



Emergency Medicine Society of South Africa

**PRACTICE GUIDELINE
EM014**

IMPLEMENTATION OF THE SOUTH AFRICAN TRIAGE SCALE

This Practice Guideline sets out a method for implementing triage in the Emergency Centre.

Excluding the cover page, this Practice Guideline is **7** pages.

Date of publication:	March 2010
Date of review:	February 2012
Responsible committee member:	Miss Michele Twomey

EMSSA Practice Guidelines provide advice on recommended practice for emergency centres, emergency personnel and emergency care activities.

The information within these papers statements is advice only. EMSSA will not be held liable for clinical outcomes related to these Guidelines.

BACKGROUND

Triage is the process of sorting patients into different priorities based upon their degree of illness or injury. The South African Triage Scale (SATS) is a scientifically derived triage tool initially developed by the South African Triage Group (SATG). A training program has been undertaken to educate Emergency Centre (EC) staff in the correct use of the SATS. EMSSA recommends that SATS be used in all ECs around the country.

Triage of patients at the point of entry into the EC allows early identification of the sickest patients. During the implementation of the SATS, the following advantages have repeatedly been observed:

- Expedites the delivery of time-critical treatment for life-threatening conditions
- Ensures that all patients are appropriately categorised
- Improves patient flow, and decreases overcrowding within the EC
- Improves patient and health provider satisfaction
- Decreases overall length of stay
- Decreases waiting times

The SATS has been validated in Community Health Centre and Hospital settings. Validation is currently being undertaken in the Pre-Hospital setting.

The triage nurse applying the SATS must address the question: *"This patient can wait for medical assessment and treatment no longer than minutes"*

DEFINITIONS

An Emergency Centre (EC) is the dedicated area within a health facility that is organised and administered to provide a high standard of emergency care to those in the community who perceive the need or are in need of acute or urgent care.

Emergency cases are those patients who present to the emergency centre seeking non-scheduled care.

The following priority groups and target times to treat are assigned by the SATS:

Red	Immediate
Orange	Within 10 minutes
Yellow	Within 60 minutes
Green	Within 240 minutes
Blue	Dead

EMSSA Practice Guidelines provide advice on recommended practice for emergency centres, emergency personnel and emergency care activities.

The information within these papers statements is advice only. EMSSA will not be held liable for clinical outcomes related to these Guidelines.

PURPOSE

The purpose of this practice guideline is to detail the procedure to be followed in triage of all emergency cases.

APPLICATION

The procedure for use of the SATS is detailed in three parts: triage requirements, the stepwise use of the SATS, and how triage fits into the patient journey.

1. Triage requirements

Accurate triage depends upon:

- **All patients are to be triaged** as soon as possible after arrival at a facility
- **A dedicated triage nurse is required at all times**
 - Any level of nursing staff that has completed the SATS training may be used to undertake triage with the SATS
 - Only experienced Professional Nurses (PN) and EC doctors may use the “Senior Health Professional’s Discretion” inherent in the SATS
- A dedicated triage area is required
 - A dedicated area is preferred, but in the absence of such a location patients may be seen at a bed space in the EC
 - Such an area requires to be well signed, secure (behind the security gate, or in easy view of security staff), large enough to accommodate the triage nurse, a patient in a wheelchair and a relative or carer. The recommended minimum size is 10 square meters
 - A desk and chair are required in this location
- The triage area is to contain triage paperwork (see Appendix 1), coloured stickers or pens to identify priority, a wall clock, a stethoscope, gloves, dry dressings, low reading thermometers, a sphygmomanometer (manual, digital or electronic) and access to a blood glucose monitor
- The triage area should contain a measuring tape, or have two marks prominently displayed on the wall against which children may be measured: one mark at 95cm and one at 150cm
- The SATS posters are to be prominently displayed in the triage location
- The SATS instruction manual is to be readily available to the triage nurse as a source of information
- The SATS patient information leaflet is to be prominently displayed in the patient waiting room.

2. The stepwise use of the SATS

2.1 Adults and all children aged 13 years or older (or taller than 150 cm) are to be triaged using the Adult SATS. Children aged between 3 and 12 years (or 96-150 cm

EMSSA Practice Guidelines provide advice on recommended practice for emergency centres, emergency personnel and emergency care activities.

The information within these papers statements is advice only. EMSSA will not be held liable for clinical outcomes related to these Guidelines.

tall) are to be triaged with the Child SATS; children under 3 years of age (or smaller than 96 cm) are to be triaged with the Infant SATS.

2.2 The procedure for ADULT triage is:

- Take a brief history
- Measure the Vital Signs and document the findings:
 - Place thermometer in axilla
 - Assess Mobility
 - Attach BP cuff and start measurement (electronic or digital)
 - Count 30 seconds of respirations and double the answer
 - Check heart rate and systolic blood pressure reading (or measure these at this point if manual BP cuff)
 - Take thermometer out & check temperature
 - Assess AVPU
- Calculate the total TEWS (Triage Early Warning Score) and document the finding
- Match the TEWS to a triage priority (Red, Orange, Yellow, Green)
- Check the discriminator list for any problems that will assign the patient a higher triage category
- Document the final triage category
- Check the Triage Intervention poster for any necessary interventions

2.3 The procedure for CHILD or INFANT triage is:

- Take a brief history
- Measure the Vital Signs and document the findings:
 - Count 30 seconds of respirations and double the answer
 - Put thermometer in axilla
 - Assess Mobility
 - Check heart rate manually or using the pulse-oximeter
 - Take thermometer out & check temperature
 - Assess AVPU & Trauma
- Calculate the total TEWS (Triage Early Warning Score) and document the finding
- Match the TEWS to a triage priority (Red, Orange, Yellow, Green)
- Check the discriminator list for any problems that will assign the patient a higher triage category.
- Document the final triage category.
- Check the Triage Intervention poster for any necessary interventions.

