



Australian Government  
Department of Health and Aged Care

AUSTRALIAN COMMISSION  
ON SAFETY AND QUALITY IN HEALTH CARE

# EMERGENCY TRIAGE EDUCATION KIT

Second edition

A RESOURCE FOR EMERGENCY TRIAGE NURSES AND EDUCATORS

The Emergency Triage Education Kit has been endorsed by the following colleges:



Australasian College  
for Emergency Medicine



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# Foreword

More than 8 million patients present to an emergency department (ED) in Australia every year, seeking care for a wide range of conditions. In most cases, the triage nurse is the first clinician they see and an important source of experience, wisdom and comfort.

The triage nurse determines the patient's need for time-critical care and the order in which they see the treating clinician. This enormous responsibility is conducted in what is often a time-pressured, challenging and noisy environment with frequent interruptions.

Clinical decisions are just one part of the triage nurse's role. The communication and emotional support they provide is just as important. Many patients and their families find attending the ED and navigating the triage process incredibly challenging when they are with a sick loved one. The triage nurse makes this stressful time much easier, by assessing a patient's urgent care needs and arranging the appropriate supports in a timely way. In coming years, triage nurses will increasingly direct patients with non-urgent needs towards Australia's growing network of Medicare Urgent Care Clinics allowing everyone to receive the care they need where they need it.

This second edition of the Emergency Triage Education Kit (ETEK) has drawn on the collective knowledge and wisdom of clinical experts, consumers and researchers to offer clear and practical guidance for nurses preparing for this critical role in our health system.

In addition to content about assessing physical illness and injury, the ETEK provides guidance on all the other facets of the triage nurse role. I am pleased to see communication and cultural considerations for First Nations people seeking care in EDs, as well as recommendations for providing effective and compassionate care for people with specific needs. These groups include people with disability, people from culturally and linguistically diverse backgrounds and those experiencing mental health challenges.

This ETEK revision was funded by the Australian Government and was developed by the Australian Commission on Safety and Quality in Health Care with the support of state and territory health departments, emergency clinician colleges, consumer organisations and many individual clinicians and researchers. I thank all the contributors for their part in producing such a valuable resource.



**The Hon Mark Butler MP**  
Minister for Health and Aged Care

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# About the ETEK

## Introduction

Triage is an evidence-based process that ensures patients with the most urgent clinical need are prioritised for care in the emergency department (ED). Accurate and consistent triage is the foundation of equitable and safe patient care, as well as effective and efficient use of ED resources.

The Emergency Triage Education Kit (ETEK) provides a consistent approach to education for nurses preparing for the triage role. The ETEK focuses on how to apply the Australasian Triage Scale (ATS) and the knowledge, communication and decision-making skills that underpin this process. The principles of person-centred care are integrated throughout the content, promoting a positive experience for patients, their support people and triage nurses.

## Development of the ETEK

The Commonwealth Department of Health and Ageing published the Triage Education Resource Book in 2002 to promote consistent application of the ATS.<sup>1</sup> This was the forerunner of the first edition of the ETEK, published in 2007.

The first edition of the ETEK was a product of a collaboration between the Commonwealth Department of Health and Ageing, the contributing authors and a working party consisting of representatives from key stakeholder groups.<sup>2</sup> A set of more than 150 validated scenarios was added in 2009 to be used for consolidation and self-test.<sup>3</sup> This second edition builds on the work of the original ETEK authors and collaborators.

In 2022, the Commonwealth Department of Health and Aged Care engaged the Australian Commission on Safety and Quality in Health Care (the Commission) to review and update the original ETEK. To produce the revised version of the ETEK, the Commission has incorporated:

- Findings of a needs analysis, including feedback from more than 1,400 ED clinicians
- Consultation with clinicians, academics and policy makers
- Consultation with consumers
- Current published evidence and guidelines, including the updated *Guidelines on the Implementation of the ATS in Emergency Departments*<sup>4</sup>
- A set of revised and revalidated scenarios.

The Commission thanks the many people who have contributed to the process with advice, feedback, reviews and testing of scenarios (see **Acknowledgements**).

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## How to use the ETEK

The ETEK includes content for learners and educators.

Chapters 1–9 contain:

- Learner content – key information related to the topic
- Educator resources – guidance on localising content for learners, discussion points, case studies and supporting resources.

Chapter 10 contains scenarios for consolidation and self-test.

The set of [quick reference resources](#) includes useful tables, including the ATS.

## Learners

You need to be aware of your state, territory and/or local requirements for undertaking the triage role before beginning this education package. Refer to your local policies and guidelines on the prerequisites for the triage role, and relevant College of Emergency Nursing Australasia (CENA) statements.<sup>5,6</sup>

The ETEK content assumes you have current knowledge and competency of ED nursing assessment approaches and processes, and have completed relevant mandatory training. Specific assumed knowledge is outlined at the beginning of each chapter. Speak to your local educator or manager if you would like additional education on any of these topics.

You should also have:

- A good understanding of patient flow in your ED
- Knowledge of your local ED policies and legislation, such as mandatory reporting for children or older people at risk.

The first four chapters of the ETEK cover foundational knowledge and should be completed first and in sequence. Chapters 5–9 can be completed in any order. The scenarios in Chapter 10 should be attempted after completing all the preceding chapters.

## Educators

Use the framework provided in the educator resources to:

- Prepare information about local considerations for triage nurses, such as processes and protocols
- Lead group conversations about key principles in the chapter and the more complex issues in the relevant area of practice
- Discuss the case studies with learners – in some cases there is no right answer, and considering the different circumstances that might influence a triage nurse's actions is a valuable learning exercise.

The supporting resources will provide useful material if you wish to supplement the learner content of the chapter.

Group discussions should allow learners to raise their questions and practise applying the principles contained in the ETEK in a safe, reflective and supported way. These discussions will work best with small groups. Learners working in areas without educator support are encouraged to discuss the concepts and case studies with more senior colleagues to develop their knowledge and thinking processes.

Completion of the ETEK should be part of a suite of activities to prepare learners for the role of triage. Other activities should include supported clinical time, which allows triage nurses to apply their new skills and knowledge in the clinical environment with the benefit of feedback in real time.

Regular audit of triage is another important opportunity for individuals to learn, and for the team to identify system gaps and opportunities to enhance quality and consistency.<sup>7</sup> Consider your local process for review and reflection on triage practice.

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## Notes about the content

- The ETEK is about triage in Australian emergency services; disaster triage is not covered
- State and territory policies should be consulted for guidance in some situations, as indicated in the text
- Links provided to resources were current at the time of publication; titles have been listed to allow for searching in the case of a broken link
- ED nurses training for the triage role are likely to be equipped to deal with confronting content in the ETEK. People who are not health professionals should note that the content includes discussion of potentially distressing subjects such as suicide and sexual assault.

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# Chapter 1: The triage role and the Australasian Triage Scale

## About this chapter

This chapter assumes knowledge of local ED models of care and experience in assessing and providing care for patients with a range of presentations.

## Learning outcomes

After completing this chapter you will be able to:

- Understand the role of triage within the ED
- Discuss the responsibilities of the triage nurse within your workplace
- Understand the Australasian Triage Scale (ATS) and its application in the clinical setting.

## Background

In the ED, any number of patients can arrive at the same time with varying needs and degrees of urgency. The triage nurse determines the order in which patients are treated, based on their need for urgent care, to prevent deterioration or further pain and suffering.<sup>1,2</sup> The underlying principles of triage include fair, effective and efficient use of ED resources to improve patient outcomes.<sup>1-3</sup>

## The triage role

As a triage nurse, you will need to make rapid decisions, often with limited information, for patients who generally do not have a known diagnosis. Due to the complexity of the role, triage nurses need specialised knowledge as well as experience with a wide range of illnesses and injuries.

The triage role involves the following steps, which are discussed in detail in **Chapter 2: Triage fundamentals**:

- Ordering the queue for triage
- Conducting a focused and efficient assessment of the patient
- Assigning a triage category based on the patient's presentation
- Providing basic first aid and emergency interventions, such as slings and dressings for open wounds
- Allocating the patient to the appropriate area.

As the first ED clinician most patients see, your communication style sets the tone for their experience. Effective communication, empathy and kindness are important parts of the triage role.



### Key point

Triage aims to ensure patients are treated in the order of their clinical urgency.<sup>2</sup>

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## Accuracy and consistency

Accuracy of triage decisions is important, as the triage category you assign can have a profound impact on patients' outcomes and on the use of resources within the ED (see Table 1.1, below). The application of the ATS also needs to be consistent:

- Within your own triaging – so patients are seen in the appropriate order
- Between different triage nurses – so patients will still be seen in order of urgency after a change in shift or if two nurses are triaging at the same time
- Regardless of means of arrival.

Table 1.1: Impact of triage accuracy

Triage category	Effect on risk
Too low (under-triage)	Risks an adverse outcome for the patient
Appropriate	Optimises time to treatment and limits the risk of an adverse outcome
Too high (over-triage)	Risks an adverse outcome for other patients waiting to be seen

## The front-end team

The make-up of the front-end team in ED varies by site and by time of day, and generally includes a triage nurse. In some smaller sites, one nurse covers triage as well as a number of other roles. If you are in this situation, be aware of when you are switching from the triage role to your other roles.

In some EDs with a rapid assessment model, the front-end team can also include other clinicians, such as a senior doctor, nurse practitioner, physiotherapist, and in some cases a junior medical officer and an emergency nurse. In larger EDs, the front-end team may include:

- Triage nurse(s)
- Clerical staff
- A waiting room nurse
- Patient experience officers or waiting room volunteers
- An early streaming nurse.

Depending on your site, you may be expected to do other tasks as well as triage. If you have competing demands that you can't prioritise safely, use your escalation process – the unknown, pre-triage patient in the waiting room may be a high risk.



## Key point

The triage category you assign can have a profound impact on patients' outcomes and on the use of resources within the ED.

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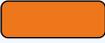
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## The ATS

The ATS states the recommended maximum waiting time for initiation of emergency care (see Table 1.2, below). See [Appendix A](#) for the complete Australasian Triage Scale.

Table 1.2: ATS categories and maximum waiting times\*

Triage category	Maximum waiting time
1 	Immediate care
2 	10 minutes
3 	30 minutes
4 	60 minutes
5 	120 minutes

Source: *Guidelines on the Implementation of the Australasian Triage Scale in Emergency Departments*, ACEM<sup>2</sup>

\* These times are intended to guide the triage nurse on the maximum time a patient should wait for the initiation of care; see local policies for KPI data definitions.

Make sure you know your ED policy on re-triage when the waiting time specified in the ATS has expired. Colours may be used as well as the category numbers in ED information systems.<sup>2</sup>

Urgency, complexity, severity and acuity –  
what do they mean?

- Urgency or acuity – how quickly a patient needs to be seen to prevent deterioration or further pain and suffering
- Complexity – the difficulty of the patient’s medical, social, psychological and environmental issues impacting the level of resources needed to find a solution
- Severity – the extent of musculoskeletal or organ system derangement, or physiological decompensation.

Note: A patient with a lower level of urgency may still have a high level of complexity or severity.

Source: *ACEM Literature Review on the Australasian Triage Scale (ATS)*<sup>4</sup>

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**Chapter 1: The triage role and the Australasian Triage Scale****Applying the ATS**

Within the ATS framework, urgency depends on both the patient's clinical risk and the severity of their symptoms and assessment findings.

**Specific populations**

Additional specific risk factors to consider in specific patient groups are discussed in later chapters:

- **Chapter 5: Psychological distress and behavioural disturbance**
- **Chapter 6: Pregnancy**
- **Chapter 7: Paediatrics**
- **Chapter 8. Older people.**

Additional considerations for people from First Nations or culturally and linguistically diverse backgrounds are discussed in **Chapter 3: Communication for triage** and in other chapters where relevant.

**Red flags**

In some cases, additional risk factors, such as medical history or extremes of age, combine with the presenting problem to increase the patient's urgency.

**Other uses of the ATS**

Although the ATS was not developed for benchmarking and for resource planning, it is also used as the basis for these purposes.<sup>4</sup> For example, data on achieving the ATS recommended time to treatment after a patient's first contact are used to monitor ED performance. It is important to recognise that time to treatment is not attributable to triage or triage nurse decisions – it is a function of ED and, to some degree, hospital performance.

Although triage categories have been used in research to review factors such as admission rates, the ATS was only designed to indicate urgency for post-triage interventions and care.

**When applying the ATS**

- Use the most urgent clinical feature to determine the category<sup>2</sup>
- Do not be influenced by how busy the ED is or the availability of resources
- Assess each presentation on its merits, regardless of the patient's previous presentations.

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## A brief history of triage and the ATS

Triage was first used in the French revolutionary wars in the 1790s, and the word triage comes from the French word 'trier' – to sort.<sup>5,6</sup> Early military triage systems evolved into scales used in modern military triage and disaster triage<sup>7</sup>; these are different from civilian ED triage scales and are not covered in the ETEK.

In Australia, a triage system was first introduced in Melbourne's Box Hill and District Hospital in the 1970s, based on the same principle as military triage – doing the greatest good for the greatest number when demand overwhelms resources.<sup>6,8</sup> This system has evolved into the current ATS<sup>3</sup> (see Figure 1.1, right).

The ATS has been shown to be a valid tool for determining urgency in the ED, and five-category triage scales are more reliable than three-category triage scales.<sup>4</sup>

Figure 1.1: Evolution of the ATS

**1976: Box Hill Hospital System introduced at Box Hill and District Hospital, Victoria<sup>6</sup>**

- Initially a three-category scale, developed by Pink<sup>6</sup>
- Developed into a five-category scale

**1985: Ipswich Triage Scale introduced at Ipswich General Hospital, Queensland<sup>7</sup>**

- Modification of the Box Hill Hospital System
- Validated by FitzGerald and Jelinek<sup>7</sup>

**1994: National Triage Scale adopted by the Australasian College for Emergency Medicine<sup>7</sup>**

- Modification of the Ipswich Triage Scale
- Validated by several groups
- More comprehensive clinical descriptors added by Whitby et al<sup>8</sup>

**2002: National Triage Scale becomes the Australasian Triage Scale<sup>4</sup>**

- Formed the basis of the Manchester Triage Scale (UK) and the Canadian Triage and Acuity Scale<sup>3</sup>

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**Take-home messages**

In summary, remember that:

- Triage is a way of prioritising patients by urgency – that is, how quickly they need to be seen to prevent deterioration or further pain and suffering
- The triage category you assign can have a profound impact on patients' safety and on the use of resources within the ED
- If you have competing demands that you can't prioritise safely, use your escalation process – the unknown, pre-triage patient in the waiting room may be a high risk
- The ATS states the maximum time patients are considered safe to wait for emergency care
- When applying the ATS:
  - Use the most urgent clinical feature to determine the category
  - Do not be influenced by how busy the ED is or the availability of resources
  - Assess each presentation on its merits, regardless of the patient's previous presentations
- In some cases, additional risk factors combine with other features of a presentation to increase the urgency; for example, medical history or extremes of age
- Take into account specific risk factors for children, pregnant women, older people and people experiencing behavioural disturbance or psychological distress (see chapters on these specific groups for more information).

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## Educator resources

## Considerations for your site

Your role as an educator is to explain:

- The composition of the front-end team in your ED and their roles, or how to manage when you are working alone
- Local policy for re-triage
- Your site's platform for triage documentation.

## Discussion points

Help learners consolidate their understanding by discussing the points below:

- Describe the aims of the triage system
- Describe some of the underlying principles of the triage system and reflect on how applying these principles may affect you as an individual
- Explain the terms 'under-triage' and 'over-triage'
- Discuss how you can reduce the risk of under-triage and over-triage in practice
- Discuss what you would do as the triage nurse if the time to treatment was delayed.

## Case studies

Some presenting problems, such as 'suspected sepsis (physiologically unstable)', are clearly described in the ATS. A number of other presentations will rely on a more thorough assessment of the patient to determine the triage category. Review the case studies below and consider how you would apply the ATS.

## Case study 1: Syncope

A patient presents post-syncope. They tell you that they felt dizzy and lightheaded before collapsing.

## Discussion points

Consider how these variations will correspond with different descriptors in the ATS:

- The patient had recent changes to their blood pressure medication, was working outside in hot weather and then:
  - Lowered themselves to the ground, but did not lose consciousness
  - Lost consciousness and fell to the ground
- The patient has a known cardiac arrhythmia and:
  - Lowered themselves to the ground, but did not lose consciousness
  - Lost consciousness and fell to the ground
- The patient is normally fit and well and had no preceding events; they lost consciousness and fell to the ground.

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## Case study 2: Trauma

Two patients present after falling:

- A 24-year-old man slid off a roof and landed on a soft dirt pile; he has no injuries and did not lose consciousness
- A 67-year-old man was cleaning gutters in the rain, slipped and fell from the roof, landing on his side on the fence and then onto concrete.

## Discussion points

- Which trauma communication framework is used in your ED?
- What physiological data, including vital signs, would influence your triage decision-making?
- Consider how these presenting problems differ in terms of the patients' ages and mechanism of injury
- Consider how both scenarios correspond to these ATS trauma descriptors:
  - Major multi-trauma requiring a rapid organised team response (category 2 descriptor)
  - Trauma, high-risk history with no other high-risk features (category 3 descriptor).

## Case study 3: Immunosuppression and diabetes

A 69-year-old man presents with generalised upper abdominal pain, with associated nausea and diarrhoea, increasing over the past three days. He has nil vomiting and nil urinary symptoms. His history is pancreatitis about one year ago and rheumatoid arthritis. He takes methotrexate and 10 mg prednisone due to increased arthritic pain. Since his pancreatitis and starting the prednisone, he needs antidiabetic medication (metformin) to control his blood sugar levels.

## Vital signs, case study 3

RR /min	SpO <sub>2</sub> %	HR /min	BP mmHg	T °C	BGL mmol/L
20	95	99	120/80	38.1	12.2

## Discussion points

- What aspects of the patient's history and presentation would put him on the sepsis pathway?
  - Possibly infective symptoms
  - Diabetes with increased sugar level – increases infection risk
  - Medications (methotrexate and prednisone) placing the patient at risk of immunosuppression, and clear signs and symptoms of infections might not be present
- Consider the vital signs in relation to the history, and therefore the potential for deterioration against the descriptors in the ATS:
  - The RR, HR and temperature are significant findings due to this patient's medical history and medications
  - Depending on his normal BGL ranges, this reading of 12.2 mmol/L might indicate a stress response to an underlying infection.

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## Case study 4: Seizure

A 20-year-old man presents after a tonic-clonic seizure that lasted about two minutes and was witnessed by friends. He fell to the floor from standing, hitting his head on a table as he fell. He was incontinent of urine. His friends report he was unresponsive for 3–5 minutes. He had been out with team mates on an end-of-year celebration and had been drinking for most of the day (more than six hours). The patient is rousable to voice but not orientated to time and place. He had seizures as a child and is not medicated. Nil other history.

## Vital signs, case study 4

RR / min	SpO <sub>2</sub> %	HR / min	BP mmHg	GCS	PERTL	T °C
22	96	98	113/87	13 (E3, V4, M6)	3+	37.1

## Discussion points

- What are the red flags in this case?
  - GCS is reduced by 2 or more from baseline
  - Possible head injury
  - Unknown cause of seizure
  - Potential lack of information because there is no one with the patient who can supplement his history and he is unable to communicate effectively
- What descriptors in the ATS would guide your allocation of a triage category?
  - Drowsiness and decreased responsiveness (GCS = 13) indicate triage category 2
- Discuss what assessment and historical factors would need to be different for this presentation to meet the triage category 3 descriptor 'seizure (now alert)'
- Where would you place this patient in your department? Consider interventions, observation needs and falls risk.

## Case study 5: Infection control

An 18-year-old non-binary person presents with fevers for the past three days. They have been taking paracetamol but continue to feel unwell. They have recently moved to the area to begin university and are living in university accommodation. Other students in the accommodation thought the person looked very unwell and brought them in.

The patient reports decreased oral intake, lethargy, a non-productive cough and runny nose. On examination, they are alert, pale and have dry mucus membranes with white blotches in their mouth. You also notice a red, blotchy, slightly raised rash on their neck; it is not itchy and blanches.

## Vital signs, case study 5

RR /min	SpO <sub>2</sub> %	HR /min	BP mmHg	T °C
20	98	96	115/74	37.7

## Discussion points

You identify that this patient potentially has measles. Consider your next steps to:

- Contain exposure to others
- Place the patient post-triage
- Alert senior staff
- Manage your own exposure.

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## Supporting resources

## CENA position statements

- [Triage Nurse](#)
- [Triage and the Australasian Triage Scale](#)

## ACEM policies and guidelines

- [Policy on the Australasian Triage Scale](#)
- [Guidelines on the Implementation of the Australasian Triage Scale in Emergency Departments](#)

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# Chapter 2: Triage fundamentals

## About this chapter

This chapter assumes knowledge of:

- ED models of care
- Escalation pathways for clinicians, patients and support people available in your hospital
- Indicators of clinical deterioration or risk of clinical deterioration.

## Learning outcomes

After completing this chapter you will be able to:

- Understand the process of triage and describe strategies to manage issues in this process
- Apply a structured approach to assessment and documentation at triage
- Identify predictors of poor patient outcomes from data collected during the triage assessment and understand the corresponding triage category.

## Background

The purpose of triage is to ensure emergency care is delivered according to clinical urgency and patient need. This is achieved through information gathering, recognising indicators of urgency (red flags), and decision-making based on assessment findings.

This chapter describes the recommended systematic approach to triage using the following steps (see [Figure 2.1](#)):

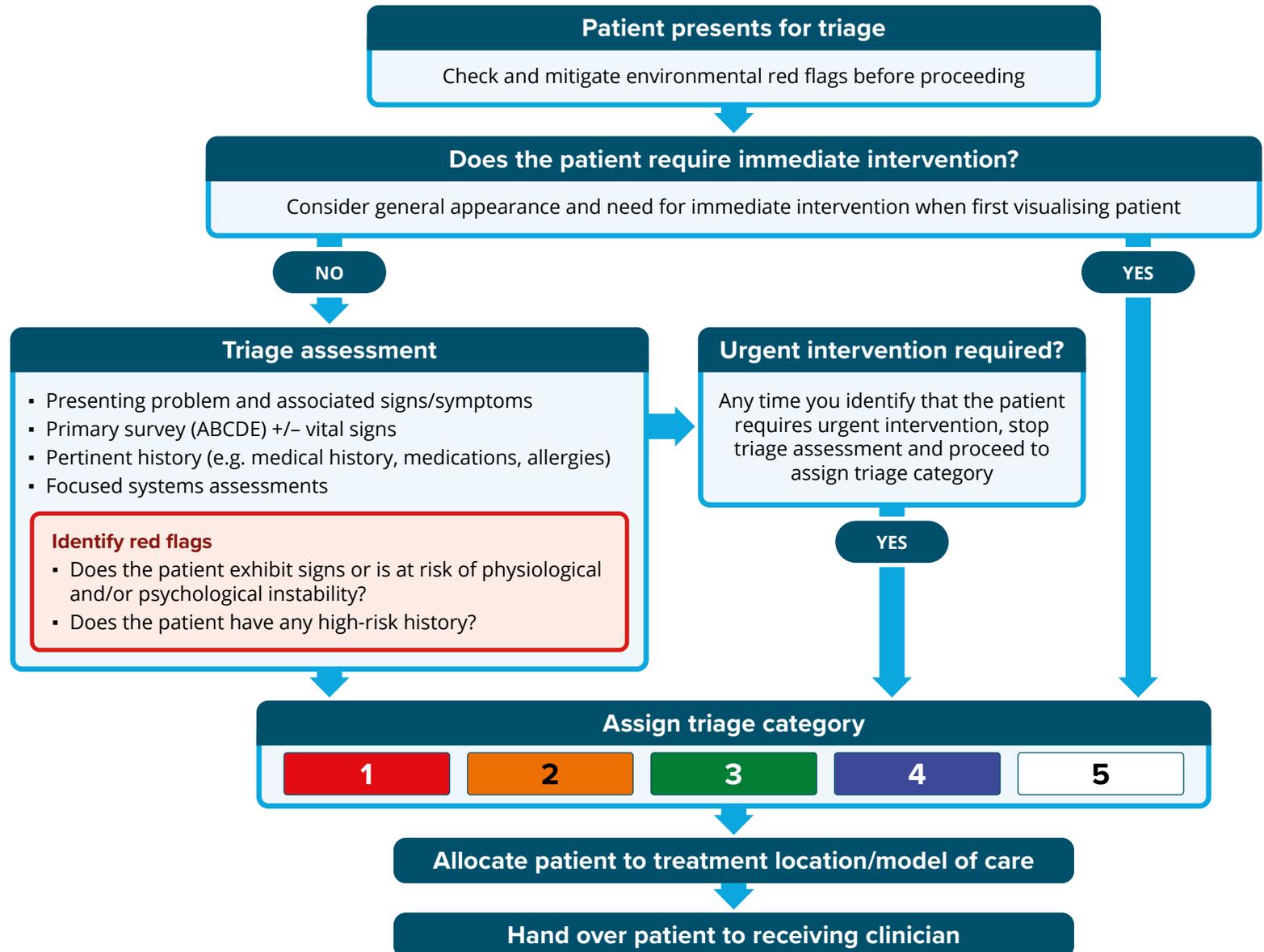
- Assess the environment for red flags
- Observe the patient's general appearance
- Determine the presenting problem
- Collect relevant assessment data to inform the triage category, using:
  - The primary survey, including relevant vital signs
  - The relevant history
  - Focused body systems assessment(s)
- Identify clinical red flags when assessing the patient
- Assign a triage category.<sup>1</sup>

Once you have assigned a triage category, you must allocate the patient to an appropriate model of ED care. At the end of the triage, talk to the patient about what will happen next (see [Conclude the triage and explain what will happen next](#) in **Chapter 3: Communication for triage**) and hand over care to the receiving clinician as required or as per local processes.

