



GUIDELINES ON THE IMPLEMENTATION OF THE AUSTRALASIAN TRIAGE SCALE IN EMERGENCY DEPARTMENTS

Contents

1.	General Principles.....	2
1.1	Function of Triage	2
1.2	The Triage Assessment	2
1.3	Safety at Triage.....	2
1.4	Time to Treatment	2
1.5	Re-triage	2
1.6	Triage Colours.....	3
2.	Extended Definitions and Explanatory Notes	3
2.1	Arrival Time	3
2.2	Time of Medical Assessment and Treatment	3
2.3	Waiting Time	3
2.4	Documentation Standards.....	3
3.	Specific Conventions	4
3.1	Paediatrics	4
3.2	Trauma.....	4
3.3	Behavioural Disturbance.....	4
4.	Clinical Descriptors	4
4.1	Source	4
4.2	Most Urgent Features Determine Category	4
5.	AUSTRALASIAN TRIAGE SCALE: DESCRIPTORS FOR CATEGORIES	5
6.	Document Review	8
6.1	Responsibilities.....	8
6.2	Revision History.....	8

1. GENERAL PRINCIPLES

1.1 Function of Triage

Triage is an essential function in Emergency Departments (EDs), where many patients may present simultaneously. It aims to ensure that patients are treated in the order of their clinical urgency which refers to the need for time-critical intervention. Clinical urgency is not synonymous with complexity or severity. Triage also allows for the allocation of the patient to the most appropriate assessment and treatment area, and contributes information that helps to describe the departmental case-mix. Changing models of care in some EDs (for example streaming, clinical initiatives nurses, triage liaison physicians) do not preclude the need for triage.

1.2 The Triage Assessment

Triage is the first point of public contact with the ED. The triage assessment generally should take no more than two to five minutes with a balanced aim of speed and thoroughness being the essence. The triage assessment involves a combination of the presenting problem and general appearance of the patient, and may be combined with pertinent physiological observations. 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. A more complete nursing assessment should be done by the treatment nurse receiving the patient. The triage assessment is not intended to make a diagnosis. The initiation of investigations or referrals from triage is not precluded if time permits.

In Australasia, triage is carried out by staff members who are both specifically trained and experienced.

1.3 Safety at Triage

It is essential that all EDs plan for the potential risk of aggressive behaviour of patients or their relatives at triage. There must be a safe and non-threatening physical environment, which is as private as possible whilst not exposing staff to risk. Front line staff should have minimisation-of-aggression training and 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.

The maximum waiting time for Category 5 represents a standard for service provision.

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.

1.5 Re-triage

If a patient's condition changes while one is waiting for the 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.

1.6 Triage Colours

Emergency Departments throughout Australia and New Zealand utilise a range of ED Information Systems (EDIS) in order to provide key functions, such as triage management and assessment. Using these systems, EDs can choose to identify each ATS Category using a specific colour.

Red (Category 1), Orange (Category 2), Green (Category 3), Blue (Category 4) and White (Category 5), are commonly utilised by EDs in order to identify each ATS Category, and are recommended to be the standard colours used throughout Australia and New Zealand. However, colour designations should only be used as an adjunct to the numerical designations identifying each triage category.

2. EXTENDED DEFINITIONS AND EXPLANATORY NOTES

2.1 Arrival Time

The arrival time is the first recorded time of contact between the patient and ED staff. Triage assessment should occur at this point.

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 is presented.

- 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'.
- Where a patient in the ED has contact exclusively with nursing staff acting under the clinical supervision of a doctor, it is the time of first nursing contact. This is often recorded as 'Time seen by nurse'.
- 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', "Time seen by nurse practitioner" or Time see 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 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

- Re-triage category with time and reason
- Assessment and treatment area allocated
- Any diagnostic, first aid or treatment measures initiated

3. SPECIFIC CONVENTIONS

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. Children should 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

Individual departments may have policies that provide for immediate team responses to patients meeting certain criteria. However, the triage category should be allocated according to their objective clinical urgency.

3.3 Behavioural Disturbance

Patients presenting with mental health or behavioural problems should be triaged according to their clinical and situational urgency. 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 ED and posing an immediate threat to staff (e.g. 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 reflect clinical and situational urgency.

Individual departments may have procedures and assessment tools to assist with identifying at risk mental health patients. These are considered as supportive to initial triage and may be applied following formal triage assessment.

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 must 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.

