological / obstetric presentations should be stabilised and transferred to another adult facility as appropriate.

11. Medical opinion must be sought by emergency centre staff prior to discharging patients who present with medical problems similar to Homozygus Prothrombin Mutation Gene 20210

TRIAGE NURSE ROLES AND RESPONSIBILITIES

- Undertake initial patient assessment and allocate the ATS category. Complete a visual assessment with the whole patient being surveyed prior to focussing on the specific area of concern.

- Rapidly assess the patients for Danger, Response, Seek help and Airway, Breathing and Circulation (DRSABC).

- Activate the medical emergency alarm if life threats are identified (Code Blue Medical).

- Undiagnosed patients can rapidly deteriorate so ongoing assessment and re-evaluation of their presenting findings should occur throughout their presentation. 30 minutely documentation of their condition in the waiting area must occur

- Obtain a history from the patient. Document all findings on the MR 021

- Initiate appropriate nursing intervention to improve patient outcomes and secure the safety of patients and staff.

- In the waiting area the type of observations required should be dictated by the patient’s clinical presentation.

- 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>
</tbody>
</table>

OBSERVATIONS IN THE EMERGENCY CENTRE

- Vital signs should only be measured at triage if required to estimate urgency or if time permits.

- Any patient identified as ATS Category 1 or 2 should be taken immediately into an appropriate assessment and treatment area.

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

- The following observations are generic for all presentations to the EC
  - Respiratory rate
  - Oxygen saturation
  - Blood pressure (manual check preferred)
  - Pulse (manual check)
- Temperature
- Conscious state
- Pain score
- Blood glucose level (in diabetic presentations or those with altered mental state)
- PV loss
- Alert, voice, pain, unresponsive (AVPU)
- Assess the patient’s skin while taking and recording the pulse.

- 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 registered nurse/midwife or 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.

REFERENCES / STANDARDS

Do not keep printed versions of guidelines as currency of information cannot be guaranteed. Access the current version from the WNHS website.