

IMPLEMENTATION OF THE SOUTH AFRICAN TRIAGE SCALE IN COMMUNITY HEALTH CENTRE EMERGENCY CENTRES

BACKGROUND

1. 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 developed by the South African Triage Group (SATG), a joint initiative between the Division of Emergency Medicine (UCT and US) and the Western Cape Department of Health. A training program has been undertaken across the province to educate Emergency Unit staff in the correct use of the SATS.
2. Triage of patients at the point of entry into the Emergency Centre (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
3. The SATS has been validated in Community Health Centre (CHC) and Hospital settings.
4. The triage nurse applying the SATS must address the question: *"This patient can wait for medical assessment and treatment no longer than minutes"*

DEFINITIONS

5. An EC is any centre seeing emergency cases. Such centres may be generally known as Casualty Units, Trauma Units or Medical Emergency Units.
6. Emergency cases are those patients who present to the emergency unit seeking non-scheduled care.
7. 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

PURPOSE

8. The purpose of this policy is to detail the procedure to be followed in triage of emergency cases in each and every EC.

DATE OF IMPLEMENTATION

9. Triage using the SATS is to be performed in all units seeing emergency cases with immediate effect.

APPLICATION

10. 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.

Triage requirements

11. Accurate triage depends upon:

- **All patients are to be triaged** as soon as possible after arrival at a facility
- **All staff that have been trained to use the SATS are required to triage at all times**
 - Any level of nursing staff 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.
 - A desk and chair are required in this location.
- The triage area is to contain triage paperwork, coloured stickers to identify priority, a wall clock, 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, in English, Afrikaans and Xhosa.

The stepwise use of the SATS

12. 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 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.

13. 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 & Trauma Score
- Calculate the total TEWS (Triage Early Warning Score) and document the finding
- Match the TEWS to a triage priority (Red, Orange, Yellow, Green) and 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.

14. 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
 - Attach BP cuff and start measurement (electronic or digital)
 - 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 & Trauma
- Calculate the total TEWS (Triage Early Warning Score) and document the finding
- Match the TEWS to a triage priority (Red, Orange, Yellow, Green) and 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.

15. 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.

16. All patients are to be triaged. Patients are to be disposed of as:

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

Incorporating triage into the patient journey

Guidelines for health staff, admin clerks and security staff

17. It is essential that all staff actively facilitate the incorporation of triage into the patient's journey.
18. All admin clerks and security staff need to be informed about the requirement that patients must be triaged. They are responsible for appropriately directing patients to the EC according to guidelines 19 – 23 below.
19. Neonates, infants and children must be prioritised before adults and taken straight through into the EC, where they will be handed over to the nurse or doctor in duty.
20. Ambulance cases – stretcher:
 - *These patients will be taken straight through into the EC, where they will be handed over to the nurse or doctor in 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.
21. 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.
22. 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 out patient appointments, radiology or similar).
 - Appropriate EC patients should be directed to administration to collect their folder.
 - Once the folder has been collected, the patient should be triaged.
23. 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

24. 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.
25. Where doctors are busy treating Red patients, all other staff not assisting are responsible for intervening (within their scope of practice) to maintain life for Orange, Yellow and Green patients according to the SATS triage Management and Intervention list.

PERFORMANCE INDICATOR THRESHOLDS

26. 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.
27. Staff and other resources should be deployed so that thresholds are achieved progressively from Red through to Green.
28. The threshold performance indicators shown are appropriate for the period 2006-2008 inclusive, and should be achievable in all ECs. Performance indicator thresholds will be kept under regular review.

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

29. 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.

QUALITY ASSURANCE

30. Triage accuracy and system evaluation will be undertaken in part by reviewing triage allocation against benchmark outcomes: such benchmarks will be promulgated from this office and will be periodically reviewed.

31. Benchmarks for ECs of similar role delineation will allow comparison between these centres. 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

32. Each EC is to assign a task team to be responsible for the implementation and functioning of triage. This team should consist of a doctor and Professional Nurse. The contact details for this task team are to be forwarded to the Implementation Manager (IM).
33. The IM is responsible for resolving implementation issues in ECs, and ongoing monitoring and evaluation.
34. The task team is responsible for providing ongoing training in their own capacity or utilising the IM for training purposes.
35. With turnover of triage staff, the task team is responsible for training all newly appointed staff members in their own capacity or utilising the IM for training purposes.

Implementation Manger

Miss Michele Twomey

Email satriage@webmail.co.za

Phone 082 4700046

SATG Chair

Prof Lee Wallis