5. AUSTRALASIAN TRIAGE SCALE: DESCRIPTORS FOR CATEGORIES

ATS Category	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 <ul style="list-style-type: none"> - 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 Suspected sepsis (physiologically unstable) Febrile neutropenia BSL < 3 mmol/l Drowsy, decreased responsiveness any cause (GCS< 13) Acute stroke Fever with signs of lethargy (any age) Acid or alkali splash to eye – requiring irrigation Suspected endophthalmitis post-eye procedure (post-cataract, post-intravitreal injection), sudden onset pain, blurred vision and red eye. Major multi trauma (requiring rapid organised team response)

			<p>Severe localised trauma – major fracture, amputation</p> <p>Suspected testicular torsion</p> <p>High-risk history:</p> <ul style="list-style-type: none"> - Significant sedative or other toxic ingestion - Significant/dangerous envenomation - Severe pain or other feature suggesting PE, aortic dissection/AAA or ectopic pregnancy <p>Behavioural/Psychiatric:</p> <ul style="list-style-type: none"> - violent or aggressive - immediate threat to self or others - requires or has required restraint - severe agitation or aggression
ATS Category	Response	Description of Category	Clinical Descriptors (indicative only)
<p>Category 3</p> 	<p>Assessment and treatment start within 30 mins</p>	<p>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</p> <p>or</p> <p>Situational Urgency There is potential for adverse outcome if time-critical treatment is not commenced within thirty minutes</p> <p>or</p> <p>Humane practice mandates the relief of severe discomfort or distress within thirty minutes</p>	<p>Severe hypertension</p> <p>Moderately severe blood loss – any cause</p> <p>Moderate shortness of breath</p> <p>Seizure (now alert)</p> <p>Persistent vomiting</p> <p>Dehydration</p> <p>Head injury with short LOC- now alert</p> <p>Suspected sepsis (physiologically stable)</p> <p>Moderately severe pain – any cause – requiring analgesia</p> <p>Chest pain likely non-cardiac and mod severity</p> <p>Abdominal pain without high risk features – mod severe or patient age >65 years</p> <p>Moderate limb injury – deformity, severe laceration, crush</p> <p>Limb – altered sensation, acutely absent pulse</p> <p>Trauma - high-risk history with no other high-risk features</p> <p>Stable neonate</p>

			<p>Child at risk of abuse/suspected non-accidental injury</p> <p>Behavioural/Psychiatric:</p> <ul style="list-style-type: none"> - very distressed, risk of self-harm - acutely psychotic or thought disordered - situational crisis, deliberate self-harm - agitated / withdrawn - potentially aggressive
<p>Category 4</p> 	<p>Assessment and treatment start within 60 mins</p>	<p>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</p> <p>or</p> <p>Situational Urgency There is potential for adverse outcome if time-critical treatment is not commenced within hour</p> <p>or</p> <p>Significant complexity or Severity Likely to require complex work-up and consultation and/or inpatient management</p> <p>or</p> <p>Humane practice mandates the relief of discomfort or distress within one hour</p>	<p>Mild haemorrhage</p> <p>Foreign body aspiration, no respiratory distress</p> <p>Chest injury without rib pain or respiratory distress</p> <p>Difficulty swallowing, no respiratory distress</p> <p>Minor head injury, no loss of consciousness</p> <p>Moderate pain, some risk features</p> <p>Vomiting or diarrhoea without dehydration</p> <p>Eye inflammation or foreign body – normal vision</p> <p>Minor limb trauma – sprained ankle, possible fracture, uncomplicated laceration requiring investigation or intervention – Normal vital signs, low/moderate pain</p> <p>Tight cast, no neurovascular impairment</p> <p>Swollen “hot” joint</p> <p>Non-specific abdominal pain</p> <p>Behavioural/Psychiatric:</p> <ul style="list-style-type: none"> - Semi-urgent mental health problem - Under observation and/or no immediate risk to self or others
<p>Category 5</p> 	<p>Assessment and treatment start within 120 minutes</p>	<p>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</p> <p>or</p>	<p>Minimal pain with no high risk features</p> <p>Low-risk history and now asymptomatic</p> <p>Minor symptoms of existing stable illness</p> <p>Minor symptoms of low-risk conditions</p> <p>Minor wounds - small abrasions, minor lacerations (not requiring sutures)</p> <p>Scheduled revisit e.g. wound review, complex dressings</p>

		Clinico-administrative problems Results review, medical certificates, prescriptions only	Immunisation only Behavioural/Psychiatric: <ul style="list-style-type: none"> - Known patient with chronic symptoms - Social crisis, clinically well patient
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6. DOCUMENT REVIEW

Timeframe for review: every five (5) years, or earlier if required.

6.1 Responsibilities

Document authorisation: Council of Advocacy Practice and Partnerships
 Document implementation: Standards Committee
 Document maintenance: Policy and Research Department

6.2 Revision History

Version	Date of Version	Pages revised / Brief Explanation of Revision
V1	Nov 00	Approved by Council
V2	Nov 05	Approved by Council
V4	Nov 13	Approved by Council
V5	Jul 16	Section 1.6: addition of recommended triage colours. Section 5: Additional clinical descriptors added to Category 2: <ul style="list-style-type: none"> - Suspected sepsis (physiologically unstable) - Febrile neutropenia - Suspected endophthalmitis post-eye procedure - Suspected testicular torsion Section 5: Additional clinical descriptors added to Category 3: <ul style="list-style-type: none"> - Suspected sepsis (physiologically stable) - Suspected stroke

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