2.4 All children under one month of age (or less than 50 cm tall) (NEONATES) are to be triaged RED (Immediate) for attention by a senior EC doctor or PN.

2.5 Patients are to be disposed of as:

- RED patients are to be taken to the Resuscitation room and handed over for emergency management

EMSSA Practice Guidelines provide advice on recommended practice for emergency centres, emergency personnel and emergency care activities.

The information within these papers statements is advice only. EMSSA will not be held liable for clinical outcomes related to these Guidelines.

- ORANGE patients are to be taken to the EC and handed over for very urgent management
- YELLOW patients are to be taken to the EC and handed over for urgent management
- GREEN patients may be referred for streaming (if this is in place at the EC) or instructed to wait in the waiting room to be seen for routine management

3. Incorporating triage into the patient journey

3.1 All patients seeking non-scheduled care are to be triaged. The disposal of patients from triage is detailed above (2.5).

3.2 Ambulance cases – stretcher:

- *These patients will be taken straight through into the EC, where they will be handed over to the nurse or doctor on duty*
- If the patient is stable, the triage nurse will be called to the patient's bedside to undertake triage as detailed above
 - The patient's folder will be retrieved by any available member of staff, or an accompanying relative
- If the patient is in need of resuscitation, this will occur immediately. Triage will be undertaken retrospectively, with the first set of physiological signs recorded during the resuscitation forming the basis of the TEWS score
 - The patient's folder will be retrieved by any available member of staff, or an accompanying relative

3.3 Ambulance cases – non-stretcher:

- *These patients will be directed to the triage nurse for triage prior to retrieval of the patient's folder*
 - The patient's folder will be retrieved by any available member of staff, or an accompanying relative

3.4 Ambulant self-presentations:

- *These patients will be rapidly seen at the front of the EC by the PN or doctor to determine whether they are appropriate for the EC.*
 - All patients are considered appropriate unless they are clearly in the wrong location (for outpatient appointments, radiology or similar)
 - Paediatric patients must always be prioritised and triaged first
- Appropriate EC patients should be directed to triage first
- Once they have been triaged, their folder may be collected from administration

EMSSA Practice Guidelines provide advice on recommended practice for emergency centres, emergency personnel and emergency care activities.

The information within these papers statements is advice only. EMSSA will not be held liable for clinical outcomes related to these Guidelines.

3.5 Non-ambulant self-presentations

- *These patients will be taken directly to the EC where they will be seen on an available bed*
- If the patient is stable, the triage nurse will be called to the patient's bedside to undertake triage as detailed above
 - The patient's folder will be retrieved by any available member of staff, or an accompanying relative
- If the patient is in need of resuscitation, this will occur immediately. Triage will be undertaken retrospectively, with the first set of physiological signs recorded during the resuscitation forming the basis of the TEWS score
 - The patient's folder will be retrieved by any available member of staff, or an accompanying relative

POST TRIAGE CARE

The duty sister in charge of the EC must ensure continuous reassessment of those patients who remain waiting and, if the clinical features change, re-triage the patient accordingly.

PERFORMANCE INDICATOR THRESHOLDS

The performance indicator thresholds represent the percentage of patients assigned a given triage priority who should receive medical attention within the relevant waiting time from the time of arrival.

Staff and other resources should be deployed so that thresholds are achieved progressively from Red through to Green.

The threshold performance indicators shown are appropriate for the period 2010-2012 inclusive, and should be achievable in all ECs. Performance indicator thresholds will be kept under regular review.

SATS priority	Target time to treat	Performance indicator threshold
Red	Immediate	95%
Orange	10 minutes	80%
Yellow	60 minutes	75%
Green	240 minutes	70%

Where ECs are chronically restricted, or in times of transient patient overload, staff should be deployed so that performance is maintained in the more urgent categories.

EMSSA Practice Guidelines provide advice on recommended practice for emergency centres, emergency personnel and emergency care activities.

The information within these papers statements is advice only. EMSSA will not be held liable for clinical outcomes related to these Guidelines.

QUALITY ASSURANCE

Benchmarks for ECs of similar role delineation will allow comparison between these units. Such benchmarks will include (but are not limited to): patterns of triage category distribution; mortality by triage category; ICU admission by triage category (for Central ECs) or referral rates (for other ECs), and waiting times by triage category.

RESPONSIBILITIES

Each EC should assign a task team to be responsible for the implementation and functioning of triage. This team should consist of a doctor and Professional Nurse.

Task teams will be responsible for regular audits of 25-50 randomly selected patients. Audits should monitor the performance in triage (i.e. errors or omissions on the TEWS and discriminator list, as well as waiting times by triage category).

EMSSA Practice Guidelines provide advice on recommended practice for emergency centres, emergency personnel and emergency care activities.

The information within these papers statements is advice only. EMSSA will not be held liable for clinical outcomes related to these Guidelines.