

Frequently Asked Questions

1. Why has systolic blood pressure been included into the TEWS for scoring and not diastolic blood pressure?

Evidence shows that systolic blood pressure is more predictive of patient outcome than diastolic blood pressure. The diastolic blood pressure may be important to the doctor when s/he eventually attends to the patient but it is not an important indicator when triaging. That allows us to ignore the diastolic blood pressure value when we triage.

2. Why are the patient's vitals measured before the history is taken?

This was an error in the printing and will be changed in the next version of the newly printed manuals. The SATG encourages triage nurses to first take a brief history and then measure the vitals.

3. If a patient's TEWS score is 2 and they are upgraded to an Orange colour code because of chest pain, does their TEWS score change to 5-6 points?

No, the TEWS score remains the same, only the colour code changes.

4. If a patient comes in complaining of chest pain can one immediately triage them Orange based on the discriminator list to fast track the triage process and then calculate their TEWS later?

No, just as A comes before B in the ABC's the SATG encourages the calculation of the TEWS before consulting the discriminator list. This is important as patients may have a TEWS score which places them into higher colour category than the discriminator list would.

5. How does one deal with adults and moreover children that are yellow or green and need to be re-triaged at regular intervals? How often should they be re-triaged and in what intervals?

Patients triaged to a green colour code do not need to be re-evaluated just as patients attending an outpatient clinic do not need their vitals re-assessed after they have been taken once (this applies to adults and children). As in the outpatient setting, rapid deterioration of someone with normal physiology and no abnormal vital signs is unlikely and re-evaluation will only be required if this changes. Remember that you are in the Emergency Department already. In the unlikely event that a patient triaged to a green colour code suddenly deteriorates, help is close by.

Patients triaged to a yellow colour code will need re-assessing and re-triaging until they are seen by a doctor. It is not possible to specify how often a patient should be re - triaged but it is very important to keep an eye on everyone in the waiting room and if there is concern re – triage the patient.

6. How does one triage and manage a patient that gets rushed straight through to resus?

These patients are provisionally triaged into the red colour category and have to be triaged retrospectively later on. This means that the TEWS and colour code need to be calculated after the resus has been terminated or the patient has stabilised. It is important to triage the patient to keep an accurate track on the workload of the department.

7. What do the grey areas indicate in the TEWS score?

The grey areas are not to be used for scoring purposes. A patient's score will always be obtained from the ranges in the white areas. The TEWS is a standardized scoring system that has been validated on our local South African population.

8. A child that is drooling will first experience stridor before drooling, so why is stridor not in the red column for children?

By the same argument, chest pain should be a red colour code as it comes before cardiac arrest - but it is not, for a simple reason. As with chest pain, stridor can still be reversed with timely treatment and not all patients with stridor will end up drooling. It is clearly more important than a yellow colour code but does not need immediate attention in all cases like a red colour code. It is therefore an orange colour code. As with cardiac arrest, drooling needs immediate intervention and is therefore a red colour code. Remember, the South African Triage Group encourages triage nurses to use their discretion and ask for help if the colour code appears inappropriate in relation to a patient's condition.

9. Why is the range for temperature so wide?

Evidence shows that a patient within this wide range still shows a good outcome but outside this range is associated with a poorer outcome. It is important to always remember that the ranges and values in the TEWS are for the purposes of Emergency Department Triage which intends to pick up those in most urgent need of services. Someone with a mild temperature may not be that well but may also not qualify for an additional point on the TEWS.

10. What does AVPU represent? If a patient comes walking into the ED crying of pain due to a fractured arm? Are they responding to pain or are they alert.

If the patient is walking and talking they are obviously awake and alert and would thus score 0 points.

*AVPU is a measure of consciousness similar to GCS. AVPU should always be assessed by starting with the first letter of the alphabet (**A**). The patient is **A** if s/he is awake, alert, walking and talking. If not **A** (- alert) then move to (**V**). The patient is **V** if s/he appears unconscious but when you speak to them, s/he responds to your **V**oice.*

*If not V (- responds to voice) then move to (P). The patient is P if s/he appears unconscious but when you inflict a painful stimulus they respond to this Pain.
If not P (- responds to pain) then the patient is (U) – Unconscious*

AVPU and GCS do not match exactly and there is some overlap. However the following rough comparison is useful for training

AVPU	GCS
A	14 – 15
V	9 – 13
P	6 – 8
U	3 – 5

 Consider airway protection for P & U

11. How does one assess mobility?

Patients should be briefly assessed whether they are able to walk as many patients arrive in a wheelchair because they are weak but in fact mobile. See if the patient can walk four paces without any help. If they can then they are mobile and score 0 points for mobility. If they cannot they score 1 point.

If the patient's permanent state is in a wheelchair s/he would still score 1 point because a paralysed patient may have additional factors worsening an acute pathology. We may also try to get a paralysed patient seen quicker for the same reasons we would give them the best parking spots at the mall.

12. Is the training that nurses receive as part of the triage package flexible? Can it be adapted to the specific context in which it is being used?

Many trained ENAs feel overwhelmed by their new triage responsibility and may appear inflexible. However their triage training encourages them to adapt what they have learnt to their unique situation. They are also encouraged to ask the CNP or doctor on duty for guidance and advice if uncertain. The CNP and doctors on duty are in turn responsible for the ongoing supervision of the triage ENAs.

13. How many staff should be in the triage area?

Not more than 2 nurses.

14. What does controlled haemorrhage mean?

This refers to a patient that is actively bleeding on arrival and the triage nurse is able to control the bleed by applying pressure to the site of trauma. If bleeding continues after pressure has been applied to the site of trauma this would be an uncontrolled haemorrhage.