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Figure 2.1: Recommended systematic approach to triage



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## Approach

## Safety in triage models

EDs are becoming increasingly busy and overcrowded.<sup>2</sup> There are many triage models to manage high presentation rates, increase efficiency and maintain patient safety. Whichever triage model you use, complete a focused and timely assessment to avoid delays to urgent treatment – early assessment by the triage nurse facilitates early detection of red flags.

In some services, triage assessment is done first, followed by patient registration by administration staff. Other services may follow the reverse order. Whichever system is used in your service, it should minimise delays to triage assessment and the potential for missing patient registration.<sup>3,4</sup>

## Window, telephone and virtual triage

Window triage can be an efficient way to triage multiple patients quickly and maintain safety (for example, it may provide a barrier from violence or infection). However, it limits the physiological data you can collect. You need to be aware of the gaps in assessment when using this method. It is also difficult to maintain privacy using window triage because the patient may have to speak loudly to be heard, which may increase anxiety and aggression in some patients. Telephone triage also limits your assessment because it relies solely on oral communication, as you are unable to see the patient or obtain physiological data.<sup>5</sup>

Virtual or telehealth triage involves conducting the triage assessment via videoconference to determine the urgency of the patient's condition and whether they need to attend the ED or another service.<sup>6</sup> As with face-to-face triage, virtual triage requires a timely approach to assessment.

## Leaving the triage area

Sometimes you may need to leave the triage area, such as to retrieve a patient from a vehicle or hand over a patient. It is good practice to never leave the triage desk unattended in case someone needs immediate assistance. If you're working in a site where you don't have back-up, you should know the local process for managing an unattended triage desk. Always consider staff safety first, followed by patient safety.

## The triage process

- Most triage assessments should only take 2–5 minutes
- If you identify the need for urgent intervention at any stage, stop the triage assessment and assign the triage category
- You should never be influenced by the activity or bed availability within the ED when assigning the triage category
- Always refer to the ATS when assigning the triage category
- Ask for help if you need it.

Source: *Emergency and Trauma Care for Nurses and Paramedics, 4th ed*<sup>1</sup>

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## Red flags

Red flags are prompts or cues indicating an actual or potential threat to:

- Yourself
- The patient
- Others, such as support people, staff or other patients.

## Environmental red flags

Environmental red flags include:

- A person who is verbally or physically aggressive<sup>8</sup>
- A person presenting with a communicable disease, such as COVID-19, influenza or varicella<sup>9</sup>
- A disaster event – when there is a rapid increase in unwell or injured patients exceeding the hospital's capacity for safe treatment.<sup>10</sup>

## Clinical red flags

Clinical red flags are cues identified in the patient's physical assessment or history that indicate the presence of actual or potential serious illness or injury.

## Physiological red flags

You may identify physiological red flags from the primary survey or from focused body region or systems assessments. Red flags identified from focused systems assessments might include an absent pulse in an injured limb, or abdominal distension in a patient with abdominal pain indicating the need for urgent assessment and treatment.

Table 2.1 provides a summary of primary survey findings and corresponding triage categories. Some descriptors are different for pregnant women, children and older people – refer to **Chapters 6, 7 and 8**, respectively, and local guidelines for changes to vital sign parameters in these groups.



## Key point

Timely recognition of red flags is critical to maintain safety and ensure the delivery of urgent care.<sup>7</sup> Red flags may present at any stage during the triage process.

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## Historical red flags

Historical red flags may be associated with the presenting problem or the patient's health history.<sup>9</sup>

Red flags relating to the presenting problem include:

- High-risk problems, such as poisoning or overdose, which require time-critical treatment
- High-risk signs or symptoms, such as sudden onset of severe headache
- High-risk mechanism of injury, such as vehicle rollover
- Re-presentation to ED with the same clinical problem
- Recent use of drugs or alcohol.

Red flags relating to the patient's health history include:

- Extremes of age (very young or very old) – see **Chapter 7** for physiological differences in children and **Chapter 8** for older people
- High-risk co-morbidity relevant to the presenting condition, such as vomiting in a renal dialysis patient or fever in a patient with a ventriculoatrial shunt
- Multimorbidity – the presence of multiple diseases or conditions, acute or chronic
- Pertinent medications, such as anticoagulants because they increase the risk of bleeding
- Cognitive impairment
- Communication challenges, such as with patients from culturally and linguistically diverse communities
- Risk of harm, such as domestic or family violence, child abuse, elder abuse or neglect.

## Assessment

## Assessment of environmental hazards

At the beginning of each shift, conduct a basic safety and environment check of the work area to optimise staff and patient safety. When a patient presents, consider any environmental red flags that may be hazardous to yourself or others. To protect yourself and others, ensure you are familiar with internal security response protocols.

Use standard precautions whenever there is potential for exposure to blood or other body fluids. Appropriate personal protective equipment should be worn when communicable diseases are suspected.<sup>9</sup>

## General appearance

Quickly observe the patient's general appearance to determine if they need immediate intervention. Your first look at the patient also informs your working assessment.<sup>1</sup>

*'Your assessment begins from the very first time you see the patient. You are collecting information from how they're walking, how they sit to stand, how they're talking, how they're tracking and looking at you.'*

– Wayne Varndell, Emergency Clinical Nurse Consultant, Prince of Wales Hospital, NSW



## Key point

When you first see the patient, consider:

- Do they look sick?
- Are they calm, agitated or in distress?
- Is their mobility normal or limited?

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## Presenting problem and associated signs/symptoms

The presenting problem is the primary reason that brought the patient to the ED. You can collect details about the presenting problem from the patient, their support person and other health professionals. Paramedics, for example, will know vital information, including about the patient's environment (their home or the place where they were found), how the person was when they first saw them, the treatment they have given and the patient's response to treatment.

You may also source information from documents such as referrals, and pathology, radiology and interventional reports.<sup>1</sup>

Begin by asking open-ended questions to determine the presenting problem, such as:

- Why have you come to the emergency department?
- What are you concerned about?
- What has changed that brings you to hospital today?

You then need to narrow down from the overarching presenting problem to explore the specific details and any associated signs and symptoms.<sup>1</sup> This includes the duration of illness and potential causes of presenting signs and symptoms.

If a patient presents following trauma, you may use the MIST framework (Mechanism, Injury, Signs and symptoms and Treatment/transport) or other framework used in your ED, as a guide to what questions to ask.<sup>11</sup> It is important to ask specific questions about the patient's symptoms to confirm or exclude the presence of life-threatening conditions and discriminate between more and less urgent cases.

While focused questioning is needed to quickly obtain pertinent information about the presenting problem, it is important to actively listen to and observe the patient to make sure you have collected all the information and to make them feel heard. See **Chapter 3: Communication for triage** for more information.

*'It's like you have a very broad funnel. You start with open-ended questions like "What's brought you to ED today"... then you drill down looking for the history of that chief complaint and associated signs and symptoms.'*

– Wayne Varndell, Emergency Clinical Nurse Consultant, Prince of Wales Hospital, NSW

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Table 2.1: Primary survey findings and triage categories

Criterion	Category 1 Immediate	Category 2 Emergency	Category 3 Urgent	Category 4 Semi-urgent	Category 5 Non-urgent
<b>Airway</b>	Immediate risk to airway	Airway risk: severe stridor or drooling with distress	Patent	Patent	Patent
<b>Breathing</b>	<ul style="list-style-type: none"> <li>■ Respiratory arrest</li> <li>■ Respiratory rate &lt;10/min</li> <li>■ Extreme respiratory distress</li> </ul>	Severe respiratory distress	Moderate respiratory distress	No respiratory distress	No respiratory distress
<b>Circulation</b>	<ul style="list-style-type: none"> <li>■ Cardiac arrest</li> <li>■ BP &lt;80 mmHg (adult)</li> <li>■ Severely shocked child or infant</li> </ul>	<ul style="list-style-type: none"> <li>■ Circulatory compromise: clammy or mottled skin, poor perfusion</li> <li>■ HR &lt;50 or &gt;150 (adult)</li> <li>■ Hypotension with haemodynamic effects</li> <li>■ Severe blood loss</li> </ul>	Moderately severe blood loss	Mild haemorrhage	No haemodynamic compromise
<b>Disability</b>	<ul style="list-style-type: none"> <li>■ GCS &lt;9</li> <li>■ Ongoing or prolonged seizure</li> </ul>	<ul style="list-style-type: none"> <li>■ GCS 9–12</li> <li>■ BGL &lt;3 mmol/L</li> <li>■ Very severe pain</li> </ul>	<ul style="list-style-type: none"> <li>■ GCS &gt;12</li> <li>■ Seizure, now alert</li> <li>■ Moderately severe pain</li> </ul>	<ul style="list-style-type: none"> <li>■ Normal GCS</li> <li>■ Moderate pain</li> </ul>	<ul style="list-style-type: none"> <li>■ Normal GCS</li> <li>■ Minimal or no pain</li> </ul>
<b>Environment</b>		<ul style="list-style-type: none"> <li>■ Fever with signs of lethargy</li> <li>■ Febrile neutropenia</li> </ul>			

**Considerations for specific groups**

Some descriptors in this table are different for specific patient groups: see **Chapter 6: Pregnancy**, **Chapter 7: Paediatrics** and **Chapter 8: Older people**; see local guidelines for changes to vital sign parameters in these groups.

Source: *Guidelines on the Implementation of the Australasian Triage Scale in Emergency Departments*, ACEM<sup>12</sup>

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## Primary survey (ABCDE) +/- vital signs

Physical assessment of the patient is important to identify physiological instability. The primary survey follows a sequential assessment of the patient's airway, breathing, circulation, disability and environment (ABCDE). Applying this structure helps to identify any high-risk features early.<sup>13</sup>

Always remember to maintain privacy when performing physical assessments, explain what you are going to do and ensure you have consent before proceeding. Discuss the options for creating privacy in your service with your educator.

The following describes key elements to consider when performing the primary survey on an adult patient. Other chapters have information on how to apply the A-E assessment in specific populations, such as people with psychological distress and behavioural disturbance (**Chapter 5**), pregnant women (**Chapter 6**), children (**Chapter 7**) and older people (**Chapter 8**).

## Airway

Always check the airway for patency. This is usually performed in seconds by simply observing the level of alertness and ability to talk and listening for any added upper airway sounds. If the patient is wearing a mask, ask them to remove it, if appropriate, so you can assess them properly.

Consider the potential for cervical spine injury and the need for spinal precautions when indicated.

 Key point

A patient with an occluded airway or an immediate risk to airway must be assigned a triage category 1 – this includes unresponsiveness with GCS of <9 and ongoing or prolonged seizure.

## Breathing

Breathing is assessed at triage by observing the respiratory rate and work of breathing. An abnormal respiratory rate is usually the first sign of clinical deterioration.<sup>14,15</sup> It is often important to expose the chest – particularly in infants – as clothing may conceal the work of breathing.

Hypoxia can be present in some conditions without an abnormal respiratory rate; for example, in COVID-19.<sup>16</sup> Pulse oximetry may be used to detect hypoxia. It can sometimes be difficult to get an accurate oxygen saturation reading at triage, particularly in children and when time is limited.

Consider other signs of respiratory distress such as nasal flaring, tracheal tug and accessory muscle use.<sup>9</sup> Unequal, decreased or added breath sounds such as wheeze or crackles are also indicators of abnormal respiratory function.

 Key point

Patients with evidence of respiratory distress should be assigned a high triage category (see [Table 2.1](#)). Patients assigned lower triage categories (ATS 4 or 5) should have normal respiratory function.

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## Circulation

Assess circulatory status by determining the pulse rate, rhythm and character, blood pressure (as indicated), skin status and fluid intake and output. It is important that haemodynamic compromise be detected during the triage assessment to facilitate early and aggressive intervention. Tachycardia is an early indicator of haemodynamic compromise. Note that low blood pressure is a late sign of haemodynamic compromise, particularly in young adults and children. A severely shocked child may present lethargic, with mottled skin and delayed capillary return, indicating the need for immediate intervention.



## Key point

Patients with signs of haemodynamic compromise should be assigned a high triage category (see [Table 2.1](#)). A severely shocked child, or an adult with systolic blood pressure of less than 80 mmHg, should be assigned a triage category 1.

## Disability

This assessment includes determining the patient's level of consciousness, if there has been a change in behaviour or new onset of confusion, and asking if the patient had a loss of consciousness.<sup>17</sup> Altered level of consciousness is an important indicator of risk of serious illness or injury. The Alert, Confused, responsive to Voice, Pain or Unresponsive (ACVPU) scale and the Glasgow Coma Scale (GCS) are quick and easy tools that may be used to assess neurological status of the patient at triage.<sup>17</sup>

If the patient shows signs of psychological distress or behavioural disturbance, perform a focused assessment after the primary survey. See [Chapter 5: Psychological distress and behavioural disturbance](#) for more information. If they are older, consider whether this could be delirium (see [Chapter 8: Older people](#)).

Point of care blood glucose and ketone levels should be measured at triage if indicated, for example, to identify or exclude hypoglycaemia and diabetic ketoacidosis in a vomiting patient with a history of diabetes mellitus. A patient with BGL <3 mmol/L should be allocated a triage category 2.

Pain is the most common symptom reported by patients who present to the ED and it should be assessed at triage. Early assessment of pain enables effective management and relief of suffering. Patients with moderately severe pain or very severe pain should be assigned a higher triage category (see [Table 2.2](#)).

The acknowledgement of pain severity in triage assessment recognises both the humane factors of providing care and the physiological effects of pain, which include increased risk of infection, delayed healing, and increased stress on cellular function and organ-system stability.



## Key point

Patients with conscious-state abnormalities should be assigned a high triage category (see [Table 2.1](#)).

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Table 2.2: Pain levels and triage categories

Triage category	Pain level
2	Very severe
3	Moderately severe
4	Moderate
5	Minimal

Source: *Guidelines on the Implementation of the Australasian Triage Scale in Emergency Departments*, ACEM<sup>12</sup>

When assessing pain, you should attempt to determine:

- The mechanisms producing the pain
- Other factors influencing the pain experience
- How pain has affected physical capacity, emotions and behaviour.<sup>18</sup>

As with the experience of pain itself, the assessment of pain requires a multifaceted approach – no single tool is able to provide an objective measurement of pain.

Elements in assessing pain should include:

- The patient's descriptors and verbal expressions, but keep in mind that some patients under-report their pain
- Information obtained from the patient about location, intensity, time factors such as onset and duration, and alleviating and aggravating factors
- The patient's facial expressions and body language
- Pain severity scales.

Neurodiversity can influence the way a patient expresses pain, see [Neurodiversity](#) in **Chapter 7: Paediatrics**.

Musculoskeletal pain can be effectively reduced in a triage setting through simple measures such as rest, ice, compression and elevation (RICE). Refer to local policy and practices regarding the administration of analgesia at triage.

## Environment

Assess temperature and expose the skin to look for rashes. Hypothermia and hyperthermia are important clinical indicators of illness and should be identified at triage.



## Key point

The absence of fever does not exclude infection: up to 20% of people with sepsis are hypothermic.<sup>19</sup>

While a rash may alert you to the possibility of serious illness such as anaphylaxis or meningococcal disease, patients with these conditions will usually have other abnormalities detected during the primary survey.

## Physiological data

- Collect relevant physiological data, such as vital signs or focused systems assessment findings, when required to decide the triage category
- Failure to collect adequate physiological data at triage can result in missing a serious underlying illness or injury, and an adverse outcome
- Only collect the data you need to make a triage decision – not all patients need vital signs at triage (e.g. if the patient has a life-threatening condition).

Source: *Emergency and Trauma Care for Nurses and Paramedics, 4th ed*<sup>1</sup>

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## Pertinent history

Collect pertinent details about the patient’s health history to identify historical red flags, indicating the potential for serious illness or injury. You only have time to ask for information that is pertinent to the patient’s presenting condition and needed to determine the triage category.

Pertinent details may include:

- Medications, such as anticoagulants in a patient presenting with a head injury
- Medical history, including co-morbidities, such as a history of asthma in a patient presenting with shortness of breath
- Allergies, such as a history of anaphylaxis to nuts in a patient presenting with angioedema<sup>1</sup>
- Reproductive history, if an obstetric or gynaecological issue
- Social history, in the context of family violence or elder abuse.

## Focused systems assessments

Collect additional physiological data through focused assessment of relevant specific body systems.<sup>9</sup> Focused assessments should be related to the presenting problem and associated signs and symptoms, and are needed to inform the triage category. For example, you should perform a neurovascular assessment for a patient presenting with a limb injury.

Eye injuries warrant careful assessment based on the mechanism of injury and the potential for ongoing visual impairment. Table 2.3, below, shows considerations for triaging eye presentations using the ATS descriptors.

Table 2.3: Ophthalmic presentations and triage categories

Category 1 Immediate	Category 2 Emergency	Category 3 Urgent	Category 4 Semi-urgent	Category 5 Non-urgent
N/A	<ul style="list-style-type: none"> <li>■ Acid or alkali splash to eye – requiring irrigation</li> <li>■ Suspected endophthalmitis post-eye procedure (post-cataract, post-intravitreal injection), sudden onset pain, blurred vision and red eye</li> <li>■ Penetrating eye injury</li> <li>■ Severe eye pain</li> </ul>	<ul style="list-style-type: none"> <li>■ Acute visual disturbance</li> <li>■ Moderately severe eye pain</li> </ul>	<ul style="list-style-type: none"> <li>■ Eye inflammation or foreign body – normal vision</li> <li>■ Moderate eye pain</li> </ul>	<ul style="list-style-type: none"> <li>■ Normal vision</li> <li>■ No eye pain</li> </ul>

Sources: *Guidelines on the Implementation of the Australasian Triage Scale in Emergency Departments*, ACEM<sup>12</sup>; *The Eye Emergency Manual*<sup>20</sup>

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## Selecting the model of care post-triage

Once the triage is complete, the triage nurse must determine which model of care the patient will be treated through. Selecting the correct model of care post-triage is crucial for ensuring the patient receives the right treatment, at the right time, by the right team and in the right place.<sup>21</sup> Failure to allocate patients to the correct model of care can create bottlenecks in flow and place the patient at increased risk of deterioration. It can also cause mismatches between available resources and the care required.

## Documentation structure

Documentation at triage should be structured and contain the same key elements as the triage assessment. These elements may include:

- Presenting problem and associated signs/symptoms
- Primary survey findings (ABCDE), including vital signs and pain score
- Focused systems assessment findings
- Pertinent history.

Sufficient information must be provided to support the allocated triage category. A structured approach to documentation helps to ensure information is recorded accurately, in a time-efficient way and that pertinent information is not missed.<sup>22</sup> See Table 2.4, right, for an example of structured triage documentation. Whatever structure you use, be consistent and in line with local policy.

See **Chapter 9: Legal issues at triage** for more information on documentation requirements.

Table 2.4: Example of structured triage documentation

Assessment element	Notes
Presenting problem	Self-presents with severe abdominal pain. Sudden onset 1 hour ago. Not relieved by paracetamol
Associated signs and symptoms	Feels nauseated, denies vomiting/diarrhoea/dysuria
Primary survey	A – patent B – RR 28 mild increase work of breathing C – pale and clammy HR 110 D – alert and orientated, pain 10/10 E – T 36.6 °C
Focused assessment	Abdomen soft, tender over right lower quadrant
Pertinent history	Type 1 diabetes

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## Reassessment and escalation of care

The patient should be regularly reassessed post-triage, particularly if their waiting time has exceeded their triage category.<sup>23</sup> This may be your role or another person's in your ED, depending on the location of the patient and staffing arrangements. Patients at triage or in the waiting room are more satisfied when the nurse is visible and available.<sup>24</sup> See **Chapter 3: Communication for triage** for more information.

Strategies to support reassessment of patients in the waiting room include:

- Know who is in the waiting room and who is at risk of deterioration
- Encourage patients to return if they feel their condition changes or if they have any concerns
- Conduct regular visual observation of patients in the waiting room
- Repeat vital signs when appropriate.

It's important to re-triage or escalate care according to local processes if the clinical status of the patient changes in any way, or if new information influences the triage category before emergency care is received.

## Front-end team

Different roles at the front end of the ED support triage, expedite care and improve patient flow. These roles may include clerical staff, nursing staff caring for patients in the waiting room, and rapid assessment teams (including nursing and medical staff).<sup>25</sup> You may also work closely with the nurse in charge of the shift. It is important to become familiar with what other roles in your ED can support you as the triage nurse. If you work in a rural or remote setting, know your local process for when and how you can speak to people for support when they are not on site.

## Managing your time

As the triage nurse, you will be required to make rapid clinical decisions, sometimes under extreme time pressures. You will need to develop sound time management skills to keep up with the fast pace. Time management strategies at triage include:

- Be systematic
- Use focused questions to extract information pertinent to the patient's presenting condition
- Prioritise urgent tasks and group tasks together where possible
- Avoid multi-tasking
- Avoid taking on additional tasks when you don't have time
- Practise active listening and effective verbal and non-verbal communication (see **Chapter 3: Communication for triage**)
- Ask for help when needed.<sup>26</sup>

*'Often the triage nurse can feel quite isolated at the front. It's challenging when it's so overcrowded. But remember we work in a team. Speak to the senior nurses to get assistance.'*

– Professor Margaret Fry, Professor of Emergency and Critical Care, Northern Sydney Local Health District, Faculty of Health, School of Nursing and Midwifery, University of Technology, Sydney

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## Managing multiple, simultaneous patient arrivals

Multiple presentations to triage at the same time can result in a queue and increase pre-triage waiting times<sup>27</sup>, which can delay the detection of, and response to, patients needing lifesaving treatment.<sup>28</sup>

When multiple patients present at the same time, it is important to decide:

- Who to see first – consider the general appearance of patients waiting. Does anyone need to be prioritised because they look unwell or are in distress? What is the presenting problem of those waiting? Which one is most urgent?
- When to ask for help – be aware of times when you are not able to safely manage the workload at triage. It is important to ask for help when you need it. Refer to your local policy on clinician-led escalation.

*'Initial cursory triages may need to be done to ensure that someone's not presenting with a life-threatening condition... then you can go back to get more detail later to ensure the safety of the people presenting.'*

– Professor Margaret Fry, Professor of Emergency and Critical Care, Northern Sydney Local Health District, Faculty of Health, School of Nursing and Midwifery, University of Technology, Sydney

 Key point

When multiple patients present at the same time, you may need to go out and perform a rapid triage of waiting patients, asking them to describe the presenting problem in a few words, to detect which patients are most urgent.

### Understanding when it is safe to undertake extra tasks

Performing clinical work at triage, such as pain management and pathology and radiological tasks, can improve the efficiency of care and patient outcomes.<sup>1</sup> However, these extended practices are not the primary role of the triage nurse and can lead to delays for patients waiting to access triage.<sup>29</sup>

Some tasks, such as first aid to reduce further injury or illness and making the patient comfortable (for example, pressure to a bleeding wound, immobilising an injured limb), are unavoidable. It is also unavoidable to perform additional tasks in some clinical settings where the triage nurse has multiple roles, such as in rural and remote services.

 Key point

If you are taking on extra tasks, be careful not to jeopardise the care of patients waiting to be triaged.

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## How to manage interruptions

Interruptions at triage are frequent, and can cause delays and hinder safe and efficient patient care.<sup>30</sup> Not all interruptions are bad and some may need to be prioritised – for example, a patient presents to your triage window looking pale and clammy to tell you they have chest pain. However, some interruptions are less urgent and you need to be able to determine which ones to prioritise.

Your ED can ensure that all staff know the challenges of interruption at triage and the importance of keeping interruptions to a minimum for critical issues.

Strategies to manage triage interruptions include:

- Consider whether the interruption is important and if you need to stop what you are doing
- Position yourself so you can focus on the patient you are assessing and minimise distractions
- Remember it is okay to ask someone to wait while you finish a task that is more urgent
- Be polite and courteous if you need to ask someone to wait – always be mindful of your body language and what message it conveys.<sup>26</sup>

## Identifying common presentations specific to the local area

Factors relating to the local physical and social environment can result in specific presentations, for example mango sap burns are a common presentation in the Northern Territory.<sup>31</sup> It is important to be aware of presentations unique to your local area so you can recognise the level of urgency and treatment needs for these presentations and allocate an appropriate triage category.

## Understanding the approach to patient escalation

Patient escalation systems allow patients and support people (families and carers) to escalate concerns about acute clinical deterioration.<sup>32</sup> Patients and support people should be told how to contact a staff member if they are concerned their condition is getting worse.<sup>22</sup> Clinicians should acknowledge and respond to a patient or support person's escalation of concern with the same level of urgency as for clinician-led escalation.<sup>33</sup> You should know how the local escalation policy works at triage.

When a patient or support person escalates their concern, ensure you:

- Listen carefully to their concerns
- Re-assess the patient
- Escalate according to local procedures if the patient has deteriorated clinically.<sup>34</sup>



## Key point

When responding to patients with chronic conditions who present to the ED, remember they will often have tried to avoid coming to the ED and may have been struggling at home for a while. When parents of children with chronic illnesses bring them to the ED, keep in mind that they have a high level of perception of what 'illness looks like' for their child.

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**Take-home messages**

In summary, remember that:

- The triage process follows a rapid systematic assessment to determine urgency and disposition
- The triage assessment starts when you first see the patient
- Only collect pertinent information about the patient's presenting problem and history
- Prioritise a rapid history and primary survey assessment, followed by focused systems assessment(s)
- Red flags indicate the patient has actual or potential serious illness or injury
- Disposition of a patient post-triage should meet their clinical need
- Document triage using a structured approach to ensure nothing is missed
- Frequent monitoring of general appearance and reassessment of patients in the waiting room is vital to detect changes in condition and the need for escalation
- Ask for help if you need it
- Listen to the concerns of the patient and support person, reassess and escalate care when appropriate.

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## Considerations for your site

Your role as an educator is to explain:

- The staff roles in your ED at triage and in the waiting room: who are they, how they work together, and how you do everything if you are on your own
- Policies about clinician- and patient-led escalation, including clinical deterioration, security and re-triage
- Clinical pathway use at triage
- Your triage environment and any modifications to the recommended triage process flow diagram
- Recognising red flags and using reference guides, according to learners' needs
- Recognising important presentations that are specific to the local area.

