ACEM POLICY DOCUMENT –

GUIDELINES FOR IMPLEMENTATION OF THE AUSTRALASIAN TRIAGE SCALE IN EMERGENCY DEPARTMENTS

1. GENERAL PRINCIPLES

1.1 Function of triage

Triage is an essential function in Emergency Departments (EDs), where many patients may present simultaneously. Triage aims to ensure that patients are treated in the order of their clinical urgency and that their treatment is appropriately timely. It also allows for allocation of the patient to the most appropriate assessment and treatment area, and contributes information that helps to describe the departmental casemix. Urgency refers to the need for time-critical intervention – it is not synonymous with severity. Patients triaged to lower acuity categories may be safe to wait longer for assessment and treatment but may still require hospital admission.

1.2 The Triage Assessment

The features used to assess urgency are generally a combination of the presenting problem and general appearance of the patient, possibly combined with physiological observations. The triage assessment should generally take no more than two to five minutes, obtaining sufficient information to determine the urgency and identify any immediate care needs. This does not preclude the initiation of investigations or referrals at this point. There must be a balance between speed and thoroughness. The triage assessment is not necessarily intended to make a diagnosis, although this may sometimes be possible. 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 the appropriate assessment and treatment area. A more complete nursing assessment should be done by the treatment nurse receiving the patient.

In Australasia, triage is carried out by emergency nurses. As triage is so important to both the smooth running of an ED and the outcome of the patients, it should be carried out by staff who are both specifically trained and experienced.

1.3 Safety at Triage

Triage is the first point of public contact with the ED. Patients with the whole spectrum of acute illness, injury, mental health problems and challenging behaviour may present there. Pain, anxiety and/or intoxication in patients or their relatives may provoke or magnify aggressive behaviour. These factors may create a risk of harm for the triage nurse and other reception staff. It is essential that all EDs plan for this potential risk by providing a safe but non-threatening physical environment, providing minimisation-of-aggression training to front-line staff, and having safe protocols and procedures for dealing with challenging behaviour. Where the safety of staff and/or other patients is under threat, staff and patient safety should take priority and an appropriate security response should take place prior to clinical assessment and treatment.

1.4 Time to Treatment

The time to treatment described for each ATS Category refers to the *maximum* time a patient in that category should wait for assessment and treatment. In the more urgent categories, assessment and treatment should

occur simultaneously. Ideally, patients should be seen well within the recommended maximum times. Implicit in the descriptors of Categories 1 to 4 is the assumption that the clinical outcome may be affected by delays to assessment and treatment beyond the recommended times. Further research is still required to describe the precise relationship between the time to treatment and the clinical outcome. The maximum waiting time for Category 5 represents a standard for service provision.

The recommended performance thresholds represent realistic practice constraints in the clinical environment. However, there is no implied justification for prolonged delays for patients falling outside the required performance standards – all attempts should be made to minimise delays.

1.5 Practicality and Reproducibility

The primary and most important role of triage is clinical. Therefore application of the ATS must occur in such a way that ensures patient safety and maximises flow through the emergency department. While it is desirable to attempt to maximise inter-rater reliability for reasons of inter-departmental comparisons and for casemix purposes, it must be recognised that no clinical coding system achieves perfect reproducibility. Acceptable levels of inter-rater agreement have been defined which allow for a realistic balance between clinical practicality and classification.

2. EXTENDED DEFINITIONS AND EXPLANATORY NOTES

2.1 Arrival Time

The arrival time is the first recorded time of contact between the patient and Emergency Department staff. A recording accuracy to within the nearest minute is appropriate. There should be no delay between the physical arrival in the ED of a patient who is seeking care and their first contact with staff.

2.2 Time of Medical Assessment and Treatment

Although important assessment and treatment may occur during the triage process, this time represents the start of the care for which the patient presented. A recording accuracy to within the nearest minute is appropriate:

2.2.1 Usually it is the time of first contact between the patient and the doctor initially responsible for their care. This is often recorded as “Time seen by doctor”.

2.2.2 Where a patient in the ED has contact exclusively with nursing staff acting under clinical supervision of a doctor, it is the time of first nursing contact. This is often recorded as “Time seen by nurse”.

2.2.3 Where a patient is treated according to a documented, problem specific clinical pathway, protocol, or guideline approved by the director of Emergency Medicine, it is the earliest time of contact between the patient and staff implementing this protocol. This is often recorded as the earlier of “Time seen by nurse” or “Time seen by doctor”.