## Discussion points

Help learners consolidate their understanding by discussing the points below:

- Identifying infection risks
- Identifying red flags from assessment findings, indicating potential poor outcomes
- Documenting case reviews (using local de-identified cases, reviewing whether the documentation matches the triage scale)
- Waiting room management:
  - Example of managing the queue
  - Example of concluding a triage
  - Example of patient waiting room experience.

## Case studies

The case studies below highlight important triage issues. Work through these cases with learners.

## Case study 1: Eye emergency

A 24-year-old man presents to the ED after pool cleaner splashed into his right eye, which is red, watery and painful. He is alert and has nil other signs or symptoms.

## Discussion points

Consider the following findings:

- You observe his general appearance and conduct a rapid primary survey – this indicates he is physiologically stable and so you proceed to focus on the presenting problem and quickly move to the focused system assessment
- Refer to the ATS and consider what triage category should be allocated. You identify a chemical splash to his right eye, which corresponds to a triage category 2.

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## Case study 2: Farm injury

Work colleagues bring in a 32-year-old farm worker after a 500 kg bull pinned him against a fence. He did not lose consciousness. He has pain in his right hip and can't mobilise. His right foot is warm and pulses are palpable.

## Discussion points

Use the MIST framework to sort the information above and identify what additional information you would collect at triage. The MIST framework consists of:

- Mechanism of injury: significant compression force (pinned against fence by 500 kg bull)
- Injuries: right hip pain with intact peripheral circulation is a reassuring sign, but there is the potential of more significant pelvic or abdominal injury and other areas of injury
- Signs and symptoms: considering the mechanism, there is the possibility of internal bleeding. You would be interested in any signs that might indicate this, such as tachycardia or hypotension
- Treatment: as this patient presented by private vehicle, consider if any first aid measures were undertaken.

Consider local trauma identification criteria at your facility. Given the dangerous mechanism, this patient should be assigned a high triage category (category 2).

## Case study 3: Woman with chest pain

A 58-year-old woman presents after an episode of chest pain that lasted around 30 minutes while she was at the gym. She recently started going to the gym due to concerns from her GP about her weight, high blood pressure and cholesterol.

On arrival, her chest pain has gone, but she has a heavy feeling in both arms and her throat feels tight. She is alert and clammy.

## Discussion points

She has had an episode of possible cardiac chest pain and still has signs and symptoms that might be considered atypical chest pain. Combined with her history, she would meet the criteria of chest pain of likely cardiac nature, which should be assigned a triage category 2.

You have enough information to conclude your triage. The next priority is to move her to the most appropriate area to conduct an ECG.

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## Case study 4: Sepsis

A 52-year-old man had an MI and cardiac stents 10 days ago. Since then, he has stopped smoking and drinking alcohol. He has now developed a productive cough and is short of breath on slight exertion, with pain to the right side of his chest on deep inspiration.

He is warm to touch and sweating. He has started on several new medications but doesn't remember their names. He has a history of depression and anxiety.

## Vital signs, case study 4

RR /min	SpO <sub>2</sub> %	HR /min	BP mmHg	T °C
25	91	120	98/60	38.9

## Discussion points

Consider the factors that make this man at risk of sepsis:

- Hospital re-presentation
- Signs and symptoms of possible respiratory infection
- Elevated temperature indicative of an infection
- Haemodynamically unstable, elevated heart rate and not maintaining his blood pressure at a level you would expect.

Given this man has possible sepsis and is physiologically unstable, he warrants a triage category 2. Discuss with your educator the triage nurse's role in response to possible sepsis.

## Case study 5: Complicated falls presentation

A 65-year-old woman presents after a fall. She reports regaining consciousness on the floor after tripping over a chair leg. You try to establish how the woman tripped over the chair. She says she felt very hot at home and was going to the kitchen to get a drink when she woke up on the floor. The woman has no history of falls and lives independently. Until recently, she has only been taking medication for hypertension. She began a course of chemotherapy for non-Hodgkin lymphoma 10 days ago.

## Discussion points

Consider the following:

- Do any factors make this patient at high risk of sepsis – for example, fever or reports of a fever, and recent chemotherapy?
- What red flags meet your local febrile neutropenic/neutropenic sepsis pathway?
- What vital signs (if any) would you collect and why?
- How would you adjust your style of conversation here if the patient required interpreter services and you were using:
  - Family – consider the family knowledge of the history of events and past medical history, keep your sentences short, still look at the patient when speaking
  - Telephone interpreter – try to use a speaker if available, continue to interact and look at the patient, ask one question at a time.

This patient is at risk of febrile neutropenia and should be allocated a triage category 2.

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## Supporting resources

- [Primary Survey Assessment – Variations & Red Flags](#), College of Emergency Nursing Australasia
- [Sepsis Clinical Care Standard](#), Australian Commission on Safety and Quality in Health Care<sup>35</sup>
- [Related resources – Sepsis Clinical Care Standard](#), Australian Commission on Safety and Quality in Health Care
- [National Consensus Statement: Essential Elements for Recognising and Responding to Acute Physiological Deterioration, third edition](#), Australian Commission on Safety and Quality in Health Care<sup>36</sup>
- [Spotlight on Sepsis video series](#), Australian Commission on Safety and Quality in Health Care
- [Safety and Security for Rural and Remote Health Professionals: A guide for individuals](#), CRANAplus
- [Eye Emergency Manual](#), Agency for Clinical Innovation
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# Chapter 3: Communication for triage

## About this chapter

This chapter assumes basic skills in communicating with patients of all ages and backgrounds, communicating for safety and de-escalation techniques and strategies.

## Learning outcomes

After completing this chapter you will be able to:

- Describe the elements of clear, collaborative and kind communication at triage
- Discuss how the quality of communication impacts on the assessment of urgency
- Identify barriers to effective communication for patients and staff at triage and describe strategies to overcome these barriers
- Describe strategies to recognise and manage distress, aggression and violence.

### A note about terms

The term 'support person' is used in this chapter to describe anyone accompanying and providing support to the patient in their ED presentation. This includes the patient's parents, other family, partner, friends, Aboriginal and Torres Strait Islander hospital liaison officers and paid and unpaid carers.

## Background

At triage, effective communication with patients and their support people is essential for gathering the information you need for an accurate assessment. Building rapport underpins effective communication and a positive experience.

## Approach

Patients and support people presenting to the ED are often anxious and frightened and may not be communicating as effectively as they usually do. This could be because of a combination of their illness or injury and the stressful and noisy ED environment. Your ability to stay calm, be kind and explain things clearly will go a long way towards reducing their anxiety.



### Key point

The way you communicate with patients at triage can have a profound impact on the safety and quality of their care as well as their emergency care experience. Consider the psychological safety of patients and use a trauma-informed approach.

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## Person-centred and trauma-informed care

Person-centred care involves respecting and responding to the preferences, needs and values of patients and their families.<sup>1</sup>

Trauma-informed care is part of person-centred care. It recognises the possible effects of past or continuing psychological trauma on health and behaviour, and avoids re-traumatisation.<sup>2</sup> It is based on the principles of trust, collaboration, safety, choice and empowerment.<sup>3</sup>

Communication strategies for the triage role should be person-centred and trauma-informed.

## Impact of psychological trauma on behaviour

Impacts of psychological trauma can include:

- Difficulty regulating emotion, so annoyance can quickly become rage
- Greater sensitivity to non-verbal 'negative' signals, such as facial expressions and body language<sup>4</sup>
- A history of trauma can create an interpersonal style that is difficult to understand (for example, combativeness or risk-taking).<sup>4</sup> Keep this in mind and be aware of your own reactions to patients' behaviour and biases
- Trauma is more common among some groups, but it can affect anybody – provide trauma-informed care to all patients.<sup>5,6</sup>

## Involving support people

Support people provide valuable information that forms part of the triage assessment. Acknowledge the support person and check with the patient that they are happy for the other person to be present and contribute to the assessment. Direct your communications to the patient, even if there is an interpreter or support person present. Be aware that support people, particularly parents, may want to share additional information with you without the patient present.

'My family help put all these pieces together when I'm too distressed or just can't find the words. Listen to them.'

– Michael, person with lived experience of mental illness

'The triage nurse had a calming nature about her, offering my father, my cousin and I lots of hope that I was in the right place and that things will be better soon. Just the caring frame of mind – and constantly offering us to approach her at any time and continually making sure we were OK – made the entire ED experience a delightful one. One that I will never forget. The care shown to us by the triage nurse made a huge impact on my recovery in the long run.'

– Evan, mental health patient advocate

Remember that communication through a third person can also increase complexity if they add their own interpretation of events or information.

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## Principles for communicating at triage

## Show respect and empathy

- Ask the patient what they like to be called
- Acknowledge their pain, discomfort or distress, when appropriate
- If someone is looking distressed, it can help to acknowledge this and let them know how you are going to help
- Don't use language that stigmatises or blames; for example, 'frequent flyer', 'addict', 'victim', 'non-compliant', 'hysterical', 'attention-seeking', 'difficult' or 'drug-seeking'.

## Create a sense of safety and trust

- Consider confidentiality
- Let them know what will happen next and encourage questions
- Don't make promises you can't keep
- Ask permission from the patient before touching them
- Don't invade their personal space (which may be larger for people with previous trauma)
- If their clothing needs to be removed for the assessment, explain why, ask them if they are okay with this, and ask them to do it themselves if possible.

## Use language the patient can understand

- Use plain language and avoid jargon
- Speak in short sentences
- Ask the patient to repeat back information you have told them in their own words.

## Use non-threatening body language

- Smile and use a friendly tone of voice
- Position yourself at the same level as the patient – sitting at eye level if possible
- Avoid crossing your arms or putting your hands on your hips
- Follow the patient's lead about eye contact – norms can vary by culture.

Sources: *Patient-Clinician Communication in Hospitals: Communicating for safety at transitions of care – an information sheet for healthcare providers*<sup>1</sup>; *Emergency and Trauma Care for Nurses and Paramedics, 4th ed*<sup>7</sup>; *Safety Fundamentals for Person Centred Communication: Hello my name is...*<sup>8</sup>

## Be sensitive to people waiting

Keep in mind that when patients are waiting and worried, they can interpret staff laughing or talking about non-work issues as being uncaring and contributing to delays in their care.<sup>9,10</sup> This is rarely the case, but this perception can be upsetting.

'I know people are allowed to have downtime, but I was really sick in there and it doesn't make you feel any good when you're there waiting for a doctor and you see people laughing and joking around.'

– ED patient<sup>9</sup>

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## Triage communication steps

## 1. Introduce yourself and explain your role

Many people don't understand the word 'triage'. You can introduce yourself and explain your role without using the word. For example: 'Hi, I'm Myu, one of the nurses. My job is to ask you some questions and find out why you've come in today.'

'Avoid saying "What's your emergency?" or "Why didn't you go to your GP?" – it can come across as judgemental. Sometimes people don't have other options, and they know they aren't dying, but they need care.'

– Triage nurse and educator

## 2. Obtain the history

Ask open-ended questions to prompt the patient to tell you why they have come to the ED. For example:

- 'How can I help you?'
- 'Can you tell me how this happened?'

You will need to ask more focused questions to get information about the signs and symptoms you want to exclude or include. This step is discussed more in **Chapter 2: Triage fundamentals** and in **Chapter 4: Decision-making**.

## 3. Conclude the triage and explain what will happen next

For patients going directly to the ED, useful phrases for concluding the triage include:

- Adult: 'Come with me into the emergency department'
- Young child: 'We're going through to where we look after kids.'

If the patient is going to the waiting room, let them know what will happen next. For example, say 'You're on the list to see one of the doctors or nurse practitioners now. I'm going to ask you to wait in the waiting room.'

Give specific instructions about when the patient should come back to a staff member. For example:

- If you have given medication, give a specific time for the patient to tell you if it has worked or not
- Describe the change that should trigger the patient coming back; for example, 'If you get tingling or numbness in your foot', or 'If your child seems to be getting drowsier' – think about red flags and symptoms that indicate the patient's condition is deteriorating
- Ask the patient to see you first if they decide they want to leave, and explain why this is important.

## Triage assessment tips

- If you are not getting the information you need, try rephrasing your question
- If you need to type your notes while doing the assessment, say 'I'm listening, I just need to look at my screen to make sure I'm writing everything down'
- If the patient is giving a lot of detail about history that isn't relevant to triage, try refocusing the conversation. For example, by asking 'What has changed in the last day or two to make you come in?' or 'What are you worried about today?'

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## Explain reasons for the wait

Understanding the psychology of waiting can help you find ways to improve the patient's experience:

- Anxiety makes the wait seem longer
- People want to get started with treatment
- Uncertain waits seem longer than finite, known waits
- Unexplained waits seem longer than explained waits
- Unfair waits seem longer than fair waits (for example, if someone thinks other patients are being seen ahead of them for no reason).<sup>11</sup>

Explaining how the triage process works can adjust expectations and reduce the risk of distress and aggression.

Useful phrases include:

- 'I'm sorry it's a long wait tonight, but you are in the right place and we will get to you as soon as we can – we appreciate your patience and make sure you let us know if you have questions or if things change'
- 'I know it's frustrating to wait, and your care is important, but we may have people who need to go in ahead of you for life-saving treatment – thank you for being patient'
- 'We will do our best to get you in to the doctor in about [estimated time], but I'm sorry it may be longer if we have more people arrive with life-threatening problems.'

## Practical comforts

Asking the patient if they need anything while they wait shows empathy and can make them more comfortable.

Helpful offers include:

- A blanket
- A quiet place to sit, if available and they need it
- Ear plugs for patients with noise sensitivity
- Information about where to find food, drinks and toilets.

Some patients don't have funds to buy food or drinks from vending machines; talk to your educator or manager about what you can provide in this situation. Patients and carers may also be anxious about parking costs – offer any practical advice you can.



## Key point

Keep in mind that annoyance is magnified when staff don't seem concerned or apologetic about the wait.<sup>12</sup> Try to remain empathetic and remind yourself that this is an unfamiliar situation for the patient and their support people.

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## Overcoming barriers to communication

## Sensitive topics

If you are talking about an embarrassing issue, avoiding key terms and using euphemisms instead can lead to misunderstandings. Use everyday language and normalise the issue to help the patient feel more comfortable. Be aware that sound travels through the waiting room – assess the patient without the glass barrier if it's safe to do so.

 Key point

If you need to talk about sensitive or embarrassing issues, find a place to talk where other people in the waiting room can't hear, if available and if it doesn't compromise your safety. Ask your educator about options for creating more privacy in your ED.

Age and gender differences between you and the patient can add to embarrassment. Building rapport can help. For example, by saying:

- 'I know this isn't something you would normally talk to a stranger about, but the more information we have, the better we can look after you'
- 'I need to ask people all sorts of personal questions every day – it can be a bit weird, but it helps us look after you better'
- 'I need to ask you some personal/intimate questions to better understand your condition/situation'
- 'You may not have shared this concern with anyone before. I want to assure you that what you say will be respected and listened to.'

## Urgent need for treatment

Patients' support people are likely to be stressed when you need to deliver time-critical care. It helps to acknowledge them, reassure them and tell them you need to focus on the patient, but that you will get back to them. Keep them with the patient if possible.

If there is more than one accompanying person, ask the patient which person they want to stay with them. Too many people in your area can block flow, making it difficult to move other patients through, and make the waiting room noisy and stressful for others.

'Don't be afraid to respectfully do crowd control and own your space.'

– Nurse educator

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## Communication difficulties

Use your usual nursing strategies to support communication with patients who have difficulties with speaking, hearing or vision. Remember to be patient and flexible, and use welcoming body language, such as smiling and having an open posture.

Keep in mind that a glass barrier and wearing a mask will make it more difficult for patients to understand you. Talk with your educator about strategies to overcome physical barriers to communication in your ED. See also [People from culturally and linguistically diverse backgrounds](#) later in this chapter.

## Cognitive issues and neurodiversity

You may need to adjust your communication for patients who are cognitively impaired or neurodiverse. Needs vary greatly – asking the patient and their support person what works best for them is a good starting point for reducing their stress and supporting communication.<sup>2,13</sup> Never talk about the patient as if they aren't there.

You may need several sources to obtain the patient's history: the patient themselves; support people and other key informants.<sup>14</sup> Don't dismiss a support person's concerns – they know what normal is and can help you determine what has changed. Keep in mind that people with cognitive impairment may not express their needs or experiences, such as pain, in words.

Cognitive issues and neurodiversity –  
communication and comfort tips

## Communication

- Talk in a normal tone and in a positive, inclusive way
- Talk with the patient directly, rather than the support person
- Stay calm, still and in the patient's line of sight when talking
- Use short sentences, simple words and concrete language
- Ask one question at a time
- Explain and show what you are going to do before you do it
- Allow time for what you say to be understood
- Clarify your understanding of what the patient has said – repeat or reword
- Check in with the person regularly to make sure they understand you
- Change your approach if the patient is not coping with the level of information.

## Comfort

- Minimise background noise and offer ear defenders if available
- Minimise bright lights and intrusive scents
- Avoid surprises or unexpected touch
- Use sensory-seeking options (for example, a weighted blanket)
- Keep the support person nearby.

Sources: *Assessment and Management of Behaviours and Psychological Symptoms Associated with Dementia (BPSD)*<sup>2</sup>; *Intellectual Disability – Actions for clinicians fact sheet*<sup>14</sup>; *Autism in ED: Tips to reduce stress and optimise care*<sup>15</sup>

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## Challenging communication encounters

Understanding signs of unmet needs can help you to respond to the issue behind the behaviour rather than to the behaviour itself (see Table 3.1, below). This will help both you and the patient. The video *Respond to Emotion by Understanding the Driver* gives further practical pointers on communication in the ED when emotions are running high.

‘When people feel heard and respected it’s much better for patients – and it makes your job easier.’  
– Triage nurse and educator

Table 3.1: Signs of unmet needs – and how to respond constructively

Need	Signs the need is not being met	Strategies to fulfil the need
To be understood	<ul style="list-style-type: none"> <li>■ Repeating the same message</li> <li>■ Speaking slowly and/or loudly</li> <li>■ Getting angry</li> <li>■ Bringing a support person to speak for them</li> <li>■ Body language suggesting frustration</li> </ul>	<ul style="list-style-type: none"> <li>■ Separate emotions from content</li> <li>■ Ask questions, including open questions, shifting the focus from the emotion to exploring the health concern</li> <li>■ Acknowledge the person’s feelings and empathise with their concerns</li> <li>■ Reflect back your understanding</li> <li>■ Inform them of what will happen and why</li> <li>■ Don’t take expressions of anger personally</li> <li>■ Check your own reactions</li> </ul>
To feel welcome	<ul style="list-style-type: none"> <li>■ Looking around before entering</li> <li>■ Looking lost or unsure</li> </ul>	<ul style="list-style-type: none"> <li>■ Provide a warm and friendly welcome</li> <li>■ Use appropriate language</li> <li>■ Keep communication lines open at the end of the triage encounter</li> </ul>
To feel respected	<ul style="list-style-type: none"> <li>■ Drawing attention to themselves</li> <li>■ Getting angry</li> <li>■ Appearing helpless</li> <li>■ Loss of control</li> </ul>	<ul style="list-style-type: none"> <li>■ Call the person by their name; acknowledge their concerns; tune into their individual needs</li> <li>■ Allow anger to diffuse: listen; say nothing; allow the person to release their emotions</li> <li>■ Try not to react to the emotion</li> </ul>
Comfort – psychological and physical	<ul style="list-style-type: none"> <li>■ Appearing ill at ease, nervous or unsure</li> <li>■ Requesting assistance or help</li> </ul>	<ul style="list-style-type: none"> <li>■ Explain the procedures carefully and calmly</li> <li>■ Reassure</li> </ul>

Source: Adapted from *Quality Customer Service, 4th ed*<sup>16</sup>

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## Aggression and violence

Early detection of warning signs of aggression and violence, and early intervention, are the first steps of de-escalation.<sup>17</sup>

Potential warning signs of aggression include:

- Being under the influence of alcohol or other drugs, particularly psychostimulants
- Slurred speech, foul language or being abusive, sarcastic or threatening
- Invading personal space, being defiant and uncooperative
- Hostile expression, prolonged eye contact
- Restlessness (excluding akathisia), pacing, clenching fists or jaw, twisting of neck.<sup>17,18</sup>

## Reducing the risk of violence

In some cases, early intervention can reduce the risk of aggression or violence. Tips for reducing the risk of aggression include:

- Avoid questioning the validity of patients' presentation to ED
- Show empathy
- Explain the process and reasons for the expected wait
- Give updates on the waiting time.<sup>19</sup>

'Compassion fatigue' in health professionals can lead to a lack of empathy towards patients and their support people, making it difficult to use the strategies above.<sup>20</sup> See [Looking after yourself](#) in **Chapter 4: Decision-making** for ways to manage the stress of the triage role.

If a patient becomes aggressive or violent, the main aim is positive engagement and safety, leading to de-escalation of their behaviour in the least restrictive way.<sup>18</sup>

## Verbal de-escalation

## 1. Get started

- Assess the need for support or back-up
- Tell another team member what is happening
- Create a safe and helpful communication space
- Introduce yourself
- Invite a conversation
- Explain that you are here to help and that you will work together to make the person feel safe

## 2. Listen and work out what the problem is

- Speak clearly
- Use each other's names
- Ask open-ended questions to learn what is happening
- Use simple words
- Speak in short sentences
- Repeat, paraphrase and check understanding
- Answer questions
- Clarify misunderstandings

## 3. Find solutions

- Work together to compromise and solve problems
- Be flexible
- Offer realistic choices and options
- Explain and give reasons for rules and decisions
- Ask open questions such as 'What can I do to help us work through this together?'
- Ask 'What can I do to help you feel safe here?'

Source: *Caring for People Displaying Acute Behavioural Disturbance – Clinical guidance to improve care in emergency settings*<sup>20</sup>

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## Communicating with specific populations

This section gives tips for communicating with children and parents, First Nations people, people from culturally and linguistically diverse backgrounds and LGBTIQ+ people. See **Chapter 8: Older people** for communication considerations in this group.

## First Nations people

First Nations people are diverse and their communication needs will vary greatly between and within settings.<sup>21</sup> Take your cues from the patient and their support people or ask a First Nations health worker or liaison officer for advice.<sup>21</sup> English is not always the primary language for First Nations people.<sup>21</sup> Use an interpreter in this case, if possible.

It is important that care takes culture into account. Some First Nations people respond best to a conversational or yarning approach. It is important to let the person tell their story – asking direct questions to obtain information may create inaccuracies.<sup>22</sup> Liaison services can help bridge the gap between healthcare providers and First Nations patients, families and communities. Clinical Yarning offers a free e-learning program that provides skills and tools for clinical communication with First Nations people.

## Cultural safety for First Nations people

Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities.<sup>23</sup> Culturally safe practice is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism.<sup>23</sup>

To ensure culturally safe and respectful practice:<sup>23</sup>

- Acknowledge colonisation and systemic racism, social, cultural, behavioural and economic factors which impact individual and community health

- Acknowledge and address individual racism, your own biases, assumptions, stereotypes and prejudices and provide care that is holistic, free of bias and racism
- Recognise the importance of self-determined decision-making, partnership and collaboration in health care which is driven by the individual, family and community
- Foster a safe working environment through leadership to support the rights and dignity of Aboriginal and Torres Strait Islander people and colleagues.

## Tips for effective communication with First Nations people\*

- Tell the patient something about yourself (for example, where you are from) and look for a common topic, such as a place you both might know
- Show personal interest in the patient and family by asking how they feel
- Use a quieter tone of voice – loudness can be seen as aggressive
- Allow space for silence rather than trying to interject or pre-empt a reply
- Be guided by the patient's behaviour regarding eye contact
- Be aware that a nod may not be an answer, but an acknowledgment of what you have said or asked.

Sources: *Cultural Safety, Skill Development and Communication. Aboriginal and Torres Strait Islander Peoples*<sup>21</sup>; *Aboriginal and Torres Strait Islander Social and Emotional Wellbeing*<sup>22</sup>; *Aboriginal Mental Health Clinical Practice Guideline and Pathways*<sup>24</sup>

\* First Nations people have diverse communication needs – adjust your communication style accordingly.

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People from culturally and linguistically  
diverse backgrounds

Culture and language can influence a person's understanding of health and expectations of what will happen in the ED. There is no 'one size fits all' solution to meeting the communication requirements of a diverse patient population – the videos below give some useful principles:

- [\*Working with Culturally and Linguistically Diverse Communities: Tips and advice\*](#)
- [\*Working with Culturally and Linguistically Diverse Communities: Steps toward cultural awareness.\*](#)

Language considerations include:

- Stress can cause a patient to revert to their first language
- If a patient's primary language is not English, an accredited interpreter may be required – only use the patient's support person as a last resort
- A prior relationship between an interpreter and the patient can be a problem in smaller ethnic groups because of concerns about confidentiality.<sup>25</sup>

Keep in mind that the patient's expectations about health care may be very different to that provided in your service, based on their past experiences in their country of origin.<sup>26</sup> They may also not understand your obligations regarding confidentiality, which you may need to explain.

Assessment tips:

- Don't assume you understand the situation for the patient based on their culture
- If the patient expects to see a doctor as the first step, explain that your job is to ask questions to find out why they have come in, and let them know what the next steps will be
- Explore responses to questions
- Some patients prefer indirect questions such as 'I wonder if you have been feeling unwell for a long time' or 'I wonder if the pain is getting worse'

- Signs and symptoms may be expressed in spiritual, somatic or behavioural ways
- Never assume people from the same cultural background are similar to each other.<sup>26</sup>

## Speaking with patients who have limited English

Many people with limited English understand it when spoken clearly:

- Speak at a measured, consistent pace
- Use a moderate volume – not soft or loud
- Enunciate clearly
- Face the patient
- Don't use slang.<sup>27</sup>

Yes or no questions for obtaining specific information may lead to misunderstandings – ask questions that require an answer in the form of a sentence. For example, 'What medicines have you had today?' rather than 'Did you take your medicine today?'<sup>27</sup>

Body language can have different meanings in other cultures – a smile or nod may not mean what you think it does.<sup>27</sup> Similarly, a 'yes' to your question may just reflect norms for politeness in the patient's culture.<sup>27</sup>

## What to do if an interpreter is not available

- Refer to local policies
- Document how, or with whose help, you interpreted information from the patient
- Re-triage once an interpreter is available, if appropriate.

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## Children and parents

Children are often frightened when they come to the ED. Finding the right strategy to gain the trust and cooperation of a child requires a flexible approach, and depends on their stage of development.<sup>28</sup> Also see **Chapter 7: Paediatrics**.

## Communicating with children and parents

- Use age-appropriate distraction techniques
- Younger children: toys, bubbles or watching a video can help them relax
- Older children: explain directly to them what you are doing, in age-appropriate language
- Adolescents: they may want privacy and to speak with you alone – you may need to discuss this with the caregiver
- The child's caregiver: they may feel anxious – listen carefully to their concerns without interrupting.

Source: *Emergency and Trauma Care for Nurses and Paramedics, 4th ed*<sup>28</sup>

## LGBTIQ+ patients

Create a welcoming and safe environment for LGBTIQ+ patients by showing respect and using inclusive language.<sup>29</sup> Practical ways to do this include:

- Don't assume patients are heterosexual
- Allow people to identify their gender
- If it is appropriate, and you are uncertain, ask respectfully 'what are your pronouns?'
- Use 'partner' rather than gender-specific terms such as 'husband' or 'wife' if you aren't sure
- Be inclusive of various family and parenting structures: use 'parent' rather than 'mother' or 'father' if you aren't sure
- Only use the terms the patient uses to describe their sexual orientation, gender or sex characteristics.<sup>29</sup>

## Speaking up for patient safety with other staff

Graded assertiveness is a way to escalate your concerns about a patient's safety to more senior staff using a stepped process.<sup>30</sup>

*PACE* and *CUSS* are two tools for graded assertiveness:

- *PACE*: Probe, Alert, Challenge, Emergency<sup>31</sup>
- *CUSS*: Concern, Uncomfortable, unSafe, Stop.<sup>32</sup>

The video *Graded Assertiveness: Comparing Approaches (PACE vs CUSS)* covers the pros and cons of each, and how they work in the Australian ED context.



## Key point

A patient's condition can change quickly in the ED, and it is important to speak up if you are concerned about their safety.

## Handover from pre-hospital providers

You may receive important information about the patient's history, condition, pre-hospital treatment and other context from pre-hospital providers. They may include paramedics, transport officers, nurses from other health services, and emergency response teams.

Pre-hospital providers have protocols guiding their treatment and handover to triage nurses, which will vary according to:

- The service's location
- Local protocols
- Their level of experience.

Let the pre-hospital provider finish their structured handover before you ask questions. Make sure you record any pre-hospital providers' treatment, including medications given.

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**Take-home messages**

In summary, remember that:

- The way you communicate with patients and their support people at triage can have a profound impact on the safety and quality of emergency care, as well as their care experience
- Showing empathy, listening actively and providing information in a way the patient can understand are central to person-centred care
- Your facial expressions, tone of voice and body language are just as important as your words – smile, use a friendly tone of voice and have an open body stance
- Support people may include the patient's family, parent, partner, friends, First Nations liaison officers and paid and unpaid carers – they are a valuable source of information and their concerns need to be listened to and understood
- If a patient or support person becomes aggressive, consider your safety and that of other people at all times
- A patient's condition can be unpredictable in the ED, and it is important to speak up with other staff if you are concerned about their safety.

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## Considerations for your site

Your role as an educator is to explain:

- When and how you escalate your concerns for patients in the waiting room
- Environmental considerations in your workplace that may enhance or negatively impact patient and staff experiences at triage – walk into your own triage space from the patient side and identify measures that support, or could support, effective triage (for example, information about waiting time); ideally have a patient with lived experience of the ED talk with learners and answer their questions
- How to manage patient preference for a triage nurse of a particular gender and, if it is not possible, how to manage the situation in a trauma-informed way
- Processes for de-escalation and management of agitation, aggression or violence in your workplace
- How handover from paramedics works in your ED; ideally have a local paramedic talk with learners about their work
- How police interactions work in your ED; for example, whether you have a memorandum of understanding in place with police about times for assessment.

## Discussion points

Help learners consolidate their understanding by discussing the points below:

- Reflect on your own communication style at different times throughout your shift, and on your own cultural and linguistic background, and how it impacts on your ability to:
  - Create rapport with patients
  - Keep the assessment focused and efficient
  - Communicate with people from backgrounds different to your own.

- Consider two presentations of men with central chest pain: one is obviously terrified and is pleading for help, while the other is loudly and angrily demanding immediate attention:
  - What are the different strategies you would use to extract indicators of urgency from each man?
  - Identify and discuss your reactions to the different behaviours and how these reactions may influence your ability to assess urgency.
- Watch the videos below and discuss strategies to prevent or manage these situations:
  - [I'm OK](#)
  - [Family Affair](#)
  - [Can't Get No Satisfaction](#).
- Watch the video [The Art of the ED](#), which gives an insight into the world of the ED:
  - Which patient(s) in the film stood out and why?
  - Which images from the film will you find difficult to forget?
  - Have you ever focused so much on completing your task that you failed to 'see' and empathise with the patient?
  - How will the video inform your empathic communication skills when caring for people in ED?<sup>33</sup>
- Consider the following points about the two versions of triage communication in [Table 3.2](#):
  - How could the triage nurse's communication in version 1 be improved to achieve a more effective assessment?
  - In version 2, find examples of the triage nurse's empathy statements, plain language, explanation of the process and open questions
  - How have the communication styles changed the assessment findings?
  - How would you adjust the communication for a patient from a First Nations or culturally and linguistically diverse background?
  - How do both encounters meet, or not meet, the requirements of person-centred or trauma-informed care?

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Table 3.2: Triage assessment communication styles – for critique and discussion

Speaker	Version 1	Version 2
Triage nurse	Hi, I'm the triage nurse. I need to know why you have come to the ED today	Hi, I'm Felix, one of the nurses. My job is to ask some question about what's going on. Can you tell me about why you have come in?
Patient	I want to see a doctor	I have pain in my stomach
Triage nurse	Yes, that's next, I need to know what's wrong	Oh, that's no good. How long has that pain been there for?
Patient	I don't feel well	When I went to bed last night it didn't feel right, but it woke me up this morning
Triage nurse	Well nobody is here 'cause they feel well. Can you tell me where you don't feel well?	Can you point to where the pain is for me?
Patient	I have pain in my stomach	It started (points to umbilical area) and now it is here (points to right iliac fossa)
Triage nurse	Okay, so how long's that been going on for and what's it feel like?	Okay, I need to ask about other symptoms you might have...
Patient	Oh a while, it's really sore	-
Triage nurse	Okay, so like a few days then, did it get worse today?	-
Patient	Yes	-

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## Case studies

The case studies below highlight communication issues with patients, support people and other staff. Work through these cases with learners using the discussion points.

## Case study 1: Concluding the triage

A young man has injured his hand by punching a wall. He has scaphoid tenderness on his dominant hand. During the triage, he is dismissive of his injury and seems concerned about waiting. He states he can't miss another day's work or he will get fired.

## Discussion points

What information would you give him at the conclusion of the triage?

- Acknowledge his concern about work and offer some solutions if possible – keep in mind he may have difficulty regulating his emotions, given that he punched a wall
- You need to explain the consequences of him not receiving treatment, for example, by saying: 'I know you aren't in heaps of pain right now, but you might have a broken bone in your hand that we can only see on an X-ray. If it doesn't get treated properly, you could have life-long complications that affect your ability to work.'

## Case study 2: Rural considerations

You are the triage nurse on night shift in a small rural facility with no overnight medical officer. A 52-year-old man presents to triage at midnight with a cough he has had for two weeks, as well as intermittent fevers. He finds it difficult to breathe when he is trying to go to sleep.

He has been using his asthma preventer and has increased use of his salbutamol to about every four hours. He finished a course of antibiotics yesterday. He states he has been lethargic and off food and fluids.

He appears alert, pale and tired. He speaks in full sentences but is using accessory muscles. On auscultation you find he has equal air entry and a fine expiratory wheeze bilaterally. He is peripherally cool and has a history of asthma and hypertension and is a smoker.

## Vital signs, case study 2

RR /min	SpO <sub>2</sub> %	HR /min	BP mmHG	T °C
24	<ul style="list-style-type: none"> <li>■ 92 – RA</li> <li>■ 98 – NP 2L</li> </ul>	98	115/65	37.6

## Discussion points

You are concerned that he may have sepsis or moderate to severe asthma:

- What processes or policies in your facility would alert you to call a medical officer or local advice line, and how would this differ by time of day? Consider local policy and procedures and/or state-based nurse-initiated care protocols
- How would you structure the conversation with the medical officer and what key points do you need to hand over?

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- What are your expectations from this phone call for your local facility? If your expectations aren't met, how could you escalate your concerns? How would you escalate if review or retrieval were delayed?
- What local treatment protocols would you consider? Does your service have a sepsis pathway? If so, does the patient fit the criteria?

## Case study 3: Peripheral sensation changes

A 65-year-old woman presents with new numbness to both legs, increasing since she woke up this morning. She needs to hold onto her partner for stability when she mobilises.

Her lower limbs are cool bilaterally, but not cold, and capillary refill time is less than two seconds. She reports she was gardening yesterday and took some paracetamol for a sore lower back last night, but this has not helped and the pain has increased this morning. She has passed urine and opened her bowels today without concern. Last week she had a viral illness, with headache and fevers, but reports she felt back to her normal self. She reports decreased sensation to touch in her feet and up to mid-thigh; upper limb strength is equal with no altered sensation. She also tells you she had a right-sided mastectomy 10 years ago.

## Vital signs, case study 3

RR /min	SpO <sub>2</sub> %	HR /min	BP mmHG	T °C
18	98	87	145/89	37.2

## Discussion points

- Consider your assessment findings, and the descriptors in the ATS, to determine a triage category.
- Her partner states there is a family history of stroke and is very concerned about getting an urgent CT scan. Consider strategies to manage this concern and request at triage.

## Case study 4: Re-presentations

A 30-year-old man re-presents for IV antibiotics and redressing 24 hours after injuring his hand at work in a meat processing factory. The dressing is intact, his hand is elevated in a collar and cuff sling and his fingertips are warm and well perfused.

## Discussion points

- What additional questions or observations would you consider in order to complete the triage?
  - Any changes to pain: this question can indicate potential deterioration in the condition of the wound or the need to escalate for analgesia. The patient states it has been increasingly sore overnight, he had paracetamol and ibuprofen two hours ago with very little effect
  - Neurovascular observations: these may indicate potential deterioration in the wound condition. The patient reports pins and needles in his index finger, which is a new symptom this morning.
- What should be your next steps?
  - Remove the dressing and assess the wound for new bleeding, swelling or signs of infection
  - Collect a set of vital signs and complete a focused assessment of neurovascular observations now the dressing has been removed.

In conversation with the patient, he tells you he has schizophrenia and is concerned the antibiotics will interfere with his medication. He says he doesn't want to take anything that might change the effectiveness of the medication.

- What might you need to consider at triage in response to this new information?
  - Reassure the patient he has done the right thing in telling you
  - Check what medication he has taken since the injury
  - Document and handover this information to other staff.

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## Supporting resources

- [Patient-Clinician Communication in Hospitals: Communicating for safety at transitions of care – an information sheet for healthcare providers](#), Australian Commission on Safety and Quality in Health Care
- [Online Learning Module](#), Teach-back
- [Communication Skills](#), Nurse & Midwife Support
- [Virtual empathy museum](#)
- [Comms Lab](#), videos on how to be awesome at difficult conversations in the ED
- [Safewards videos](#)
- [A Better Way to Care – Safe and high-quality care for patients with cognitive impairment or at risk of delirium in acute health services](#), Australian Commission on Safety and Quality in Health Care
- [Intellectual disability training videos](#), NSW Agency for Clinical Innovation
- [Cultural Considerations in Health Assessment – Tip sheet](#), Centre for Culture, Ethnicity & Health
- [NSQHS Standards User Guide for Aboriginal and Torres Strait Islander Health](#), Australian Commission on Safety and Quality in Health Care
- [Community Health Pride](#), LGBTIQ+ inclusive practice resources, Department of Health, Victoria
- [Speaking Up](#), Life in the Fast Lane

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# Chapter 4: Decision-making

## About this chapter

This chapter assumes knowledge of cultural safety (completion of cultural safety requirements).<sup>1</sup>

## Learning outcomes

After completing this chapter, participants will be able to:

- Describe evidence-based factors that optimise safe triage decision-making
- Describe the concepts of cognitive and implicit bias and consider how these ways of thinking may influence triage decision-making and affect equitable access to emergency care
- Apply strategies to inform focused information-seeking and assessment for safe triage decision-making
- Develop and apply strategies to mitigate risks associated with cognitive overload and decision bias at triage.

## Background

The triage environment is busy, unpredictable and complex.<sup>2</sup> Triage nurses are required to make decisions under time pressure and where available information may be incomplete or ambiguous.

Decision-making processes are often interrupted, and almost every patient who attends will have undifferentiated illness or injury. These conditions of uncertainty can hinder effective and accurate clinical decision-making in practice.<sup>2,3</sup>

Despite the challenges, there are ways to optimise triage decisions and to manage the potential impact of non-clinical factors on clinical decision-making.

## Triage decisions

People presenting to EDs can have unmet social, emotional and physical needs. As a triage nurse, you need to use your clinical reasoning and judgement to make evidence-based decisions under conditions of uncertainty and time pressure.<sup>4</sup>

Several related terms describe the cognitive concepts that underpin clinical decision-making:

- Critical thinking (analysis and interpretation of patient data)
- Clinical reasoning (the process of integrating data to formulate an outcome)
- Clinical judgement (decision outcome).<sup>5</sup>

Triage nurses combine observed, measured and communicated information with clinical knowledge and experience to determine a patient's level of urgency and assign a triage category.

*'The ED is a unique environment. It is difficult to imagine any other workplace in which there exists such [a] range of problems, acuity, time pressure and decision density.'*

– Professor Pat Croskerry, Professor of Emergency Medicine, Halifax University, Canada, and researcher in cognitive bias and clinical decision-making<sup>2</sup>

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When making triage decisions, you need to consider clinical risks associated with:<sup>6</sup>

- The patient's presenting problem
- Your assessment findings
- The patient's history of illness and injury, including past medical history and prescribed and over-the-counter medications.

You may need to consider one – or a combination – of these categories of information to make a triage decision. See **Chapter 2: Triage fundamentals** for more information.

### What nurses say: tips for beginner triage nurses about making decisions

- Always follow the ATS clinical guideline and do a primary survey (ABCDE) and targeted observations
- Use evidence-based algorithms for specific presentations (for example, sepsis pathways) when available
- Don't allow location or available departmental resources to influence the triage category
- Take your time to get it right. You will get quicker
- Ask yourself: 'Have I justified my triage category?'
- If in doubt, ask someone.

Source: Triage nurses and nurse educators<sup>7</sup>

## How to make triage decisions

### Thinking processes

Several useful models explain how people make decisions under conditions of uncertainty. Information processing theory describes how people take in information from the external environment, integrate multiple cues (for example, triage assessment data) and use memory to generate a decision outcome (for example, a triage category).<sup>8,9</sup>

When accessing information to make a decision, information must first be perceived through a sensory filter. As information passes through the sensory filter, it is first processed in short-term memory. Here relevant cues are examined together in an attempt to quickly generate a decision outcome. Short-term memory has a limited capacity to store information, so if patterns are not quickly recognised from recent experience, long-term memory will be accessed in an attempt to make a decision.<sup>8,9</sup>

### Application at triage

In the real world, people make decisions on a cognitive continuum. Under time pressure, decisions are typically highly unstructured and uncertain. With more time and information, uncertainty is diminished and decisions tend to be more highly structured.<sup>10</sup>

Cognitive continuum theory has real applications for triage practice, which typically occurs in a time-pressured environment and under conditions of uncertainty. While it is not always possible to slow down the triage assessment, you can reduce uncertainty by considering as much available data as possible before arriving at a decision. An example of these data at triage is the routine collection of easily accessible physiological data (vital signs) to inform triage decisions.

### Errors in perception at triage

Interruptions to the flow of information to the triage nurse can lead to errors if cues relevant to a decision fail to pass through your sensory filter.<sup>11</sup> Examples of errors of perception that occur at triage include being interrupted while taking a patient's history and missing an important line of questioning about the nature and quality of a patient's pain. Other factors, such as excessive noise and fatigue, can also lead to errors. See **Chapter 2: Triage fundamentals** for tips on managing your time to make decisions under pressure.

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## Fast and slow thinking

Information processing theory suggests that, generally speaking, people use two systems to make decisions: fast or system 1 thinking and slow or system 2 thinking (see [Figure 4.1](#)).

## System 1 thinking

System 1 thinking is intuitive and automatic and allows you to react to make quick decisions.<sup>12</sup> In this type of thinking, you make a judgement by recognising patterns from previous experiences.<sup>13</sup> These patterns are called heuristics, which are mental shortcuts that give you a quick result without having to work too hard.<sup>10</sup> Heuristics can be useful at triage, but over-reliance on heuristic thinking can lead to errors.

An example of how system 1 thinking is used at triage is in recognising tell-tale signs of respiratory distress. When you see a patient who has a rapid respiratory rate, is speaking in short sentences and appears to be using accessory muscles to breathe, you immediately know this patient has severe work of breathing. You can recognise a pattern because you have observed these signs many times before.

The downsides of system 1 thinking include:

- The risk of cognitive bias and errors because mental shortcuts are based on what is most likely, not on what is certain<sup>10,12</sup>
- Pattern recognition may be of limited use in patients with atypical signs or symptoms of clinical deterioration.

## What nurses say: how to minimise errors when thinking fast (system 1 thinking)

- Focus on the patient in front of you and minimise distractions
- Touch the patient and note their skin colour, temperature and perfusion
- Don't make assumptions about a patient's presentation – always check whether a feature is present or not
- Use focused observations to support your assessment
- Verbalise key points of the triage so the patient can confirm.

Source: Triage nurses and nurse educators<sup>7</sup>

## System 2 thinking

In system 2 thinking, a systematic deductive process is used to analyse all the information being presented to make a clinical judgement. This is slow and methodical thinking that takes effort.<sup>12</sup>

An example of how this type of thinking is used at triage is when a patient with a complex history presents with generalised abdominal pain. The signs and symptoms don't indicate a high degree of clinical urgency, and you don't recognise a pattern, creating conditions of uncertainty. Using system 2 thinking, you would do a more comprehensive assessment and take a more detailed history before using this information to make a judgement and assign a triage category.

System 2 thinking may be less vulnerable to cognitive bias (see next page) because you are actively analysing and synthesising each piece of information.<sup>14</sup>

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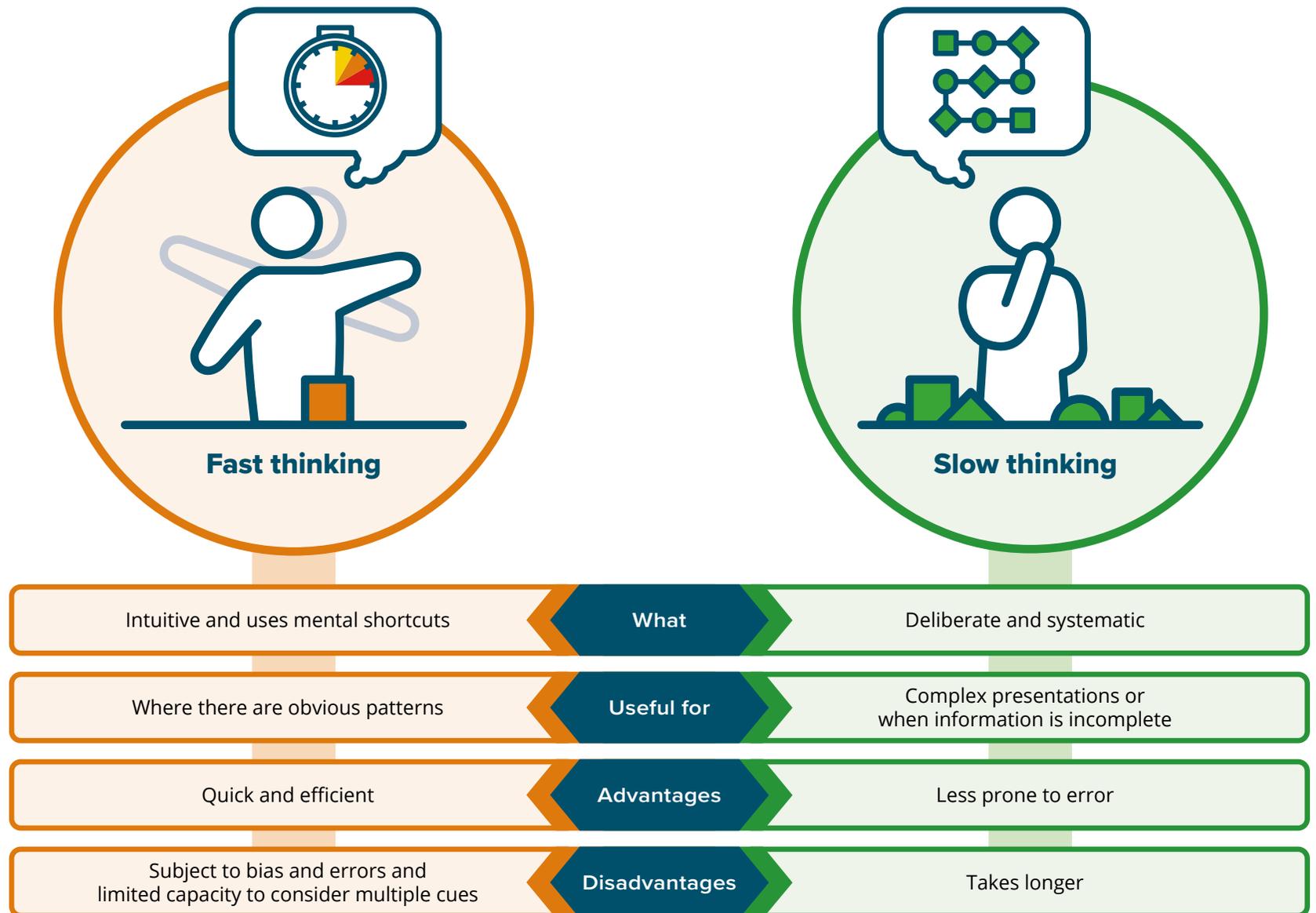
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Figure 4.1: Systems of thinking



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To create time for system 2 thinking, take time at the end of every triage to stop and read your documentation before allocating a triage category – and be aware of any assumptions that may be influencing your judgement. That final check helps to process your assessment findings and identify any gaps.

'You can create space for system 2 thinking by taking a full set of obs. Counting the respiratory rate and feeling a manual pulse usually result in the patient going quiet and it gives you a minute to collect your thoughts after you have your numbers (HR, RR).'

– Nurse educator

Most expert triage nurses use a combination of system 1 and system 2 thinking. As a beginner triage nurse, you will use both types of thinking but may rely initially on the methodical approach of system 2 thinking, which may improve the accuracy of your decisions but takes longer.<sup>15</sup> With the development of mental models and pattern recognition, many of your decisions will become quicker and more efficient (system 1 thinking).<sup>14</sup>



## Key point

A critical part of developing expertise as a triage nurse is accumulating and reflecting on your experiences, so you can easily and correctly recognise patterns in patients who present to ED (system 1 thinking).

It is equally important to learn when to take a moment and think methodically (system 2 thinking) – to allow for the possibility of alternative or less likely conclusions.<sup>15,16</sup>

## How bias affects decision-making

## Cognitive bias

Cognitive bias is a term for unconscious influences that affect information processing, decision-making and behaviour.<sup>13</sup>

The risk of cognitive bias at triage can be increased by non-clinical factors, including:

- Environmental conditions (for example, high patient volume, overcrowding, lack of resources and frequent interruptions)
- Personal factors (for example, hunger, stress and fatigue).<sup>14</sup>

Many types of cognitive bias can affect decision-making at triage. Examples of some of the most common types of bias include:

- Premature closure: drawing a conclusion before performing a full assessment, such as for a patient who often attends the ED with the same symptoms
- Gender bias: failure to recognise right shoulder or arm pain as potential acute coronary syndrome in women
- Inheriting others' thinking (also known as conformity bias): accepting other people's assessment of urgency without doing your own assessment or not questioning a diagnosis that has been applied when there is evidence to the contrary
- Availability bias: overestimating the likelihood of a rare clinical disease after another patient has recently been diagnosed with that condition.

See [Table 4.1](#) for more examples of cognitive bias at triage.

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## Implicit bias

Implicit biases are unconscious thoughts and feelings that cause unintentional discriminatory behaviour.<sup>17</sup> Implicit bias can have both positive and negative consequences. In health care, negative implicit bias can lead to reduced access to care and poor outcomes.<sup>18</sup>

Negative implicit bias can lead to suboptimal triage decisions for some patient groups due to their:

- Race/ethnicity
- Age
- Gender
- LGBTIQ+ identity
- Socioeconomic status
- Clinical status (primarily mental illness, HIV and alcohol/drug use)
- Appearance (disability and weight)
- Other social categories.<sup>18,19</sup>

## Using bias for good

Not all patients in ED are on equal footing. Although the ATS is applied universally, some patients won't be able to explain their presenting problem as well as others. We need to recognise these situations and be prepared to work with the patient to support them – see **Chapter 3: Communication for triage** for tips.