2.3 Waiting Time

This is the difference between the time of arrival and the time of initial medical assessment and treatment. A recording accuracy to within the nearest minute is appropriate.

2.4 Performance Indicator Thresholds

Where a patient has a waiting time less than or equal to the maximum waiting time defined by their ATS category, the ED is deemed to have achieved the

performance indicator for that presentation. Achievement of indicators should be recorded and compared between large numbers of presentations.

2.4 Documentation Standards

The documentation of the triage assessment should include at least the following essential details:

- Date and time of assessment
- Name of triage officer
- Chief presenting problem(s)
- Limited, relevant history
- Relevant assessment findings
- Initial triage category allocated
- Retriage category with time and reason
- Assessment and Treatment area allocated
- Any diagnostic, first aid or treatment measures initiated

2.5 Re-triage

If a patient's condition changes while they are waiting for treatment, or if additional relevant information becomes available that impacts on the patient's urgency, the patient should be re-triaged. Both the initial triage and any subsequent categorisations should be recorded, and the reason for the re-triage documented.

3. SPECIFIC CONVENTIONS

In order to maximise reproducibility of ATS allocation between departments, the following conventions have been defined:

3.1 Paediatrics

The same standards for triage categorisation should apply to all ED settings where children are seen – whether purely Paediatric or mixed departments. All five triage categories should be used in all settings. This does not preclude children being seen well within the recommended waiting time for the ATS Category if departmental policy and operational conditions provide for this. However, for the sake of consistency and comparability, children should still be triaged according to objective clinical urgency. Individual departmental policies such as "fast-tracking" of specific patient populations should be separated from the objective allocation of a triage category.

3.2 Trauma

All victims of trauma should be allocated a triage category according to their objective clinical urgency. As with other clinical situations, this will include consideration of high-risk history as well as brief physical assessment (general appearance +/- physiological observations). Although individual departments may have policies that provide for immediate team responses to patients meeting certain criteria, these patients should still be allocated an objective triage category according to their clinical presentation. Again, departmental "fast-tracking" policies or systems should occur separately to the objective allocation of a triage category.

3.3 Behavioural Disturbance

Patients presenting with mental health or behavioural problems should be triaged according to their clinical and situational urgency, as with other ED patients. Where physical and behavioural problems co-exist, the highest

appropriate triage category should be applied based on the combined presentation.

While some acutely-disturbed patients may require an immediate clinical response (perhaps combined with a security response) to ensure their safety, it is recognised that some individuals entering an emergency department and posing an immediate threat to staff (eg brandishing a dangerous weapon) should not receive a clinical response until the safety of staff can be ensured. In this situation, staff should act so as to protect themselves and other ED patients, and obtain immediate intervention from security staff and/or the police service. Once the situation is stabilised, a clinical response can take place as (and if) required, and triage should then reflect clinical and situational urgency.

4. CLINICAL DESCRIPTORS

4.1 Source

The listed clinical descriptors for each category are based on available research data where possible, as well as expert consensus. However, the list is not intended to be exhaustive nor absolute and must be regarded as indicative only. Absolute physiological measurements should not be taken as the sole criterion for allocation to an ATS category. Senior clinicians should exercise their judgement and, where there is doubt, err on the side of caution.

4.2 Most Urgent features Determine Category

The most urgent clinical feature identified determines the ATS category. Once a high-risk feature is identified, a response commensurate with the urgency of that feature should be initiated.

AUSTRALASIAN TRIAGE SCALE: DESCRIPTORS FOR CATEGORIES

ATSCategory	Response	Description of Category	Clinical Descriptors (indicative only)
Category 1	Immediate simultaneous assessment and treatment	**Immediately Life-Threatening** Conditions that are threats to life (or imminent risk of deterioration) and require immediate aggressive intervention.	Cardiac arrest Respiratory arrest Immediate risk to airway – impending arrest Respiratory rate <10/min Extreme respiratory distress BP< 80 (adult) or severely shocked child/infant Unresponsive or responds to pain only (GCS < 9) Ongoing/prolonged seizure IV overdose and unresponsive or hypoventilation Severe behavioural disorder with immediate threat of dangerous violence