Cognitive and implicit biases are often associated with negative patient experiences and diminished quality of care.<sup>18,20</sup> For example, there is evidence that First Nations people experience negative implicit bias in EDs.<sup>20</sup> Coronial reports highlight how racial stereotyping and pre-conceived assumptions have contributed to the deaths of First Nations people in ED.<sup>20</sup>

## What nurses say: how to minimise the impact of bias

- Remind yourself that everyone experiences situations differently
- Stick to the ATS framework: previous presentations by the same patient can bias your decision and clinical judgement
- Avoid making assumptions ('You can't have a serious problem; you've waited two months to come')
- Try to focus on what you need to do right now – memory tools and a system or structure can help
- Ensure you have a safe and well-stocked environment
- Minimise distractions and interruptions (for example, crowd, noise control and the telephone); see **Chapter 2: Triage fundamentals**.

Source: Triage nurses and nurse educators<sup>7</sup>

'Don't be frightened to ask for help when you have a queue. It reduces the pressure of triage. Pressure and stress = mistakes.'

– Triage nurse

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Table 4.1: Cognitive bias at triage

Type	Definition	Triage examples	Discussion
<b>Framing effect</b>	Presenting options or information in a manner so it is perceived in a particular way <sup>21</sup>	The triage nurse thinks a patient is not sick enough to be in ED and says 'It's really busy tonight and because you're not that sick, you're going to be waiting a really long time...'	While the patient may not be very sick, they still need treatment. This comment suggests to the patient that they should leave and doesn't tell them what to do if symptoms change
<b>Overconfidence</b>	The tendency to believe we know more than we do or are better than average <sup>21</sup>	The triage nurse assumes a patient's reaction to pain is behavioural rather than reflecting the seriousness of the illness. They think 'Why are they carrying on like that? They shouldn't have that much pain'	Thinking that we have seen and experienced everything can lead us to miss crucial information. It also doesn't show empathy or build trust with the patient
<b>Confirmation</b>	Seeking information that supports existing decisions and rejecting information that doesn't fit <sup>22</sup>	A paediatric patient presents with a fever, tachycardia and lethargy. The triage nurse assumes they have a viral illness	If the nurse only expects to see viral illness, they won't be on the lookout for sepsis
<b>Availability</b>	Using information that comes readily to mind and applying it to the current situation <sup>23</sup>	A patient who comes in often to ED presents again. The triage nurse applies their usual signs and symptoms to this presentation, thinking 'This is X who always come in and here they are again with X'	Associating information that readily comes to mind without looking at each patient and presentation can prevent us from finding assessment data that will affect the current presentation
<b>Anchoring</b>	Relying on the first piece of information as the baseline for all future information <sup>24</sup>	A patient presents with vomiting and diarrhoea and says they recently ate a ham sandwich. The triage nurse focuses on the ham sandwich as the cause and doesn't consider other possibilities	This is an example of when we think we have a diagnosis and try to fit all signs and symptoms into that diagnosis. The ham sandwich may or may not have caused the patient's symptoms – many causes need to be considered

*Continued over...*

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Table 4.1: Cognitive bias at triage (continued)

Type	Definition	Triage examples	Discussion
<b>Premature closure</b>	Ending an encounter without getting critical information <sup>15</sup>	A patient presents, saying they have a 'bad migraine'. The triage nurse does not ask about the usual migraine pattern and their pain	Without completing a full assessment, we might not find out if the signs and symptoms of the migraine are different to the normal pattern and might increase the urgency
<b>Fundamental attribution error</b>	Tendency to blame patients for their situation	A patient with a history of COPD presents with shortness of breath. As part of the history, it is apparent the patient still smokes	The patient still needs assessment and care, and shortness of breath is a risk factor for serious illness. Patients continue to smoke for many reasons; their choice is not relevant to triage decision-making
<b>Cloven hoof effect</b>	Generalising one negative aspect of a person to all areas of that person	A patient presents looking dishevelled and the triage nurse thinks that they are not looking after themselves, including not taking their medication as prescribed	Making assumptions about the patient's situation can cloud your assessment. The patient may also feel judged and may withhold information

## Looking after yourself

Non-clinical factors, such as feeling stressed and anxious, under time pressure, hungry, tired or dealing with difficult or hostile people, can affect how you make triage decisions.<sup>26</sup> It is important to take care of your own health so you can continue to make accurate clinical decisions.

Building resilience and self-compassion can help you to deal with this stress. Simple steps that may help include:

- Taking assigned breaks
- Seeking support when you are feeling overwhelmed
- Maintaining connections with friends and families
- Talking to your manager if your colleagues' stress or behaviour is affecting you
- Self-monitoring overload, stress, fatigue or substances that affect decision-making.<sup>27</sup>

See the [Wellness and Self-Care Strategies](#) from the College of Emergency Nursing Australasia for more tips.

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**Take-home messages**

In summary, remember that:

- The triage nurse needs to make quick and accurate decisions in a time-pressured, interruption-driven and uncertain environment that can hinder clinical decision-making
- Fast (system 1) thinking can be efficient under conditions of uncertainty because people use mental shortcuts to inform judgements (heuristic thinking). The downside is the risk of cognitive bias and errors
- Slow (system 2) thinking is deliberate and systematic. It is generally more reliable but takes much longer than system 1 thinking
- Cognitive biases are unconscious mental shortcuts that affect interpretation and processing of information
- Implicit biases are unintentional attitudes that result in discrimination and can reduce access to health care
- Cognitive and implicit biases can unintentionally affect triage decision-making
- The first step to minimise the impact of bias is awareness of non-clinical factors that may influence your decision-making
- Incorporate self-reflection into your daily work to understand more about your biases and how they might affect your triage decisions.

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## Considerations for your site

Your role as an educator is to:

- Observe the triage nurses' interactions with patients and carers to assess their clinical judgement in a dynamic and changing environment<sup>28</sup>
- Provide structured, qualitative feedback using agreed assessment tools<sup>28</sup>
- Use reflective strategies, such as auditing, to examine previous triage decisions<sup>15</sup>
- Provide cheat sheets for applying the ATS
- Support deliberate practice to increase expertise<sup>29</sup>
- Provide cognitive aid tools (for example, visual prompts in your triage area)
- Let triage nurses know who they can call for help when they are unsure
- Provide a triage preceptorship program, audit and feedback processes and documentation standards.

## Discussion points

Help learners consolidate their understanding by discussing the points below:

- Consider the situation where you have a full waiting room, with a large number of untriaged and undiagnosed patients.
  - What are the potential risks for your triage decision-making?
  - What strategies would you use to mitigate these risks?
- The [Virtual Empathy Museum](#) is a repository of open-access, evidence-based curriculum resources to enhance healthcare students' and clinicians' empathy skills.
  - Use the report of [a young man experiencing homelessness](#) as the basis of a group discussion about how we all view the world differently
  - Review the participants' interactions with health professionals in the [discussion of the ABC program \*You Can't Ask That\*](#) and look at ways you could reduce these biases at triage.
- Use [Table 4.1](#) to discuss the risks of cognitive bias and how to address them.

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## Case studies

The case studies below highlight common presentations and low-frequency, high-risk presentations. Work through these cases with learners using the discussion points.

## Case study 1: Trauma after a fall

A 72-year-old man had been standing on a ladder cleaning the gutters. On his way down the ladder, he misjudged the last rung, slipped and inverted his right ankle, causing pain and swelling to his lateral malleolus. The ring on his left hand caught on the ladder, partially degloving his ring finger.

The ring is stuck over the knuckle. There is minimal blood loss. He didn't hit his head and denies other injuries. The tip of his left ring finger is dusky with decreased sensation. He has a history of coronary artery bypass grafts, and is taking antiplatelets and medication for cholesterol and hypertension.

## Discussion points

- Part of the assessment of this presentation includes ruling out a more serious cause of the fall and potential for more serious trauma. What other information would you collect to do this?
- Consider the presenting problem, injuries and history. Which findings prompt you to collect vital signs?
- The man is from a culturally and linguistically diverse background. He speaks English, but you're not sure if you have understood the mechanism correctly and if he has other injuries. The man refused an interpreter on arrival. How would you manage this situation at triage?

## Case study 2: Fever, diarrhoea and vomiting in a child

A 3-year-old child presents with two days of fever, diarrhoea and vomiting. Their foster carer tells you she has not tried giving the child fluids and hasn't given paracetamol at home. The child has decreased oral intake and urine output is unknown due to diarrhoea. The child is pale and lethargic.

## Vital signs, case study 2

RR /min	HR /min	T °C
42	178	38.4

## Discussion points

- What possible bias could affect this triage assessment?
  - The child's respiratory rate and heart rate is considerably higher than normal for a 3 year old. There may be a temptation to attribute these vital sign abnormalities to the child's fever, which may be true in part. However, the respiratory rate and heart rate abnormalities are considerable, so the possibility of hypovolaemia or sepsis must be considered. It is important to not become complacent or to look for ways to make the assessment match the assumption that it will be a benign viral illness.

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## Case study 3: Headache with stress

A 46-year-old woman presents with a headache. She describes recent stress at work and says her headaches have been increasing. Her headache came on suddenly today and is more painful than others she has had (pain score 6/10). She is teary, will only answer questions with a single word, and has not taken any analgesia as she didn't want to mask the symptoms. Her doctor wanted her to start medications for her blood pressure, but she didn't want to and has started taking a diet pill. She is alert.

## Vital signs, case study 3

RR /min	SpO <sub>2</sub> %	HR /min	BP mmHg	T °C
20	97	78	152/87	36.5

## Discussion points

- The patient's limited engagement during the triage assessment may be interpreted as being uncooperative, creating a bias that she is not sick enough to be in the ED or is 'being difficult'. This may result in failure to consider her changes in mentation as a red flag for her presenting problem
- The patient's decision not to take analgesia before presenting may be interpreted as lack of responsibility or engagement in her own health or premature attendance at the ED. Patients' reasons for not taking analgesia before presenting to the ED include:
  - A fear that if their pain is reduced, ED clinicians will not believe the severity of their pain
  - A perception that they need to demonstrate the degree of pain or distress to be taken seriously in the ED
  - Varying levels of health literacy and problem-solving
  - Cultural or societal norms.
- The patient hasn't wanted to take a prescribed blood pressure medication but is happy to take an over-the-counter diet pill. Again, we are comparing the decision we would make with the decision made by a person with different experiences and health knowledge.

## Case study 4: Disorientation and slurred speech

A First Nations man aged in his thirties presents to the ED. He is disorientated, has slurred speech and is clammy. He answers yes to all questions and is vague in his responses. He says he has not been drinking alcohol and feels weak. He asks for a sandwich and cup of tea. He has diabetes.

## Vital signs, case study 4

RR /min	HR /min	BP mmHg	T °C
26	102	175/80	36.0

## Discussion points

- He is disorientated, has slurred speech and is clammy.
  - Biases occur when ethnicity and assumptions about particular groups of people are considered in the triage process. Bias may lead to attributing disorientation and slurred speech to an assumption that First Nations people are heavy users of alcohol, and therefore this patient is under the influence of alcohol. This may prevent further assessment, such as taking a BGL
- The man answers 'yes' to all questions.
  - This may indicate the man wants to appease the triage nurse and not be seen as difficult or non-compliant
- He is asking for a sandwich and a cup of tea.
  - A biased view of this request is that he is asking for free food. If the man has diabetes, he may know he needs to eat to treat a hypoglycaemic event.

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## Supporting resources

- *Five Minute Fridays*, summaries of information that may be useful at triage, College of Emergency Nursing Australasia (CENA)
- *External clinical resources*, apps to support decision-making at triage, Emergency Care Institute
- *Cognitive Bias in the ED*, Trainee Focus, *Emergency Medicine Australasia*, October 2020

## Cultural safety resources

- *Indigenous Health and Cultural Competency Program*, Australasian College for Emergency Medicine
- *Learning and Education Modules on Understanding Bias in Health Care*, Health Quality & Safety Commission (New Zealand)
- *To Heal the Nation We Need Understanding*, video on understanding the impact of generational trauma, Foundation for Indigenous Sustainable Health
- *Five Cross-Cultural Capabilities for Clinical Staff*, Queensland Health
- *Ask Away!* videos and discussion guide to support health workers to meet the needs of First Nations people, Tasmanian Government

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# Chapter 5: Psychological distress and behavioural disturbance

## About this chapter

This chapter assumes knowledge of:

- Common presentations seen in the ED involving psychological distress or behavioural disturbance
- Nursing assessment for a person experiencing psychological symptoms or behavioural disturbance.

## Learning outcomes

After completing this chapter, you will be able to:

- Demonstrate effective trauma-informed care
- Discuss the range of contributing factors to psychological symptoms and behavioural disturbance – situational, medical, current experience of mental illness, psychological, neurocognitive and substance-related issues
- Describe the signs and symptoms indicating the need for time-critical intervention for psychological distress or behavioural disturbance, and apply a triage category that reflects the person's need for emergency care.

## Background

A person may come to the ED with psychological distress or behavioural disturbance stemming from many different causes, including mental illness, drug and alcohol use, acute situational stress and medical conditions. They may have physical health problems and social circumstances that combine with their behavioural or psychological issues to create a need for care in the ED.

In all cases, empathy, respect and compassion are the foundation for establishing rapport with the person.<sup>1</sup> This connection is the basis for effective communication, appropriate assessment and a positive interaction.<sup>1</sup>

## Common presentations

People presenting to ED due to psychological distress or behavioural disturbance may be experiencing or displaying the following, often in combination:

- Suicidal behaviour or ideation
- Self-harm
- Depressed, withdrawn or distressed mood
- Hyperactive, loud, grandiose or elevated mood
- Nervousness, anxiety, panic or excessive worry about health
- Physical symptoms
- Confusion
- Bizarre behaviour or speech
- Aggression.<sup>2</sup>

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## Chapter 5: Psychological distress and behavioural disturbance

## Presenting to ED can be overwhelming

Visiting the ED can be an overwhelming and scary experience for people seeking help for psychological distress or behavioural disturbance and for their support people.<sup>1</sup> Some have experienced the ED as unwelcoming and traumatising in the past, and have been met with stigmatising attitudes and a lack of empathy.<sup>1,3</sup>

Being in the ED may trigger memories of past trauma, and for a person who has experienced trauma in the past, attempts to provide care in the ED can be perceived as a threat to their safety.<sup>4-6</sup> This is especially true for First Nations people, people from culturally and linguistically diverse backgrounds and people with disability.

These factors make the principles of trauma-informed care particularly important when triaging people seeking care for psychological distress or behavioural disturbance. See [Person-centred and trauma-informed care](#) in **Chapter 3: Communication for triage** for more information.



## Key point

Trauma-informed care makes a positive and safe experience more likely for the person, their support person and for you.<sup>4</sup>

## Support people

Support people, such as family, are often key players in convincing the person that they need care and in getting them to the ED. Support people may be stressed from the preceding days, or even weeks, of the person's increasing unwellness. Work with them – they will be the ones supporting the person and are an important source of information about the person's condition and history. Also see [Involving support people](#) in **Chapter 3: Communication for triage**.

'Work with me and my family. Don't keep them sitting in the waiting room or in the car. Help them to remain hopeful, patient, persistent and determined to encourage me with the many small and consistent steps that I need to take every day.'

– Michael, person with lived experience of mental illness

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## Approach

## Trauma-informed care

Trauma-informed care recognises the possible effects of past or continuing psychological trauma on health and behaviour. A patient's psychological trauma can be a result of many different types of experiences (for example, adverse childhood experiences, physical injuries, discrimination, natural disasters). Trauma-informed care is based on the principles of trust, collaboration, safety, choice and empowerment.<sup>7</sup> Also see [Person-centred and trauma-informed care](#) in **Chapter 3: Communication for triage**.

The noisy, bright and chaotic environment of the ED often adds to a person's distress.<sup>1</sup> If possible, find a place for assessment that promotes a sense of safety and minimises the risk of re-traumatising them.<sup>4</sup>

## What does trauma-informed care look like?

- Treating people with empathy and compassion
- Taking the time to engage with people to build psychological safety
- Asking questions to understand the person's experience
- Providing people with access to space, resources or supports when dysregulated
- Providing choice and collaboration wherever possible
- Assuming at all times that people are doing the best they can with the resources they have.

Source: *Trauma-Informed Care in Mental Health Services Across NSW – A framework for change*<sup>4</sup>

## Communication

When people are distressed, patience and empathy are key for establishing rapport.<sup>9</sup> Show that you are trying to understand what is happening for them.<sup>9</sup> Keep in mind that the support person is also likely to be feeling distressed.



## Key point

Direct or challenging questions that might be interpreted as critical are not likely to help.<sup>5</sup>

As with all people, you should use clear, plain language without clinical jargon when talking to people presenting with psychological distress or behavioural disturbance.<sup>4</sup> Trauma-sensitive language and your non-verbal communication are also important for creating rapport and a sense of safety (see the box [Principles for communicating at triage](#) in **Chapter 3: Communication for triage**).<sup>4</sup>

If someone tells you about a traumatic experience, it is important to respond in a supportive way. For example, by saying 'Thank you for telling me – that's important to know' or 'I'm so sorry that happened to you – I'm glad you were able to tell me'.<sup>10</sup> If you are asking someone about trauma, let them know that it is up to them what they disclose.<sup>10</sup>

'Previously I'd always seen challenging behaviours as annoying in the emergency department... but the biggest thing I took [from the training] was that there's a reason for that, there's always something underlying.'

– Participant in trauma-informed care training for emergency nurses<sup>8</sup>

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## Communicating with people experiencing thought disorder

Giving a message of safety and de-escalating their stress as much as possible is key for people experiencing thought disorder.<sup>5</sup> Use calming and reassuring verbal and non-verbal communication, and follow these principles:<sup>5</sup>

- Use short sentences, simple words and don't rush
- Be prepared to repeat yourself
- Make your verbal and non-verbal communication match
- Give suggestions rather than orders when you want the person to do something
- Foster trust by following through on commitments you make
- Give careful explanations of what will happen
- Let the person control the amount of information they disclose.<sup>5</sup>

## Information from other people

Information from other people can be very helpful for understanding the circumstances leading up to a person's presentation to the ED and for understanding what is normal for them. With the person's permission, talk to their support person and anyone else who accompanied them (for example, paramedics).

*'Families see, feel and experience the consequences every day with the person, often picking up the pieces. After all, it's their life too because it is shared with the person.'*

– Sharon, carer of a person with lived experience of mental illness

## Assessment

Perform the usual physical assessment, including primary survey steps A–E, before the psychological distress or behavioural disturbance assessment, and incorporate findings from each in your triage decision. In some cases, the physical assessment will indicate higher urgency.



## Key point

Don't assume that psychological distress or behavioural disturbance is the person's only problem. Make sure you do a set of observations at the earliest possible time, when the person consents to, and complies with, the procedure.

## Focused assessment

Consider your observations and the person's reported behaviour and history in your assessment and when using the Mental Health Triage Tool.<sup>2</sup> Features of the person's presenting problem may include:

- Behaviours (for example, self-harm, aggression, bizarre actions, agitation, overactivity)
- Emotions (for example, distress, anger, worry, sadness)
- Thoughts (for example, suicidal ideation, delusions).<sup>2</sup>

As the triage nurse, your ability to observe and pick up on subtle cues can help identify issues and focus the assessment. Examples of useful assessment questions are shown in [Table 5.1](#).

Typical presentation features for people experiencing psychological distress or behavioural disturbance and the corresponding triage categories from the Mental Health Triage Tool are listed in [Table 5.2](#). See [Appendix B](#) for the complete Mental Health Triage Tool.

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## Development of the Mental Health Triage Tool

Tools to aid the triage of people presenting to EDs with psychological distress or acute behavioural disturbance have been developed and refined in Australia from the 1990s. These include guidelines in NSW and a triage rating scale in Tasmania.<sup>14,15</sup> A mental health triage tool was developed by South Eastern Sydney Area Health Services and further refined by Broadbent et al.<sup>16,17</sup>

## Common risk factors for suicide

## All ages

- Mood disorder
- Suicidal ideation
- Relationship problems
- Alcohol and drug problems, intoxication
- History of self-harm
- Anxiety and stress disorders
- Death of a family member
- Legal or employment problems
- Male gender
- Access to means to carry out suicide
- Living in a regional or remote area
- Stressors for First Nations people, such as racism and trauma
- Limitation of activities due to disability
- Pain
- Hopelessness and helplessness.

## Risk factors for suicide

Consider risk factors for suicide when deciding on the triage category, where the person should wait and whether to flag the person's risk to senior staff. See Common risk factors for suicide (below).



## Key point

You should ask the person whether they are having suicidal thoughts – asking this does not increase the risk of suicide.<sup>5</sup> Sensitively framed, but direct, questions are best.

## Adolescents

- Hostility, aggression and impulsivity
- Stressors related to sexuality or gender identity
- Recent commencement of antidepressant therapy
- Close friends who have died by suicide.

## Older people

- Social isolation
- Concerns about being a burden to other people
- Tension with caregivers
- Recent change in accommodation.

Sources: *Causes of Death, Australia 2021*<sup>11</sup>; *Demoralization in Suicide: A systematic review*<sup>12</sup>; *Working with the Suicidal Person – Clinical Practice Guidelines for Emergency Departments and Mental Health Services*<sup>13</sup>

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Chapter 5: Psychological distress and behavioural disturbance

Table 5.1: Useful assessment questions for patients experiencing psychological distress or behavioural disturbance

Question	Comment
<b>Understanding the presenting problem</b>	
Things seem to be difficult for you at the moment – can you tell me more about it?	These are open-ended questions to encourage people experiencing distress to talk about their difficulties <sup>5</sup>
I sense that you are feeling worried – do you feel safe?	If these strategies don't work, the person's silence may indicate serious illness – they should never feel forced to speak
I can see that you are feeling angry/anxious – can you tell me why?	
Has anything happened today or recently that made you need help from us?	Stressful situations can increase the risk of suicide (e.g. relationship problems, employment-related or legal issues, bereavement) <sup>11</sup>
I have to ask some sensitive questions now: Do you have any thoughts of suicide now? If yes: do you have any plans to do this? Do you have access to what you would need to do this? Have you tried to take your life today?	Yes to any of these questions increases the risk of suicide <sup>11</sup>
Have you tried, or wanted, to hurt yourself? If yes: is this to release emotions?	Self-harm to release emotions has a different intent to suicide
Do you have any thoughts of harming someone else? If yes: do you have a specific person in mind?	Threat of harm to others suggests a triage category of 2
Do you hear voices when there is no one else around or have other unusual experiences you can't explain? If yes: are these voices telling you to do things? If yes: do you feel like you have to do what the voices tell you?	Command hallucinations that the person is unable to resist suggest a triage category of 1. The person may not be able to tell you about these experiences – do not press them
Did someone bring you here?	People brought in by police, paramedics or mental health workers may not have been able to identify their own health needs People presenting alone may be at greater risk of leaving <sup>2</sup>

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Table 5.1: Useful assessment questions for patients experiencing psychological distress or behavioural disturbance (continued)

Question	Comment
<b>Identify factors that may impact on the presenting problem</b>	
Do you take any prescribed medication? If yes: have you been taking it? How much have you been taking? Do you have any medication with you?	If the person has medication with them, ask if you can take it from them
Do you take any non-prescribed medications or other drugs, or drink alcohol? If yes: have you had any today and if so how much?	Intoxication is a risk factor for suicide and reduces capacity to make an informed decision to not wait Alcohol and substance-related disorders increase the risk of suicide <sup>11</sup>
Have you hurt yourself in the past? If yes: was this to release emotions or did you want everything to end?	This can help understand a person's suicide risk
Have you experienced mental illness in the past? If yes: is this presentation similar or different? Have you attempted suicide in the past? Do you have other medical conditions?	This context can help you understand the person's needs and suicide risk
Do you feel safe to stay? Do you feel safe to tell me if anything changes?	This can help determine an appropriate location post-triage

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Table 5.2: Mental Health Triage Tool – summary

	Category 1 Immediate	Category 2 Emergency	Category 3 Urgent	Category 4 Semi-urgent	Category 5 Non-urgent
Description	Definite danger to life (self or others)	<ul style="list-style-type: none"> <li>■ Probable risk of danger to self or others, and/or</li> <li>■ Client is physically restrained in ED, and/or</li> <li>■ Severe behavioural disturbance</li> </ul>	Possible danger to self or others: <ul style="list-style-type: none"> <li>■ Moderate behaviour disturbance</li> <li>■ Severe distress</li> </ul>	Moderate distress	No danger to self or others
Typical presentation features	<b>Observed</b> <ul style="list-style-type: none"> <li>■ Violent behaviour</li> <li>■ Possession of a weapon</li> <li>■ Major self-harm in the ED</li> <li>■ Extreme agitation or restlessness</li> <li>■ Bizarre/disoriented behaviour</li> </ul> <b>Reported</b> <ul style="list-style-type: none"> <li>■ Verbal commands to do harm to self or others, that the person is unable to resist (command hallucinations)</li> <li>■ Recent violent behaviour</li> </ul>	<b>Observed</b> <ul style="list-style-type: none"> <li>■ Extreme agitation/restlessness</li> <li>■ Physically/verbally aggressive</li> <li>■ Confused/unable to cooperate</li> <li>■ Hallucinations/delusions/paranoia</li> <li>■ Requires restraint/containment</li> <li>■ High risk of absconding and not waiting for treatment</li> <li>■ Unable to wait safely</li> </ul> <b>Reported</b> <ul style="list-style-type: none"> <li>■ Attempt at self-harm/threat of self-harm</li> <li>■ Threat of harm to others</li> </ul>	<b>Observed</b> <ul style="list-style-type: none"> <li>■ Agitation/restlessness</li> <li>■ Intrusive behaviour</li> <li>■ Confusion</li> <li>■ Abivalence about treatment</li> <li>■ Not likely to wait for treatment</li> <li>■ Hallucinations/delusions/paranoia</li> <li>■ Thought disorder</li> <li>■ Bizarre/agitated behaviour</li> <li>■ Severe symptoms of depression</li> <li>■ Withdrawn/uncommunicative and/or anxiety</li> <li>■ Elevated or irritable mood</li> </ul> <b>Reported</b> <ul style="list-style-type: none"> <li>■ Suicidal ideation</li> <li>■ Situational crisis</li> </ul>	<b>Observed</b> <ul style="list-style-type: none"> <li>■ No agitation/restlessness</li> <li>■ Irritable without aggression</li> <li>■ Cooperative</li> <li>■ Gives coherent history</li> </ul> <b>Reported</b> <ul style="list-style-type: none"> <li>■ Pre-existing mental health disorder</li> <li>■ Symptoms of anxiety or depression without suicidal ideation</li> <li>■ Willing to wait</li> </ul>	<b>Observed</b> <ul style="list-style-type: none"> <li>■ Cooperative and able to engage in developing management plan</li> <li>■ Able to discuss concerns</li> </ul> <b>Reported</b> <ul style="list-style-type: none"> <li>■ Known patient with chronic psychotic symptoms</li> <li>■ Pre-existing non-acute mental health disorder</li> <li>■ Known patient with chronic unexplained somatic symptoms</li> <li>■ Request for medication</li> <li>■ Minor adverse effect of medication</li> <li>■ Financial, social, accommodation, or relationship problems</li> </ul>

Source: Adapted from the [Mental Health Triage Tool](#)

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## Overarching considerations

When deciding on the triage category and where the person should wait, consider if they are:

- In obvious, severe distress
- Likely to wait until seen by an ED clinician or mental health specialist
- Likely to ask for help if circumstances change
- Currently under the care of a mental health service
- Under an involuntary order
- Responsible for young children
- A danger to themselves or others.<sup>13</sup>

If the person has a lower urgency presentation, offer a warm blanket and explain that they may need to wait a while – but to come back and see you if they feel they can't wait any more. See **Chapter 3: Communication for triage** for more tips on offering practical comforts in and improving the experience of waiting.

 **Key point**

Consider whether the person has capacity to make an informed decision not to wait. Know your local policy about where the person should wait if they do not have capacity and are at high risk of leaving.

## Behavioural disturbance

There are many causes of acute behavioural disturbance, including medical conditions, situational crises and experiencing mental illness, intoxication or withdrawal.<sup>18</sup> Medical causes include head trauma, thyroid disease, delirium, hypoglycaemia, encephalitis, encephalopathy, toxins (including medication) and pain (especially in people with an intellectual disability).<sup>18</sup>

Use the Mental Health Triage Tool (see [Table 5.2](#)) and, when safe and appropriate, always obtain a:

- Detailed history
- Physical examination, at an appropriate and safe time
- Set of vital signs (heart rate, respiratory rate, blood pressure, temperature, conscious state)
- Blood sugar level.

 **Key point**

The clinical condition of people displaying acute behavioural disturbance can change quickly, so regular reassessment is important.<sup>18</sup>

## Psychostimulants

Common psychostimulants include methamphetamines (ice/crystal meth, base and speed). Psychostimulants may cause symptoms similar to paranoid psychosis, including delusions of persecution, hallucinations and violent outbursts. Follow the descriptors in the Mental Health Triage Tool summary (see [Table 5.2](#)) to determine urgency.

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## Considerations for specific groups

Some people have additional risk factors for past trauma, discrimination, social exclusion, isolation and mental illness. For example:

- First Nations people
- People experiencing homelessness
- LGBTIQ+ people
- People from culturally and linguistically diverse backgrounds
- Refugees and asylum seekers
- People with an intellectual disability
- People in rural and remote Australia
- Veterans and people in the military
- Perinatal women.<sup>2,19-21</sup>

Understanding the person's individual experience and using the principles of trauma-informed care is particularly important for these people.<sup>20</sup> See **Chapter 3: Communication for triage** for more on trauma-informed care and language to assist specific populations feel acknowledged and accepted at triage.

## The influence of culture and background

The way a person experiencing psychological distress presents may be strongly influenced by their culture, mental health literacy, education, language proficiency and perception of stigma.<sup>20,22</sup> Psychological distress may be considered a weakness in some cultures, and a source of shame or guilt.<sup>22</sup> Try to find out how the person's culture affects the way they think of, and experience, their psychological distress. Useful information includes:

- The person's description of the illness
- Cultural meaning or perception of this illness
- Perceived cause or explanation for mental health challenges
- Traditional treatment options.<sup>23</sup>



## Key point

Signs and symptoms may be expressed in spiritual, somatic or behavioural ways.<sup>23</sup>

Keep in mind that suicide is rarely spoken about in many communities, and may be considered unacceptable, a sin or a crime.<sup>19</sup> It is still important to raise the issue; for example, by prefacing specific questions about the person's thoughts of suicide with 'sometimes people will feel sad or worried, or may be having a tough time. Some people who feel like this may think about taking their life.'

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## First Nations people

The rate that First Nations people present to ED with mental health challenges is more than four times that of other Australians.<sup>24</sup> First Nations people may also have complicated healthcare needs due to multiple stressors, such as socioeconomic disadvantage, chronic illness, racism, inter-generational trauma and poor past experiences of healthcare services.<sup>25</sup>

Keep the following points in mind when interpreting your findings:

- Spiritual beliefs: consider the cultural norm in the person's community to avoid assumptions about hallucinations, delusions, pathological thinking or signs of emotional imbalance
- Don't mistake shyness or shame for sadness, or reserved responses as a sign of flat affect
- Minimal speech or delayed answers may not be a sign of slow or impaired functioning – gaps of silence can have various meanings, such as the person is reflecting on information or feeling uncomfortable in an unfamiliar environment
- Involve First Nations staff and support people if possible (with the person's permission).<sup>26</sup>



## Key point

First Nations people may prefer the term 'social and emotional wellbeing' to describe a holistic view of health that includes mental health as well as the emotional, spiritual, social, cultural and physical wellbeing of a person and their community.<sup>25</sup>

## People from refugee backgrounds

Many people from refugee backgrounds, including people seeking asylum, have experienced psychological trauma. Navigating life in a new country in this context may add to their risks for psychological distress.<sup>20</sup> Specific questions about experiences of torture and trauma are generally not advisable.<sup>20</sup>

## LGBTIQ+ people

LGBTIQ+ people have higher rates of mental health challenges than the general population, often because of experience of stigma and discrimination, including from family members and healthcare staff. For guidance on providing inclusive and supportive care, see LGBTIQ+ Health Australia's [Workforce Resources](#) and [LGBTIQ+ patients](#) in **Chapter 3: Communication for triage**.

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## Young people

Rates of mental health presentations related to mental health challenges in young people have increased in Australian EDs in the past decade.<sup>27,28</sup> Common ED presentations in this group include stress-related, mood, behavioural and emotional disorders, self-harm and psychoactive substance use.<sup>28</sup>

People with autism spectrum disorder or ADHD are over-represented among young people presenting to ED with acute severe behavioural disturbance.<sup>29</sup> **Chapter 3: Communication for triage** has [communication and comfort tips](#) for people with cognitive issues and neurodiversity.

When assessing a child or adolescent, always consider their family, peer, social and educational context.<sup>2</sup> Involve parents, carers or guardians if they are present, but also see the young person alone for part of the assessment to allow them to share sensitive information confidentially.<sup>2,30</sup> Explain confidentiality to the young person, and the circumstances when you would have to inform other people or agencies.<sup>2</sup>

Other principles to consider with young people include:

- Suicidal thinking in young people should always be taken seriously
- Co-morbidity of physical and psychological problems is common
- Delirium is common and can have a rapid onset
- Substance use disorders are common<sup>2</sup>
- Signs of depression in children include somatic complaints, sad appearance, non-communicativeness, separation anxiety and irritability
- Emotional sequelae are common in children with chronic illness<sup>2</sup>
- Signs of depression in adolescents include irritability, social withdrawal, declining school performance and oppositional behaviour
- Anger in adolescents may reflect shame, hurt, guilt, fear or vulnerability.<sup>2</sup>

## Older people

The interplay of biological, psychological and social issues can make assessment of older people challenging. Be alert to the possibility of delirium in older people with acute onset of unusual behaviour. See **Chapter 8: Older people** for more information.

 Key point

Delirium is a common cause of aggression and challenging behaviours in an older person, although depression and thought disorder may also cause behavioural changes.<sup>2</sup>

Consider the following when assessing older people:

- An agitated older person may have major depression
- Withdrawn behaviour may be a sign of a hypoactive form of delirium, depression or cognitive impairment
- Older men have high rates of death by suicide, and men aged over 80 years have the highest rate per capita in Australia<sup>11</sup>
- Physical illness and functional impairment are often associated with depression
- Change from their baseline functioning (for example, how are they now compared to two weeks ago?)
- Medication (prescribed or over the counter) can cause a variety of psychological symptoms
- Misinterpretations of the environment can be due to sensory deficits.<sup>2</sup>

Older people may minimise depressive or suicidal symptoms and are more likely to report somatic symptoms such as insomnia, weight loss and pain.

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**Take-home messages**

In summary, remember:

- Trauma-informed care makes a positive and safe experience more likely for the person, their support person and for you
- There are many causes of acute behavioural disturbance, including medical conditions, situational crises, mental illness and intoxication or withdrawal
- Perform the usual physical assessment, including primary survey steps A–E, before the psychological distress or behavioural disturbance assessment, and incorporate findings from each in your triage decision
- The way a person experiencing psychological distress presents may be strongly influenced by their culture, gender, previous experiences of health care, mental health literacy, education, language proficiency and perception of stigma
- Asking about suicidal thoughts, when appropriate, is important and does not increase the risk of suicide
- For people experiencing thought disorder, give a message of safety and de-escalate their stress as much as possible
- Be alert to the possibility of delirium in people with acute onset of changed behaviour, especially in older people and those with previous neuro-cognitive illness.

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## Educator resources

## Considerations for your site

Your role as an educator is to explain:

- Environmental considerations, such as barriers, open area, small spaces – how you can manage the need for privacy and safety for staff, the person and their support person
- Local policies and other staff you can call for help, such as a mental health clinical nurse consultant or nurse practitioner
- Local models of care, such as a referral pathway
- Appropriate locations in the ED to support observation and assessment of the person, and criteria used to support decision-making about locations (for example, is there a safe assessment room?)
- How and when you call for security
- State- or territory-based legislation for involuntary care (for example, Mental Health Act).

## Discussion points

Help learners consolidate their understanding by discussing the points below:

- Questions and communication techniques you can use to gather your assessment data; use cases to highlight relevant issues
- How to determine red flags in different types of presentations; the case studies below may be useful
- Assessment of a person's risk of self-harm at triage
- Key risk factors for suicide and how to assess these at triage.

## Case studies

The case studies below highlight common presentations and low-frequency, high-risk presentations. Work through these cases with learners using the discussion points.

## Case study 1: Suicidal thoughts in an older man

An 81-year-old man is brought in by police after telling his family he has no reason to live since his wife died a week ago. He says he 'just wants to be let go' and plans to take his wife's leftover medication. During assessment, you notice he is withdrawn, gives limited responses to questions and mentions a history of renal dialysis. On physical examination, you find he has elevated blood pressure and a slow heart rate.

## Discussion points

This man has a high suicide risk: he is older, has a recent bereavement, has a plan for suicide and access to the means to carry it out. Refer to the Mental Health Triage Tool (see [Table 5.2](#)) descriptors to determine the appropriate triage category.

You should do a physical assessment to check for signs of an organic cause. As an older person caring for his wife, he may not have been looking after himself well. This increases the likelihood of an organic contributor to his state of mind. His history of renal dialysis adds to this risk. The physical examination findings in this case add to the urgency for care.

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## Case study 2: Auditory hallucinations

A 34-year-old woman self-presents saying that she needs to speak with the mental health team because she is hearing voices and it is worse than usual. She says she has run out of her regular medications for schizophrenia and that she is not eating well. She seems withdrawn and her clothes appear baggy on her.

## Vital signs, case study 2

RR /min	HR /min	BP mmHg	T °C	BGL mol/L
16	98	102/65	36.5	5.3

## Discussion points

Consider where would be an appropriate place in the ED for this woman to wait, given that she is alone, hearing voices and has not been taking her medication. She may not have the clear decision-making capacity to wait alone in the waiting room. If she is able to tell you, knowing what the voices are saying and how ordered her thoughts are will also help you decide on the safest place for her to wait.

Consider how you might adjust your approach if this woman belonged to one of the groups mentioned in [Considerations for specific groups](#). What communication techniques or behaviours could you use to help her feel more comfortable?

## Case study 3: Psychological distress

A 52-year-old man is brought in by his parents, who describe his increased distress and lack of contact with them over the past two weeks since his wife left him. He is crying and says he wants to go home. He will not answer your questions about thoughts of suicide or self-harm. His parents are stressed because he is not engaging with them.

## Discussion points

- Refer to the open-ended questions in [Table 5.1](#). If these approaches fail, pushing him further to answer questions about suicide risk may do more harm than good. His interactions with his parents may guide your triage decision
- How would observed friction with his parents versus supportive interactions influence your thinking?
- How would this family dynamic influence where you might allocate this man post-triage?
- What adjustments might you make if he was from a culturally and linguistically diverse background?
- What adjustments might you make if he was a teenager whose first serious relationship has ended?

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## Case study 4: Overdose

A 32-year-old woman is brought in by paramedics after taking an overdose of sertraline (12 × 50 mg) and drinking a bottle of wine. She called Lifeline, who called the paramedics.

The woman is crying and saying she doesn't want to die. She tells you she had a serious argument with her partner. Your primary survey shows no physiological abnormalities. She has a history of depression.

## Discussion points

She appears intoxicated, so is at risk of leaving and not understanding the consequences of her decisions. Her suicide risk is high because she has a plan, access to the means and a relevant history (depression).

The recent stressor of the argument with her partner adds to her risk. Her depression is also not well managed currently because she hasn't been taking her medication regularly. How do these factors relate to the observed and reported descriptors in the Mental Health Triage Tool (see [Table 5.2](#))?

Case study 5: Cognitive impairment  
and behaviour changes

A 40-year-old man with an intellectual disability has been brought in by carers from his group home. His carers tell you that hitting his head and biting are normal for him, but that these behaviours have increased over the past 12 hours. They have noticed he is off his food, but his bowel function and urination are normal; they have given him all the additional PRN medication they have access to.

You are unable to measure vital signs. He is non-verbal and requires the two carers to stop him hitting his head on the wall.

## Discussion points

Behaviour change in a person with cognitive impairment may indicate pain or other organic cause such as delirium. Your physical assessment is important in this situation. Safety for the person and others is paramount and this need may be an indicator to assign a higher triage category.

Carers or support people can be an invaluable source of information about what normally calms the person – ask their advice and employ these strategies.

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## Case study 6: Suicidal intent

Paramedics and police bring in a 30-year-old woman who told her partner that she was going to 'jump in front of a train' and then left the couple's home and refused to answer phone calls. Her partner contacted emergency services, who had received a call about a woman of similar appearance standing close to the edge of the tracks at a nearby train station. Station staff had reported that she would not speak with them and had not boarded a train. She refused to speak with paramedics and required police assistance to remove her from the train station and escort her to hospital.

The woman doesn't appear intoxicated. She is sitting with police officers and is continuously tapping and jiggling her leg and looking towards the door. Police officers have redirected her back to her seat a few times. She is refusing to answer any questions about thoughts of suicide or self-harm. Her partner had informed emergency services that she has a history of self-harm and previous suicide attempts.

## Discussion points

This woman has a high risk of suicide – she has a high lethality plan with intent. She poses a risk of absconding. She is acting impulsively, experiencing interpersonal conflict, current suicidal thoughts and hostility that required police assistance.

Her impulsivity and restlessness make remaining in the waiting room inappropriate. Safety for the woman is paramount. Despite currently sitting calmly, other behaviour indicators such as restlessness and unwillingness to engage suggest a need to assign a higher triage category and find an appropriate space inside the ED to wait for assessment.

## Case study 7: Relationship stressors in an adolescent

A 17-year-old girl is brought in by her friend. The friend is concerned by a message the girl sent after having a fight with her partner, stating that she didn't want to wake up in the morning. The girl is currently living alone while her parents are away. You observe the girl to be teary and not making eye contact. When you talk to her, she responds with short answers and says, 'I really didn't mean it.'

## Discussion points

Consider [Table 5.1](#) and how you could assess the girl using shorter, more casual questions to match a younger person's conversational style. In many cases, an issue with a relationship will impact on a person's presentation, and questions such as 'Has anyone been mean or horrible to you' can give them a chance to give their interpretation of events. Don't be surprised if it's difficult to build rapport at triage with adolescents, who may need more time and support to discuss thoughts and feelings.

Observation of behaviour is also an important part of your assessment. Look for extremes, such as agitation, restlessness, a lack of emotion or swinging emotions.

Additional considerations include:

- Location post-triage – the risk of impulsive behaviour means that the girl needs a post-triage location that allows for close observation; she should also be placed away from visible exit doors. Consider what local processes and protocols guide where she might be able to safely wait
- Try to match the triage nurse's and young person's gender if possible
- She may be reluctant to engage with clinicians of her parents' age
- Offering food can be a good icebreaker (for example, 'Are you hungry? I'm hungry, let's have a biscuit')
- Offering help with phone charging also shows an understanding of adolescents' communication needs (but be aware of self-harm risk with cords).

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## Supporting resources

- [Clinical Update – Mental Health Assessment with Tim Wand](#), *This Emergency Life* podcast
- [Better Mental Health in the ED](#), Australasian College for Emergency Medicine (free registration required)
- [Trauma-Informed Care and Practice in Mental Health Services](#), NSW Agency for Clinical Innovation
- [Supporting CALD Communities to Talk about Suicide – a guide for professionals](#), Conversations Matter
- [Working with Aboriginal Communities in NSW – A resource for professionals](#), a series of fact sheets to guide conversations about suicide, Conversations Matter
- [Workforce resources](#), LGBTIQ+ Health Australia
- [Soft Words](#), video, Safewards
- [Calm Down Methods](#), video, Safewards
- [Mental health resources](#), Emergency Care Institute NSW.

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# Chapter 6: Pregnancy

## About this chapter

This chapter assumes knowledge of common and high-risk pregnancy-related presentations and maternal medical terminology.

## Learning outcomes

After completing this chapter you will be able to:

- State the main physiological and anatomical changes that occur in pregnancy and explain how these changes influence the assignment of a triage category
- Identify the common conditions with which pregnant women present to triage, and discuss how urgency is determined for the woman and foetus
- Apply strategies to support the pregnant woman's psychological needs when presenting to the ED.

### A note about terms

In this chapter, we have used the words 'woman' and 'women' as this is the way that most people who are pregnant will identify. Using these words is not intended to exclude those who give birth and do not identify as women.

## Background

Pregnant women may present with any injury or illness. Pregnancy changes the presentation of some illnesses, and some illnesses only occur in pregnancy. Compared to non-pregnant women of child-bearing age, pregnant women are at an increased risk of some specific conditions.

Pregnancy is a natural process and complications are rare, but when complications occur they often create a high risk of adverse outcomes for the pregnant woman and/or the foetus. Early warning signs of severe illness in pregnant women often go unrecognised. Early detection is a challenge because of the physiological and anatomical adaptations of pregnancy that can affect assessment.<sup>1</sup>

For this chapter, the population group is defined as women who are pregnant or up to six weeks postpartum. Triage should consider the wellbeing of both the woman and the foetus and potential threats to either.



### Key point

It is important to have a high suspicion of pregnancy in all women of child-bearing age.

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## Common presentations

Knowledge of common pregnancy-related presentations will help inform your assessment of urgency. Some of the presentations seen in the ED are outlined below.

## Under 20 weeks' gestation

## Vaginal bleeding

This is the most common presentation before 20 weeks. Common maternity-related causes include:

- Miscarriage (threatened, inevitable, complete, incomplete and septic)
- [Ectopic pregnancy](#).

## Nausea and vomiting

Women will commonly present to ED with pregnancy-related nausea and vomiting, which usually starts about week six. Causes are unknown, but nausea and vomiting are linked to hormonal changes. In hyperemesis gravidarum, the woman has severe and persistent vomiting that prevents adequate intake of food and fluids. Occurring in up to 3.6% of pregnancies<sup>2</sup>, hyperemesis gravidarum can result in severe fluid and electrolyte disturbances and is associated with venous thrombosis.

## Abdominal pain

Maternity-related causes include:

- Miscarriage
- [Ectopic pregnancy](#)
- Implantation pain
- Hyperosmolar syndrome
- Infection.<sup>3</sup>

## Over 20 weeks' gestation

## Vaginal bleeding

Maternity-related causes include:

- Pre-term rupture of the membranes and labour
- Antepartum haemorrhage, defined as >15 mL of blood loss from the vagina from 20 weeks' gestation. Common causes of antepartum haemorrhage include placenta praevia and placental abruption. In placenta praevia, per vaginal (PV) blood loss is usually visible and not usually accompanied by pain.

## Abdominal pain

Maternity-related causes include:

- Placental abruption: symptoms include abdominal pain and a tense, hard abdomen. Associated blood loss may be concealed between the placenta and uterine wall
- Pre-term and term labour: pain comes and goes but may be constant if associated with placental abruption.



## Key point

Suspect ectopic pregnancy in all women of child-bearing age who present with abdominal pain.<sup>1</sup>

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**Hypertension (BP  $\geq$ 140/90 mmHg)**

Maternity-related causes include:

- Pre-eclampsia
- HELLP (haemolysis, elevated liver enzymes and low platelet) syndrome is a severe form of pre-eclampsia.

Other symptoms suggestive of pre-eclampsia:

- Headache
- Vision changes
- Epigastric pain
- Right upper quadrant pain
- Non-dependent oedema
- Reduction or absence of foetal movements.

**Up to six weeks postpartum**

Postnatal women may present with the following:

**PV bleeding and discharge**Postpartum haemorrhage is the loss of 500 mL or more of blood from the genital tract following childbirth.<sup>4</sup> There are two types of postpartum haemorrhage:

- Primary: within 24 hours after delivery
- Secondary: between 24 hours and six weeks after delivery.

Retained products of conception can cause infection and increase the risk of postpartum haemorrhage.

**Pain**

Maternity-related causes include:

- Wound infections (secondary to Caesarean section or episiotomy)
- Mastitis
- Retained products of conception.

**Hypertension**

Maternity-related causes include:

- Eclampsia and pre-eclampsia.

**Neurological symptoms**

Maternity-related causes include:

- Generalised seizure (could be eclampsia up to two weeks postpartum or another cause)
- Stroke (cerebral venous thrombosis is more common in the postpartum period).

**Psychological distress and behavioural disturbance**

Maternity-related causes include:

- Postnatal depression
- Postpartum psychosis.

**New physiological symptoms, such as palpitations or shortness of breath**

Maternity-related causes include:

- Postpartum cardiomyopathy
- Amniotic fluid embolus
- Pulmonary embolus
- Heart failure, related to known or unknown cardiac disease.

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## Approach

## Holistic approach to the pregnant woman

It is important to respond to a pregnant woman's psychological needs as well as her physical needs. This is especially true for women who present with early bleeding, which can be traumatic due to the risk of pregnancy loss.<sup>5</sup>

When communicating with women presenting with bleeding in early pregnancy:

- Be an active listener and show thoughtfulness and empathy<sup>6</sup>
- Acknowledge and validate their concerns and distress, particularly if pregnancy loss is a possible outcome<sup>6</sup>
- Communicate clearly about what to expect during their ED visit<sup>6</sup>
- Use sensitive and plain language – acknowledge the trauma of the pregnancy loss<sup>6-8</sup>
- Avoid hurtful comments, such as 'It's probably for the best' or 'You can always try again'.<sup>5</sup>

'I think if there is any kind of loss or concern for the woman, they need to give you privacy to be able to talk or cry... I think that helps women deal with what is going on.'

– Woman presenting to ED with early pregnancy bleeding<sup>6</sup>

## Include and respect the partner

Women and their partners 'present as one' when coming to the ED with problems in pregnancy such as possible miscarriage.<sup>5</sup> It is important to communicate with both the woman and her partner.<sup>5</sup> If partners feel excluded, it can lead to agitation and anger, especially when combined with a long wait.<sup>5,7</sup>

It is important to:<sup>5</sup>

- Be aware of the partner's role and emotional needs
- Acknowledge and include the partner in care.

'When we got to the front, the lady at the desk told people to step back behind the line so they couldn't listen in on my conversation... If she hadn't, I may have spoken softly or been a bit more shy about it because of people around.'

– Woman presenting to ED with early pregnancy bleeding<sup>6</sup>



## Key point

Talk to your educator about how to manage privacy for assessment, discussions and waiting within your local conditions.

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## Red flags

You should be on high alert for the presentations below.<sup>1</sup> The presence of one or more of these signs and symptoms suggests a serious injury or condition:

- Tachycardia and increased respiratory rate, with or without hypotension
- PV bleeding, abdominal pain and amenorrhoea, with or without shoulder tip pain
- Severe pain, including abdominal, chest or headache
- Symptoms suggestive of pre-eclampsia, such as hypertension, visual disturbances, persistent headache and right upper quadrant pain
- Reduced or absent foetal movements
- Hypertension
- Fever (maternity-adjusted threshold)
- Breathlessness at rest or when lying flat
- Bright red blood loss more than four days postpartum.

*'A tachycardic patient is hypovolaemic until proved otherwise. A patient with tachypnoea has a cardiorespiratory cause until proved otherwise. Attributing tachycardia and tachypnoea to anxiety is naïve and dangerous.'*

*– Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer<sup>9</sup>*

## Assessment

## Airway

## Physiological background

- Pregnant women commonly experience increased nasal and airway vascularisation and mucosal oedema.

## Potential problems

- Injury and swelling in the airway increase the risk of airway compromise.