Category 2	Assessment and treatment within 10 minutes (assessment and treatment often simultaneous)	**Imminently life-threatening** The patient's condition is serious enough or deteriorating so rapidly that there is the potential of threat to life, or organ system failure, if not treated within ten minutes of arrival **or** **Important time-critical treatment** The potential for time-critical treatment (e.g. thrombolysis, antidote) to make a significant effect on clinical outcome depends on treatment commencing within a few minutes of the patient's arrival in the ED or Very severe pain Humane practice mandates the relief of very severe pain or distress within 10 minutes	Airway risk – severe stridor or drooling with distress Severe respiratory distress Circulatory compromise - Clammy or mottled skin, poor perfusion - HR<50 or >150 (adult) - Hypotension with haemodynamic effects - Severe blood loss Chest pain of likely cardiac nature Very severe pain - any cause BSL < 2 mmol/l Drowsy, decreased responsiveness any cause (GCS< 13) Acute hemiparesis/dysphasia Fever with signs of lethargy (any age) Acid or alkali splash to eye – requiring irrigation Major multi trauma (requiring rapid organised team response) Severe localised trauma – major fracture, amputation High-risk history: - Significant sedative or other toxic ingestion - Significant/dangerous envenomation - Severe pain suggesting PE, AAA or ectopic pregnancy Behavioural/Psychiatric: - violent or aggressive - immediate threat to self or others - requires or has required restraint - severe agitation or aggression

Category 3	Assessment and treatment start within 30 mins	**Potentially Life-Threatening** The patient's condition may progress to life or limb threatening, or may lead to significant morbidity, if assessment and treatment are not commenced within thirty minutes of arrival **or** **Situational Urgency** There is potential for adverse outcome if time-critical treatment is not commenced within thirty minutes **or** Humane practice mandates the relief of severe discomfort or distress within thirty minutes	Severe hypertension Moderately severe blood loss – any cause Moderate shortness of breath SAO2 90 – 95% BSL >16 mmol/l Seizure (now alert) Any fever if immunosupressed eg oncology patient, steroid Rx Persistent vomiting Dehydration Head injury with short LOC- now alert Moderately severe pain – any cause – requiring analgesia Chest pain likely non-cardiac and mod severity Abdominal pain without high risk features – mod severe or patient age >65 years Moderate limb injury – deformity, severe laceration, crush Limb – altered sensation, acutely absent pulse Trauma - high-risk history with no other high-risk features Stable neonate Child at risk Behavioural/Psychiatric: - very distressed, risk of self-harm - acutely psychotic or thought disordered - situational crisis, deliberate self harm - agitated / withdrawn potentially aggressive

Category 4	**Assessment and treatment start within 60 mins**	**Potentially serious** The patient's condition may deteriorate, or adverse outcome may result, if assessment and treatment is not commenced within one hour of arrival in ED. Symptoms moderate or prolonged. **or** **Situational Urgency** There is potential for adverse outcome if time-critical treatment is not commenced within hour **or** **Significant complexity or Severity** Likely to require complex work-up and consultation and/or inpatient management **or** Humane practice mandates the relief of discomfort or distress within one hour	Mild haemorrhage Foreign body aspiration, no respiratory distress Chest injury without rib pain or respiratory distress Difficulty swallowing, no respiratory distress Minor head injury, no loss of consciousness Moderate pain, some risk features Vomiting or diarrhoea without dehydration Eye inflammation or foreign body – normal vision Minor limb trauma – sprained ankle, possible fracture, uncomplicated laceration requiring investigation or intervention – Normal vital signs, low/moderate pain Tight cast, no neurovascular impairement Swollen “hot” joint Non-specific abdominal pain Behavioural/Psychiatric: - Semi-urgent mental health problem - Under observation and/or no immediate risk to self or others

Category 5	Assessment and treatment start within 120 minutes	**Less Urgent** The patient's condition is chronic or minor enough that symptoms or clinical outcome will not be significantly affected if assessment and treatment are delayed up to two hours from arrival or **Clinico-administrative problems** results review, medical certificates, prescriptions only	Minimal pain with no high risk features Low-risk history and now asymptomatic Minor symptoms of existing stable illness Minor symptoms of low-risk conditions Minor wounds - small abrasions, minor lacerations (not requiring sutures) Scheduled revisit eg wound review, complex dressings Immunisation only Behavioural/Psychiatric: - Known patient with chronic symptoms - Social crisis, clinically well patient