## Breathing

## Physiological background

- Progesterone changes the sensitivity of the respiratory centre and can increase the drive to breathe, which increases tidal volume but has no significant impact on respiratory rate
- Oxygen consumption increases by 20% during pregnancy and oxygen saturation remains above 95% in healthy pregnant women.<sup>1</sup>



## Key point

Pregnant women who are sick often look well for longer than they would when not pregnant due to the physiological compensatory changes of pregnancy.<sup>1</sup> If available, use maternal observation charts to detect deterioration.<sup>10</sup>

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## Potential problems

- Changes in the woman's oxygen saturation can affect foetal wellbeing. A small reduction in maternal oxygenation can severely affect foetal oxygenation because of the left shift in the oxyhaemoglobin dissociation curve associated with foetal haemoglobin. Consider assessing oxygen saturation when triaging all pregnant women
- About one-third of women with asthma experience a deterioration of their illness during pregnancy
- Pregnancy is associated with severe acute respiratory infection due to a decreased ability to fight infection
- There is a higher risk of pulmonary embolism during pregnancy due to changes in the coagulation system – breathlessness and tachycardia are key to recognising pulmonary embolism
- A feeling of breathlessness is common in pregnancy, especially during the third trimester.<sup>1</sup> However, breathlessness at rest or a need to sleep on multiple pillows (or in a chair) are significant symptoms and may indicate cardiac failure or pulmonary embolism.

'A full set of vital signs on every pregnant woman increases the chance of early identification of deterioration for the mother and foetus.'

– Nurse educator

## Circulation

## Physiological background

- Pregnancy is a hyperdynamic state and physiological changes occur as early as 6–8 weeks' gestation
- Heart rate increases by 10–15 beats per minute
- Progesterone causes widespread vasodilatation
- Oestrogen is thought to contribute to a 40–50% increase in blood volume
- Diastolic blood pressure falls during pregnancy, with BP lowest during the second trimester
- Cardiac output increases by 30–50%. By term, the uterus receives 500–700 mL of blood per minute.<sup>1</sup>

## Potential problems

## Blood pressure

- Hypertension (>140/90 mmHg) is an important sign of a more serious problem, such as pre-eclampsia. A woman who also has associated symptoms of pre-eclampsia is at risk of having an eclamptic seizure and placental abruption, and the foetus is at a higher risk of placental insufficiency
- In women with pre-eclampsia, intracranial haemorrhage can occur with relatively mild levels of hypertension compared to the general population<sup>11</sup>
- Major changes in blood pressure (high or low) are not well tolerated by the foetus.

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## Blood flow and vessels

- High-volume, dynamic blood flow and unspecified changes to blood vessels predispose pregnant women to spontaneous arterial dissections
- The splenic artery, subclavian artery, coronary artery and aorta have an increased tendency to spontaneous dissection, even in women with no previous medical history
- The risk of DVT is increased during pregnancy due to changes in clotting.

## Blood loss

- Women with non-ruptured ectopic pregnancies generally present with vaginal bleeding (most commonly brown) due to low progesterone and consequent shedding of the decidua
- Active vaginal bleeding at any gestation is a risk to the foetus
- Substantial concealed haemorrhage, such as placental abruption, may not initially result in significant changes in heart rate and blood pressure.

## Cardiac

- Physiological changes can unmask previously unknown cardiac disease
- Women can present with signs and symptoms of heart failure
- Pregnant women may present with arrhythmias, such as supraventricular tachycardia, even without underlying cardiac disease.

## Disability

## Physiological background

- Changes in circulation as listed previously.

## Potential problems

- The risk of cerebral haemorrhage (especially sub-arachnoid haemorrhage) is increased in pregnancy
- Women with insulin-dependent diabetes may experience hypoglycaemic episodes in early pregnancy.

'Take notice of the woman's intuition. Be alert if they tell you something isn't right even if they can't find the words to describe the specific problem.'

– Nurse educator

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## Exposure

## Physiological background

- The febrile response is reduced due to decreased immune response during pregnancy
- Despite the increase in metabolic rate, temperature remains in the normal range during healthy pregnancy, due in part to the generalised vasodilation
- The location of organs and abdominal pelvic structure will be different in different stages of pregnancy
- Placental hormones relax joints and ligaments, potentially causing pain and increasing the risk of injury.

## Potential problems

## Infection

- The decrease in immunity increases the risk of infection and sepsis during pregnancy. Although a woman may have infection without temperature, a raised temperature is a concerning sign.

## Pain

- Shoulder tip pain can indicate a ruptured ectopic pregnancy
- Abdominal pain may represent a pathological process threatening the foetus. It is the most common symptom in ruptured ectopic pregnancy (see Ectopic pregnancy, right)
- An abdomen that is hard and tender to palpation is a concerning sign.

## Ectopic pregnancy

Many women who come into the ED with symptoms of ectopic pregnancy don't know – or don't tell you – that they are pregnant.<sup>1</sup> This means it is important to consider ectopic pregnancy in all women of child-bearing age who present with abdominal pain.

Symptoms of an ectopic pregnancy include:

- Lower abdominal unilateral pain
- Light vaginal bleeding following a period of amenorrhoea
- Shoulder tip pain
- Shock.<sup>1</sup>

Less specific symptoms include generalised abdominal pain, diarrhoea and vomiting. Syncope in early pregnancy may indicate an ectopic pregnancy.<sup>1</sup>

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## Focused assessment

Once you have identified and excluded life-threatening conditions for the mother and the foetus in the A-E assessment, you need to perform a focused systems assessment. For maternal presentations, this assessment includes:

- Pregnancy status, gestation and whether the woman has had an ultrasound in this pregnancy
- History of previous ectopic pregnancies, STIs, gynaecological surgery, IVF and the use of oral and intrauterine contraceptive devices
- History of previous births and type of delivery
- The volume and colour of PV loss. This will help to categorise the urgency of the case. Bright red blood loss is usually a sign of active bleeding, while brownish red blood loss is usually old
- Absent or reduced foetal movements.

## Other considerations

## Sepsis

Pregnant women are at greater risk of sepsis due to decreased immune function. Sepsis may present differently due to physiological changes in pregnancy.<sup>12</sup>

- Refer to local maternal observation charts
- Refer to your local sepsis pathway
- Consider the specific differences for a pregnant woman's observations.<sup>10,13</sup>

## When a woman is in labour

## Signs of imminent birth

- Strong regular contractions
- Low back pain
- Feeling a pressure in the vagina or rectum
- Urge to push or involuntary pushing while grunting.<sup>1</sup>

Consider your local resources and if there is time to move the woman to a birthing suite if available or move to an appropriate location in ED.

## If the cord is on show

A woman whose waters have broken may report a sensation in the vagina or between her legs. The baby's head can then engage and compress the cord. Place the woman in a kneeling position – with head down and hips high – to reduce pressure on the cord.<sup>14</sup>

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## Trauma

Trauma in pregnancy is one of the most common causes of coincidental deaths in pregnant women. (Coincidental deaths occur during pregnancy, but are not caused by pregnancy.)<sup>15</sup>

Even minor injuries in pregnant women have been associated with placental abruption, pre-term labour, massive foeto-maternal haemorrhage, uterine rupture and foetal loss.<sup>16</sup>

When assessing a pregnant woman with trauma:

- Consider all the usual trauma criteria
- Also consider trauma to the uterus, placenta or foetus
- Be aware that a pregnant woman's vital signs may remain stable even when she has lost one-third of blood volume.

## Domestic and family violence

Domestic violence can be more common and severe during pregnancy. It is associated with an increase in obstetric complications for the mother and adverse foetal outcomes.<sup>1</sup>

You should be on high alert to consider domestic violence when:

- A woman presents with depression, anxiety, self-harm or somatic symptoms
- Her description of events does not match her symptoms
- She has had repeated ED attendances
- She is reluctant to speak about her injuries in the presence of her partner.<sup>17</sup>

Follow local processes for escalation and reporting for the mother and the foetus.

## Take-home messages

In summary, remember that:

- It is important to have a high suspicion of pregnancy in all women of child-bearing age
- While pregnancy is a natural process and complications are rare, complications are often high risk
- Pregnant women who are sick often look well for longer than they would if they were not pregnant
- You need to consider the pregnant woman's psychological needs as well as her physical needs
- It is important to acknowledge and include the woman's partner in care
- You should consider ectopic pregnancy in all women of child-bearing age who present with abdominal pain.

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## Considerations for your site

Your role as an educator is to explain:

- Local policies on referral, clinical escalation and identification of child protection issues and violence and neglect
- The local process for use of maternal observation charts
- How escalation will occur for pregnant women presenting to your service (for example, transfer to a birthing suite or early referral to retrieval services if there are no maternity services on site, and recognition and response to trauma)
- Conditions with which pregnant women will present to your ED
- Referral pathways to access pregnancy care in the local area
- Local policies to recognise and respond to maternal sepsis.

## Discussion points

Help learners consolidate their understanding by discussing the points below.

- What are the key questions you would ask a woman presenting to triage at:
  - Under 20 weeks' gestation
  - Over 20 weeks' gestation.

Think of the high-risk presenting problems you might want to exclude at these two pregnancy stages to structure your assessment.
- Consider the following information and how it affects your triage category for a 42-year-old woman with no other symptoms, G4P1, in these two situations:
  - 30 weeks' gestation, presents with no foetal movements since waking two hours ago
  - 12 weeks' gestation, presents after an ultrasound that detected no foetal heart rate.
- What additional information would you require to assign a triage category for a 28-year-old woman, G1P0, with the following history and symptoms:
  - 10 weeks' gestation, presents with vomiting, no diarrhoea and no fever
  - 39 weeks' gestation, presents with vomiting. She appears uncomfortable. She has not had diarrhoea but feels like she needs to open her bowels
  - 34 weeks' gestation, presents with vomiting, epigastric pain and a headache.

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## Case studies

The case studies below highlight common presentations and low-frequency, high-risk presentations during pregnancy.

## Case study 1: Bleeding and abdominal pain

A 26-year-old woman (G1P0 and eight weeks' gestation on ultrasound) presents after having a gush of PV blood and she is now passing clots. She describes the associated abdominal pain as like a severe period. She has no other relevant history.

## Vital signs, case study 1

RR /min	HR /min	BP mmHg	T °C
20	98	102/78	36.4

There are no beds available in the ED and she will need to return to the waiting room.

## Discussion points

- What triage category would you assign and why?
  - There isn't enough information about blood loss and pain assessment to assign a triage category
- Look at the ATS descriptors – what components of her triage would match the descriptors?
  - Are her vital signs outside normal parameters?
  - How much blood is she losing? (The number of pads used can help to differentiate between categories)
  - How severe is her pain?
- How would you write up this presentation to meet your triage documentation requirements?
- What information would you discuss with the woman at the conclusion of triage?
  - Ask if she has any questions
  - Acknowledge her situation
  - Ask if she needs any support
  - Tell her to come back if her pain or bleeding increase.

## Case study 2: Sudden lower abdominal pain

A 19-year-old woman presents with sudden onset lower abdominal cramping (pain score 6/10). She says she hasn't had a period for 'some time' but has had irregular and intermittent spotting. A pregnancy test four weeks ago was negative. She is a smoker. Pain on palpation to her abdomen is worse on the lower left side. She has left shoulder tip pain.

## Vital signs, case study 2

RR /min	HR /min	BP mmHg	T °C
18	97	98/68	37.3

## Discussion points

- Discuss the red flags in this case.
  - She could be pregnant, unilateral abdominal pain, left shoulder tip pain and low BP
- What triage category would you assign and why?
  - Triage category 2; positive findings suggestive of blood in the abdomen (pain and shoulder tip) as well as changes in haemodynamic status
- How would you write up this presentation to meet your triage documentation requirements?
  - Educator to lead this discussion to include local requirements.

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## Case study 3: Vomiting and diarrhoea

A 28-year-old woman (G2P1 and 30 weeks' gestation) presents with sudden onset of vomiting and one episode of diarrhoea. She says she keeps needing to pass urine. Her wife tells you her symptoms started about six hours ago and there have been numerous vomits. She now has abdominal pain, which she says is associated with vomiting. Nil PV loss. She can feel the baby move. She has been well throughout her pregnancy after some nausea at 8–10 weeks, but nil since. She feels warm and looks pale.

## Vital signs, case study 3

RR /min	SpO <sub>2</sub> %	HR /min	BP mmHg	T °C
24	96	108	101/65	37.9

## Discussion points

- Identify the red flags in this case and review them against the descriptors in the ATS to allocate a triage category.
  - Being pregnant
  - Acute onset of new vomiting and diarrhoea and urinary changes, which are risk factors for the sepsis pathway
  - Volume loss and looking pale (pregnant women can look well for longer)
  - Temperature is considered high for a pregnant woman.

While the other observations do not meet maternal track-and-trigger parameters, they are all borderline in their criteria. This means she would meet the sepsis pathway criteria with only a small change. It is important to ensure the woman is somewhere in your department where she will get reviewed regularly as she is at risk of deterioration.

- Where would you place this patient after triage? In your answer, consider the need for stabilisation in the ED, the ongoing care the patient may require, and your local facility's ability to provide that care or the need for retrieval to a larger facility. Consider the circumstances of the presentation, local policy, and access to higher-level care
- What local process would you use to monitor foetal heart rate and wellbeing?

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## Case study 4: A fall

A 30-year-old pregnant woman presents after falling off a step ladder. She rolled her ankle and landed heavily on her side on the ladder edge. She limps into triage and describes pain to her hip and right side. Her right lateral malleolus is swollen and her neurovascular observations are intact.

## Discussion points

Discuss the additional information you would need for triage if the woman was less than 12 weeks pregnant or more than 20 weeks pregnant.

- Under 12 weeks pregnant:
  - Does she have medical conditions?
  - Has her pregnancy been normal so far?
  - How far did she fall?

There is limited risk of direct trauma to the foetus at this stage of pregnancy because the uterus is still below the level of the symphysis pubis. However, due to neurovascular changes and increased blood flow, the injured ankle is more likely to swell and will need monitoring. Completing the triage will include sitting the woman where she can elevate her foot and applying ice.

- Over 20 weeks pregnant:
  - How long ago did this happen?
  - Has she felt the baby move since?
  - Does she have any PV bleeding or abdominal pain?

While there are many variables in this case, you would be concerned about a direct blow to the uterus damaging structures that provide blood flow to the foetus. Do a complete set of vital signs to look for haemodynamic instability because bleeding can be concealed.

- How would you manage an admission of this patient for observation in your local facility?

## Supporting resources

- [\*Maternity and Neonatal Clinical Guideline, Trauma in pregnancy\*](#), Queensland Health
- [\*Family and Domestic Violence and Abuse\*](#), Australasian College for Emergency Medicine
- [\*Perinatal Practice Guidelines\*](#), SA Health
- [\*Maternal Quality Improvement Toolkits\*](#), California Maternal Quality Care Collaborative
- [\*Irish Maternity Early Warning System\*](#), Government of Ireland
- [\*Sepsis Clinical Care Standard\*](#), Australian Commission on Safety and Quality in Health Care
- [\*Early Pregnancy Bleeding\*](#), Breeze C. *Australian Family Physician*
- [\*Gestation-Specific Vital Sign Reference Ranges In Pregnancy\*](#), Green et al. *Obstetrics & Gynecology*

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# Chapter 7: Paediatrics

## About this chapter

This chapter assumes knowledge of:

- Assessment of different age groups of paediatric patients, including infants
- Anatomical, physiological, cognitive and psychological differences between children and adults, and their impact on assessment, such as vital signs and communication
- Common diseases and injuries seen in the paediatric population
- Local policy requirements related to:
  - Paediatric patient deterioration and escalation
  - Child safety detection and reporting
  - Streaming and allocation of treatment areas.

## Learning outcomes

After completing this chapter, you will be able to:

- Identify the physical, mental, behavioural and psychosocial factors that inform the assessment of paediatric patients at triage
- Communicate effectively with children, their parents and carers and incorporate information into triage decision-making
- Apply the ATS, considering the different presentation patterns in children.

## Background

Children differ from adults anatomically, physiologically, cognitively and psychologically. As a result, they present with different symptoms and different types of illness and injury compared to adults.

*‘Developmental limitations mean that children can’t tell you what’s wrong... this makes the strategies and other resources you use to gather information at triage instrumental to safely identifying triage urgency.’*

– Lorelle Malyon, nurse educator, Queensland

### A note about terms

The definition of a child can vary by location, but in this chapter a child is defined as anyone aged under 18 years. Where appropriate, more specific age-related terms are used, such as ‘infant’ for children aged less than one year and ‘neonate’ for infants aged under four weeks.

‘Parent’ is used in this chapter to refer to the primary caregiver of the child, regardless of their relationship to the child. However, keep in mind that not all primary caregivers are the biological parent; some children are in out-of-home care and some present alone.

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A number of factors can make triage of paediatric patients more challenging compared to adults:

- Clinicians may be less familiar with the features of serious illness and injury in children, as they are not common
- Early signs of serious illness and injury can be more difficult to recognise and appreciate
- Seriously ill and injured children may initially appear stable before rapidly deteriorating – placing them at significant risk of poor outcomes
- There may be assessment difficulties in infants and young children due to their fear and lack of cooperation
- The history is often obtained from a parent
- Cultural issues may impact communication with families from culturally and linguistically diverse backgrounds.

This chapter gives you strategies for addressing these challenges.

## Approach

The general approach to triage has been described in **Chapter 2: Triage fundamentals**. Additional considerations are discussed in this chapter. Also see **Chapter 3: Communication for triage** for more tips.

## Age-appropriate strategies

### Infants and young children

Infants and young children are often fearful and distressed by the ED environment and strangers, making assessment particularly difficult. Many features of serious illness and injury are observable, so it is important to watch the child closely before attempting to examine them.

Information about the presentation is often provided by a parent. However, older children and young people should be included in the triage process and asked to provide details of their presenting problem and symptoms. Even young children can contribute useful details, especially if the child has been in the care of another adult or an injury was unwitnessed.

Involving the child will require you to develop rapport using a child-friendly approach and age-appropriate language. Distracting the child with a game or toys (for example, watching and reaching for bubbles) can relax them and aid your assessment.<sup>2</sup>

### Adolescents

Adolescents are usually able to give you information about their own history and presentation, and they should be given the opportunity to do this. Show that you are taking them seriously and that you are listening to what they are telling you.

Communication principles to keep in mind with adolescents include:

- Speak to them respectfully
- Include them in the discussion
- Show kindness and empathy
- Be non-judgemental
- Be aware of privacy and confidentiality concerns.<sup>3</sup>

*'I felt like they were stereotyping my presentation – just a teenage girl seen as psychosomatic. It's like if I say it they don't believe me, but if my parents say the same thing it's true.'*

– Representative, Sydney Children's Hospital Network youth council

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Young people may wish to discuss their health concerns without their parents present. Giving them this opportunity may increase the information available to inform your triage decision.

'It was super awkward, my dad took me to ED... I had stomach pain and I was feeling really sick. When we got to ED, the nurse kept asking questions, about things I didn't really want to talk about in front of my dad...'

– 16-year-old patient

## Young people with chronic illness

Paediatric patients, like adults, can be living with chronic disease and the complexity that comes with it. They will know their condition well, and older children may have important insights about what they usually need in the ED.

Keep in mind that they may have been putting off coming in, and then reached a point where they know from past experience that they need ED care. It is also important to recognise that their past experiences in the ED may make returning stressful.

'With a chronic illness when you come to ED you have been struggling at home for a while before you come to ED. You come in for help, but then you get "you don't look that sick".'

– Representative, Sydney Children's  
Hospital Network youth council

## Neurodiversity

Assessment of neurodiverse children can be difficult and their capacity to tolerate the ED environment may be lower than other children's. Parents will be able to provide advice regarding their child – consider this when making your triage assessment, determining urgency and allocating care environments.

See [Cognitive issues and neurodiversity – communication and comfort tips](#) in **Chapter 3: Communication for triage**.

## Expression of pain

Neurodiversity can influence the expression of pain. Some children with autism spectrum disorder express pain with atypical facial expressions, sensory processing difficulties, physiological responses and emotional responses.<sup>4</sup> Communication difficulties may mean that responses to pain are non-verbal, such as increased aggressive and repetitive behaviour.<sup>4</sup>

Consider the child's non-verbal responses, along with reports from the child and parents, and use an appropriate pain scale.<sup>4</sup>

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## The role of parents

Children presenting to the ED are usually accompanied by a parent. They are a vital source of information for your triage assessment. Parents also continue to provide care to their children, and advocate for their needs, during their presentation.

Information from parents may reveal:

- Red flags for serious illness
- The mechanism of injury, alerting you to the risk of specific and significant injuries
- Subtle but important deviations from normal that you may not be able to detect.

When talking with parents, remember to:

- Listen carefully to the information they provide about their child's condition
- Clarify understanding (yours and theirs) when necessary
- Acknowledge and address their concerns early.



## Key point

Parents can play a crucial role in detecting deterioration while in the ED – showing respect and taking their concerns seriously will encourage them to escalate changes in their child's condition.

Health literacy is variable among parents. Their knowledge and experience will influence their understanding and the information they provide. Use plain language when asking questions or giving information. Encourage them to explain what they mean and to give examples when needed.

Parents are often anxious when they bring their child to the ED and may hold specific fears about their child's condition. If left unaddressed, parents may feel that their concerns are not being taken seriously enough, which can lead to anger and aggression and difficulty establishing a therapeutic relationship. This in turn can affect communication throughout the ED journey and negatively impact the patient experience. Identifying and addressing these concerns early can help to avoid this and provide reassurance.

'Most of the parents that I deal with who become aggressive do so because they are anxious and frightened and feel as though we aren't listening. Avoiding this is about meeting their needs, but you can only do that if you know what they are – it might be as simple as asking them what they are worried about or what they are worried might happen...'

– Bec Adams, paediatric triage nurse and hospital code grey coordinator, Victoria

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## Red flags

Features of possible serious illness and risk of rapid deterioration in children include:

- Signs of respiratory distress
- Acute pallor
- Decreased activity or drowsiness
- Floppiness
- Inconsolable distress
- Decreased fluid intake (for example, less than half the usual volume in the past 24 hours) and output (such as less than four wet nappies in the past 24 hours)
- Looking unwell
- Parental concern
- Re-presentation
- Age less than 3 months and fever or temperature less than 36 °C.<sup>5-7</sup>

See Table 7.1, right, for selected low-frequency but high-risk presentations in children. Any of these features should prompt further, careful assessment and consideration of higher urgency.

Table 7.1: Selected low-frequency, high-risk paediatric presentations

Feature	Comment
Pale, floppy episodes in infants	Linked to serious illnesses, such as anaphylaxis and intussusception
Abdominal pain of sudden onset	Indicates risk of conditions needing urgent surgical treatment, including torsion of the testes or ovary
Tachycardia, especially if afebrile	Linked to sepsis
Bilious (green) vomiting	Indicates bowel obstruction
Exercise-induced collapse	Likely cardiac cause
Sudden onset of neurological symptoms in a previously well child	Linked to stroke
Magnets and button batteries	High-risk foreign bodies requiring urgent removal
Non-blanching rash	Associated with meningococcal disease
Severe mechanism of injury	e.g. fall >2 m, MVC* >60 km/h, ejection/rollover, prolonged extrication (>30 minutes), death of same-car occupant, pedestrian, MBC**/cyclist >30 km/h
Expressing intent to harm self or others	Suggests a triage category 2. See Chapter 5: Psychological distress and behavioural disturbance
Delayed presentation History inconsistent with the presentation	May suggest the child is at risk of harm

\*Motor vehicle collision \*\*Motorbike collision

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## Assessment

See [Table 7.2](#) for primary survey findings and corresponding triage categories.

## General appearance and vital signs

You can identify important features of serious illness by observing the child's general appearance at a distance before attempting to examine them more closely. A clinician's impression that the child 'looks sick' is a predictor of significant illness.<sup>5,7</sup>

Also consider the child's:

- Perfusion
- Respiratory effort
- Alertness
- Behaviour
- Muscle tone
- Interest in surroundings.

Abnormal vital signs indicate significant illness or injury. In contrast, normal vital signs do not exclude all serious illness and injury, and should be considered together with other assessment findings.<sup>1,8</sup>

 **Key point**

Use a systematic approach to the assessment of children, apply local track-and-trigger thresholds for escalation and remember the red flags associated with significant illness and injury in children.

## Airway

The size and structure of the airway in children significantly increases the risk of obstruction. A child's airway can be significantly compromised by relatively small amounts of swelling associated with common paediatric illnesses, such as croup and anaphylaxis, and by small foreign bodies.

Signs of obstruction include stridor and drooling. Determine the extent of the obstruction by assessing work of breathing – do this by observation to avoid upsetting the child and worsening their obstruction. The pitch or volume of the stridor should not be considered an indicator of the severity of the airway obstruction.

Although rare in children, cervical spine injury can be difficult to detect on physical assessment, so it is important to have high suspicion of this possibility, based on the mechanism of injury. Appropriate spinal precautions are difficult to maintain in uncooperative children. These factors may increase the relative urgency of this presentation.

## Breathing

Respiratory illnesses are common in children. Anatomical and physiological differences reduce their capacity to tolerate respiratory distress.

Your observation for signs of respiratory distress should include:

- Looking for nasal flaring and head bobbing
- Exposing the chest to look for signs of intercostal and subcostal retraction
- Counting the respiratory rate.

 **Key point**

Be vigilant when assessing children for serious illness and injury – while it is relatively uncommon, the signs can be difficult to recognise, and children can deteriorate rapidly.<sup>1</sup>

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Elevated respiratory rates more accurately predict serious illness and deterioration in children than other vital signs such as heart rate and blood pressure.<sup>8,9</sup> Hypoxaemia is poorly predicted by clinical signs, so should be confirmed by measuring oxygen saturation.<sup>10</sup> Grunting is an indicator of significant respiratory disease and is linked to poor outcomes.<sup>11,12</sup>

When assessing infants, include a brief assessment of feeding – reduced feeding can be an indirect indication of respiratory distress. It is also linked with more severe disease and the need for escalation of care.<sup>11,12</sup>

## Circulation

Triage assessment of circulation should include an assessment of heart rate and perfusion.

Assessment of perfusion should include:

- Inspecting skin for colour and signs of mottling
- Feeling for warmth and the strength of peripheral pulses
- Assessing capillary refill time.

Assessment items are only indirect indicators of perfusion, so you should not be reassured by a single normal finding.<sup>13</sup>

Increasing heart rate is the primary compensatory mechanism for hypovolaemia in children. However, a normal heart rate does not exclude the possibility of serious illness<sup>1</sup> and hypotension is a very late sign of haemodynamic compromise.

 Key point

In children with darker skin, it can be difficult to detect pallor, mottling and capillary refill time. It is crucial to use other parameters to evaluate perfusion, such as warmth, pulse volume and rate. It can be useful to look at nail beds, conjunctiva and palmar creases to assess perfusion.

## Dehydration

Illness in children is frequently accompanied by poor fluid intake and/or significant losses, which puts them at risk of dehydration. The severity of dehydration is best determined by the number of signs linked to dehydration as individual signs are not considered predictive.<sup>14</sup>

Signs linked to dehydration include:

- Decreased tissue turgor
- Decreased capillary refill time
- Sunken eyes
- Absent tears
- Dry mucous membranes
- Decreased urine output/wet nappies
- Tachycardia
- Weak pulse
- Reduced activity
- Looking unwell.

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## Disability

Neurological signs and symptoms can be subtle, and children develop cognitively and psychologically at varying rates. Therefore, assessment of these features will rely heavily on parents' information about what is normal for their child and what has changed.

Indicators of an urgent primary neurological condition, inadequate oxygenation or circulation, poisoning or metabolic derangements include:

- Decreased consciousness level
- Changes in behaviour, such as irritability or poor social engagement
- Changes in activity, such as increased sleep
- Reduced muscle tone
- Special considerations and parental input for children with disability.



## Key point

Low blood glucose can present as neurological changes, and early detection at triage will allow timely treatment.

## Stroke

Stroke is uncommon in children. It is frequently missed and is associated with significant morbidity and mortality. It is crucial to consider stroke in a child presenting with sudden onset of neurological symptoms, focal signs, poor coordination and headache, or new onset seizures associated with other neurological signs or symptoms.<sup>15</sup>

## Psychological distress and behavioural disturbance

A brief assessment of mental state, including risk of harm to self or others, should be undertaken for children and young people presenting with psychological distress or behavioural disturbance. Developmental factors and neurodiversity can significantly influence this assessment.

Parents can help you interpret the findings and determine urgency. Clinical and situational factors will contribute to the assessment of urgency. See **Chapter 5: Psychological distress and behavioural disturbance** for more information.

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Table 7.2: Primary survey findings and triage categories – children

Criterion	Category 1 Immediate	Category 2 Emergency	Category 3 Urgent	Category 4 Semi-urgent	Category 5 Non-urgent
<b>Airway</b>	<ul style="list-style-type: none"> <li>Obstruction</li> <li>Partial obstruction (e.g. stridor, drooling) with severe respiratory distress</li> <li>Immediate risk of obstruction</li> </ul>	<ul style="list-style-type: none"> <li>Partial obstruction (e.g. stridor, drooling) with moderate respiratory distress</li> <li>Imminent risk of obstruction</li> </ul>	<ul style="list-style-type: none"> <li>Partial obstruction (stridor only with activity, no drooling) with minimal respiratory distress</li> </ul>	No signs of obstruction	No signs of obstruction
<b>Breathing</b>	<ul style="list-style-type: none"> <li>Respiratory arrest</li> <li>Hypoventilation</li> <li>Signs of severe respiratory distress:                             <ul style="list-style-type: none"> <li>Severe use of accessory muscles</li> <li>Severe intercostal and subcostal retraction</li> <li>Acute cyanosis</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Signs of moderate respiratory distress:                             <ul style="list-style-type: none"> <li>Moderate use of accessory muscles</li> <li>Moderate retraction</li> <li>Tachypnoea</li> <li>Pallor</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Signs of mild respiratory distress:                             <ul style="list-style-type: none"> <li>Mild use of accessory muscles</li> <li>Mild retraction</li> <li>Normal perfusion</li> </ul> </li> </ul>	No signs of respiratory distress	No signs of respiratory distress
<b>Circulation</b>	<ul style="list-style-type: none"> <li>Cardiac arrest or severe bradycardia (e.g. HR &lt;60 bpm in an infant)</li> <li>Signs of severe shock:                             <ul style="list-style-type: none"> <li>Absent peripheral pulses</li> <li>Pallor, cold, clammy, mottled</li> <li>Severe tachycardia</li> <li>Capillary refill &gt;4 secs</li> </ul> </li> <li>Uncontrolled bleeding</li> </ul>	<ul style="list-style-type: none"> <li>Signs of shock:                             <ul style="list-style-type: none"> <li>Weak/thready peripheral pulses</li> <li>Pallor, cool</li> <li>Moderate tachycardia</li> <li>Capillary refill 3–4 secs</li> </ul> </li> <li>Signs of severe dehydration [&gt;5 signs]*</li> <li>Severe blood loss</li> </ul>	<ul style="list-style-type: none"> <li>Mild haemodynamic compromise:                             <ul style="list-style-type: none"> <li>Palpable peripheral pulses</li> <li>Pallor, warm</li> <li>Mild tachycardia</li> <li>Capillary refill 2 secs</li> </ul> </li> <li>Signs of moderate dehydration [3–5 signs]*</li> <li>Moderately severe blood loss</li> </ul>	<ul style="list-style-type: none"> <li>No signs of haemodynamic compromise</li> <li>Less than 3 signs of dehydration*</li> <li>Mild haemorrhage</li> </ul>	<ul style="list-style-type: none"> <li>No signs of haemodynamic compromise</li> <li>No signs of dehydration*</li> </ul>

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Table 7.2: Primary survey findings and triage categories – children (continued)

Criterion	Category 1 Immediate	Category 2 Emergency	Category 3 Urgent	Category 4 Semi-urgent	Category 5 Non-urgent
<b>Disability</b>	<ul style="list-style-type: none"> <li>Unresponsive or responds to pain only</li> <li>Ongoing/prolonged seizure</li> </ul>	<ul style="list-style-type: none"> <li>Decreased conscious state: GCS &lt;13</li> <li>Severe decrease in activity/change in behaviour:                             <ul style="list-style-type: none"> <li>Lethargic (quiet, disinterested in surroundings, goes back to sleep after being disturbed)</li> <li>No eye contact</li> <li>Decreased muscle tone</li> </ul> </li> <li>Focal neurological signs</li> <li>Severe pain</li> <li>BGL &lt;3 mmol/L</li> </ul>	<ul style="list-style-type: none"> <li>Head injury with short LOC, now alert</li> <li>Moderate decrease in activity/change in behaviour:                             <ul style="list-style-type: none"> <li>Lethargic (quiet, tired looking)</li> <li>Eye contact when disturbed</li> </ul> </li> <li>Moderately severe pain</li> </ul>	<ul style="list-style-type: none"> <li>Normal/no acute change to usual GCS</li> <li>Mild decrease in activity or change in behaviour:                             <ul style="list-style-type: none"> <li>Quiet but eye contact and interacts with parents</li> </ul> </li> <li>Moderate pain</li> </ul>	<ul style="list-style-type: none"> <li>Normal/no acute change to usual GCS</li> <li>No signs of lethargy or decrease in activity or change in behaviour:                             <ul style="list-style-type: none"> <li>Smiling, playing</li> </ul> </li> <li>Mild or no pain</li> </ul>
<b>Exposure</b>		Fever with signs of lethargy			
<b>Other (secondary survey red flags)</b>		<ul style="list-style-type: none"> <li>Major fracture</li> <li>Amputation (including partial)</li> <li>Suspected sepsis (physiologically unstable)</li> <li>Suspected testicular torsion</li> <li>Overdose or toxic ingestion</li> </ul>	<ul style="list-style-type: none"> <li>Parietal, occipital or temporal haematoma following a fall in a child under 2 years</li> <li>Limb – altered sensation, acutely absent pulse</li> <li>Stable neonate</li> <li>Sepsis (stable)</li> <li>Child at risk of abuse/suspected non-accidental injury</li> </ul>		

\* Signs of dehydration: Decreased tissue turgor; decreased capillary refill time; sunken eyes; absent tears; dry mucous membranes, decreased urine output or decreased wet nappies, tachycardia, weak pulse, reduced activity and looking unwell

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## Brain injury

Head injuries are common in children and most are not serious. Table 7.3, right, lists red flags for serious brain injury in children.

## Pain

Pain determines urgency, but many children are too young or unwell to report their pain. Under these circumstances, a parent's assessment is usually the most efficient way to obtain an indication of the child's pain to determine clinical urgency. Keep in mind that a stoic child may have a significant injury but state they are not in pain. Cultural factors can also impact how a child expresses pain.

The impact of pain on the child may compromise your ability to assess or interpret signs of significant illness or injury. You should be cautious when assuming that pain and/or distress is the cause of vital sign derangements.

## Exposure

The immune system is immature in neonates, infants and young children, which makes them more susceptible to infection and sepsis. However, they may not exhibit the classic signs of sepsis, such as fever and low blood pressure. Although fever should be considered a risk factor for serious illness in infants, hypothermia is a particularly concerning sign in this age group.

Rashes are a common feature of illness in infants and young children and are often worrying for parents. Rashes should be viewed at triage to identify non-blanching (petechial or purpuric) rashes. Also look for rashes suggesting an infectious disease, such as chicken pox or measles, which may require infection control actions.

Table 7.3: Red flags for serious brain injury in children

Age group	Feature
All	<ul style="list-style-type: none"> <li>GCS of 14 or less, or other signs of altered mental status</li> <li>Severe mechanism of injury</li> <li>Post-traumatic seizures</li> <li>Abnormal neurological examination</li> </ul>
Children aged less than 2 years	<ul style="list-style-type: none"> <li>Palpable skull fracture*</li> <li>Occipital, parietal or temporal scalp haematoma†</li> <li>History of loss of consciousness for 5 secs or more</li> <li>Not acting normally, according to parent</li> </ul>
Children aged 2 years and older	<ul style="list-style-type: none"> <li>Signs of base of skull fracture§</li> <li>History of loss of consciousness</li> <li>History of vomiting#</li> <li>Severe headache</li> </ul>

Source: Adapted from *Australia and New Zealand Guideline for Mild to Moderate Head Injuries in Children*<sup>16</sup>

\* Palpable skull fracture: on palpation or possibly based on swelling or distortion of the scalp

† Non-frontal scalp haematoma: occipital, parietal or temporal

§ Signs of base of skull fracture: haemotympanum, 'raccoon eyes', cerebrospinal fluid (CSF) otorrhoea or CSF rhinorrhoea, Battle's sign

# Isolated vomiting, without any other risk factors, is an uncommon presentation of clinically important traumatic brain injury. Vomiting, regardless of the number of episodes or persistence, in association with other risk factors, increases concern for clinically important traumatic brain injury.

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## Assessment tools

The Paediatric Assessment Triangle (PAT) is an example of a paediatric-specific rapid assessment that can help identify children requiring urgent care.<sup>17</sup> It has three components: appearance, work of breathing and circulation to the skin.

Paediatric early warning scores (PEWS) are designed to detect signs of deterioration and allow for early intervention. Their value to triage decision-making has not been fully explored, but it is likely that low scores should not be considered reassuring.<sup>18</sup> However, they point to important parameters for assessment and thresholds for escalation.

The vital signs components are the basis for the track-and-trigger systems in place in most hospitals. High PEWS scores or a breach in track-and-trigger thresholds are indicative of serious illness and potential for rapid deterioration.<sup>19</sup>

## Focused assessment

Once you have completed the primary survey and identified or excluded immediate and imminent life-threatening conditions, collect a brief past history and demographic details (see Table 7.4, right) and targeted history of the presenting problem (see Table 7.5). This will help identify risk factors for serious illness or injury and the potential for deterioration.

Past history and other demographic factors should also be evaluated for their potential impact on the child's condition and risk of deterioration.

Table 7.4: Past history and demographics

Topic	Notes
<b>Age, prematurity and low birth weight</b>	Neonates, infants and other younger children are particularly vulnerable to serious illness, including sepsis and respiratory illness, and those born prematurely are at additional risk <sup>6</sup>
<b>Pre-existing illnesses, including congenital diseases</b>	These increase the likelihood of contracting specific illnesses and the risk of more severe disease and poor outcomes (e.g. cardiac disease increases the risk of cardiorespiratory dysfunction associated with minor respiratory illnesses) <sup>2</sup>
<b>Allergies</b>	Allergies are extremely common and allergen exposure may account for the presentation
<b>Vaccination status</b>	Unvaccinated or partially vaccinated children are at increased risk of vaccine-preventable diseases – many of which are linked to serious illness
<b>Socioeconomic factors</b>	Children from socially disadvantaged and marginalised communities are at greater risk of serious illness and injury <sup>20</sup>

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Table 7.5: Targeted history – the presenting problem

Topic	Notes
<b>Oral intake</b>	Decreases should trigger concern regarding hydration, particularly when coupled with significant losses (e.g. vomiting and diarrhoea); decreased feeding is also a sign of serious illness and an indirect indication of respiratory distress in infants <sup>11,12</sup>
<b>Behaviour and activity levels</b>	Acute or recent changes in behaviour (e.g. irritability) and reduction in activity may indicate significant illness and injury <sup>2,20</sup>
<b>Mechanism of injury</b>	Prediction of potential injuries is important as children may not exhibit obvious signs of injury and are likely to maintain relatively normal vital signs until substantial blood volume is lost
<b>Medication or toxin ingestion</b>	Assume that a young child has ingested the largest dose possible; if more than one child is involved, treat each child as if they ingested the total dose
<b>Sick contacts</b>	May identify children at increased risk of infectious illness, placing them at risk of serious illness, and other children at risk of hospital-acquired infection <sup>2</sup>
<b>Risk assessment</b>	Suicide and self-harm risk should be assessed in children and young people presenting with behavioural disturbance and mental health concerns

## Other considerations

## Unaccompanied minors

Children may present to the ED unaccompanied for various reasons, including self-referral and ambulance transfer following trauma. This may limit the information available, increase the child's distress and raise concerns about consent and the safety of the child while waiting (for example, undetected deterioration and leaving before being seen). Consider these factors and local processes when assessing urgency and suitable care environment for the child.

## Family violence and children protection issues

These issues are common and may be identified during an ED presentation. Risk factors for family violence and/or child abuse include:

- Infants: injuries in a non-ambulant child, specific patterns consistent with inflicted injuries, unsettled infants, signs of poor attachment and avoidant gaze
- Children and adolescents: recurrent unexplained symptoms, regressive behaviours, poor social skills, erratic school attendance, mental health problems, substance use
- Caregivers: inconsistent history of circumstances, significant injuries attributed to another child, delayed presentation, previous contact with protective services, parental distress inconsistent with presentation, one parent dominating the interaction.

Health professionals are required by law to report to child protection services signs that a child or young person is at risk. If suspicion is raised at triage, follow local policies to prompt further enquiry and reporting.

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## Communicable diseases

Communicable diseases are more common in children. Keep this in mind when considering the likelihood of an infectious illness in the patient and when deciding where they should be located to avoid the potential spread of illness to other children in the waiting room.

## Applying the ATS

Follow the triage process in **Chapter 2: Triage fundamentals** to determine clinical urgency for children presenting to the ED. The ATS clinical descriptors are considered to apply equally to adults and children. However, they include three specific descriptors for children:

- Severely shocked child/infant: triage category 1
- Stable neonate: triage category 3
- Child at risk of abuse/suspected non-accidental injury: triage category 3.<sup>21</sup>

A summary of the physiological signs of serious illness/injury is provided in Table 7.1. Physiological signs are a guide to the appropriate category, but the presence of red flags may warrant a higher triage category. The extent to which the category is increased will depend on the level of risk associated with the red flag; for example, a history of anaphylaxis in a well-looking child following exposure.

The ATS descriptors and discriminators in [Table 7.5](#) should be used to help guide triage category allocation.

It is common for organisations to make additional recommendations about triage category allocation for children. These are usually recommendations for increased urgency for groups of children considered at risk, but are based on broad characteristics such as age, past history or specific signs or symptoms, regardless of severity or other findings, such as chest pain or headache. Consider these recommendations when you make paediatric triage decisions.

## Take-home messages

In summary, remember that:

- Children present differently to adults and may exhibit non-specific signs and symptoms
- Use a systematic approach to assessment and use available assessment tools
- Parents provide crucial information, can identify important deviations from normal and play an important part in ensuring a child's safety while in the ED
- Pallor, lethargy and poor feeding are worrying signs in infants and young children
- Normal vital signs can be falsely reassuring – careful assessment for other features of serious illness or injury is crucial
- It is important to be familiar with low-frequency, high-risk presentations such as stroke and sepsis to avoid poor outcomes.

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## Considerations for your site

Your role as an educator is to explain:

- When and who to call for paediatric clinical support from your site
- Local escalation pathways designed to support parents to alert clinicians to concerns about their child's condition
- Inclusion and exclusion criteria for paediatric care areas in your department
- Identification and discussion of specific paediatric presentations in your local area (for example, those driven by location, population demographics and those with case management plans)
- How to incorporate local track-and-trigger paediatric observation parameters in triage decision-making
- Local paediatric triage category recommendations and their rationale and implications.

## Discussion points

Help learners consolidate their understanding by discussing the points below.

- Non-specific red flags for serious illness:
  - Review the markers for serious illness and sepsis
  - Discuss the implications of specificity to triage decision-making (under- and over-triaging); for example, explore the challenge associated with differentiating between children with serious and more benign illnesses based on non-specific signs and symptoms
- High-risk, low-frequency presentations:
  - Discuss how low frequency affects triage decision-making
  - Encourage learners to identify uncommon but high-risk presentations from their experience and features that may help them to recognise and differentiate these presentations from others
  - Identify local policies and pathways, such as the sepsis pathway, to support assessment, identification and treatment in high-risk, low-frequency presentations
- Specific red flags:
  - Review the list of high-risk illnesses and identify red flags that may assist learners to identify these presentations at triage
- Parent role in triage:
  - Explore ways to quickly identify and address a parent's concerns, assumptions and expectations
  - Explore the ways in which miscommunication occurs at triage; consider language, health literacy, parental concern and how these impact on the triage decision
  - Discuss the information that should be given to families at the end of the triage process before sending them to the waiting room
  - Discuss ways to effectively prepare parents to identify and escalate signs of deterioration in their child's condition.

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## Case studies

The following cases represent common paediatric presentations and lower-frequency but high-risk paediatric presentations. Work through these cases with learners using the discussion points.

## Case study 1: Respiratory distress

A 4-year-old boy presents after three days of cold symptoms and increasing difficulty breathing. His parent describes an increasing cough that wakes him frequently at night. He does not have a history of asthma but was seen by a GP about four hours ago and prescribed salbutamol four puffs via a spacer when needed and a preventer.

The boy has had two doses of salbutamol: one at the GP practice and the last dose one hour ago. He has not started the preventer. He is intermittently coughing and has mild increased work of breathing. He is alert and telling you about the dinosaur toy he brought with him. His parent says he has not had much to eat today, but he is drinking okay.

## Vital signs, case study 1

RR /min	SpO <sub>2</sub> %	HR /min	T °C
34	97	152	38.6

## Discussion points

- Is there information missing that would help you allocate a triage category?
  - For example, previous ICU or hospital admission
- What would be the value of listening to his chest and would the outcome influence the decision?
  - Auscultation assists with diagnosis but is unlikely to contribute greatly to assessment of urgency; the triage decision can be made based on the child's effort and effectiveness of breathing

- What category would you allocate to this child and why?
  - Description suggests triage category 3
- Review the paediatric discriminators and local track-and-trigger charts to identify the level of urgency indicated
- If there were no cubicles available for this child and he needed to be placed temporarily in the waiting room, what information should you give the parent before sending them to the waiting room? Points to cover include:
  - Signs of deterioration
  - Escalation pathway
  - Next steps and likely timeline.

## Case study 2: Pale, floppy episode in an infant

A 7-month-old girl presents after a pale, floppy episode, followed by a vomit 30 minutes ago. She remains pale but is no longer floppy and is awake. She has been rubbing at her eyes since. She was well in the morning and fed well two hours ago. She has no prior history and is fully vaccinated.

## Discussion points

- Are there any red flags associated with this presentation and what might they indicate?
  - Red flags: pale floppy episode, ongoing pallor
- Discuss the implications of the presenting problem and assessment findings to your assessment of urgency (risk of rapid deterioration therefore higher category than physiological signs may warrant)
  - Implications: possible anaphylaxis
- What additional information do you require to allocate a triage category?
  - Airway assessment, work of breathing, heart rate and respiratory effort will help differentiate between categories in this case
  - Normal findings for above indicate triage category 2; any abnormal observations – triage category 1.

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## Case study 3: Fever in a toddler

A 14-month-old boy presents with his parents. They tell you that he has had a fever for three days and has been vomiting for two days (2–3 times/day). He had one slightly loose stool yesterday, but none since. He has also been increasingly less active and has had no appetite. Today he is also refusing to drink. He attends childcare where there have been cases of gastroenteritis and hand foot and mouth disease in the past week. He is normally a well child and has been fully vaccinated. He was born at 32 weeks.

He is in his mother's arms, leaning against her with his eyes open. He doesn't object when you approach or touch him. He has mild tachypnoea but no increase in respiratory effort. His skin is cool peripherally, slightly mottled and his capillary refill is about three seconds.

## Vital signs, case study 3

RR /min	HR /min	T °C	BGL mmol/L
42	162	38.2	5.2

## Discussion points

- Use the physiological discriminators and local track-and-trigger charts to assist you
- Red flags for serious illness:
  - Elevated heart rate and respiratory rate
  - Cool peripheries, mottling and slightly delayed capillary refill
  - Decreased conscious state (does not object to handling – not typical for age, which you can confirm with his mother)
- Discuss the value of oxygen saturation and blood pressure measurements to decision-making in this case.
  - Do you anticipate that this information will have an impact on the allocation of a category?
  - Collecting these measurements may be difficult, therefore delaying triage process and care
- Normal values will not impact on assessment of urgency
- What triage category would you allocate?
  - Description suggests triage category 2.

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## Case study 4: Head injury

A 20-month-old girl presents following a fall at home an hour ago. Her carer did not see the fall but thinks the child climbed onto a table and fell, landing on the tiled kitchen floor. The carer says she heard a bang and then within seconds the child cried. She settled within 5–10 minutes. Her carer gave ibuprofen at home before coming to the ED. She has not vomited since the incident but refused her lunch.

She has a haematoma to her forehead and cries when it is touched. She is otherwise quiet and cuddling her carer tightly. Her vital signs are normal.

## Discussion points

- Is there other information that you need from the child's carer to make an assessment and allocate a triage category?
  - Is it unusual for her child to refuse lunch?
  - Is she responding normally now – are the child's responses to a stranger and her carer as she would expect?
- What features of this presentation will influence your triage decision and why?
- How would a delayed presentation (over 24 hours later) affect your triage?
- What category would you allocate to this child?
  - Mechanism of injury was a fall from about 1 m onto a tiled surface, therefore not minor; unwitnessed, therefore unclear
  - Grizzling, but analgesic effective
  - Appetite loss suggests possible nausea
  - Quiet – could be a change in conscious state or behaviour
  - Description suggests a triage category of 3
- How will you document this presentation to communicate your assessment and decision to colleagues?

## Case study 5: Sudden onset abdominal pain

A previously well 11-year-old boy presents to the ED with sudden onset abdominal pain. His father says that he was well this morning, but after his soccer game (about three hours ago) he suddenly complained of severe lower abdominal pain. His father notes that he has a high pain tolerance but has been very upset and crying 'so it must be bad'. He has complained of nausea since the onset of pain. He looks distressed and says it is the worst pain he has ever had. He points to his pelvic region when asked where it hurts. His skin is pink and warm and his capillary refill is two seconds.

## Vital signs, case study 5

RR /min	HR /min	T °C	CRT secs
22	118	36.7	2

## Discussion points

- Identify the red flags in this presentation and explain their significance to the assessment of urgency:
  - Sudden onset abdominal pain
- Some children may be too embarrassed to mention symptoms involving the genitals – you may need to ask him whether his testicles are painful
- Children with testicular torsion may only present with abdominal pain
- What category would you allocate to this presentation?
  - Description suggests triage category 2
- Would your decision be different if this was an 11-year-old girl?
  - Implications of gender: sudden onset pelvic pain associated with nausea suggests ovarian torsion, which should be treated with the same level of urgency as testicular torsion

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- Consider when measuring BGL would be indicated.
  - While you have a clear category 2 in this case study because of the risk of testicular torsion, in non-specific abdominal pain presentations early identification of diabetic ketoacidosis is appropriate.

## Case study 6: Persistent vomiting

An 8-week-old boy presents with vomiting. His mother says he started vomiting when he was only a few weeks old when he vomited after some feeds. The vomiting has increased in the past week or two and now he projectile vomits after every feed. He continues to feed vigorously but has not gained as much weight in the past few weeks as he did initially. Peripherally his skin is cool and slightly mottled.

## Vital signs, case study 6

RR /min	HR /min	T °C
72	172	37.2

## Discussion points

- Identify the red flags in this presentation and explain their significance to the assessment of urgency:
  - Elevated HR and RR
  - Cool mottled peripheries
  - Age
  - Increasing vomiting
- Use your local track-and-trigger charts to review vital signs. Review them against the ATS descriptors and the paediatric physiological discriminators – what triage category would you allocate to this infant?
  - Description suggests triage category 2.

## Case study 7: Elbow injury

A 4-year-old boy presents with an injured elbow following a fall from play equipment at kindergarten today. He cried immediately and has continued to cry when moved. The teacher took him inside and immediately called his grandfather to collect him. The fall was witnessed by the kindergarten teacher who told his grandfather that he landed on his right side but didn't hit his head. The grandfather tells you the boy is having tests for autism.

On arrival he is pale, quiet and holding his arm close to his body.

## Discussion points

- What information do you require to assist with allocating a triage category to this child?
  - Neurovascular assessment
  - Pain assessment and analgesic details
- Following review of the ATS descriptors and the Paediatric Physiological Discriminators, how might these findings influence the category allocated to this case?
  - Pulseless limb = triage category 1
  - Severe pain OR motor and/or sensory changes = triage category 2
  - Moderate pain and no neurovascular changes = triage category 3
  - Mild pain and no neurovascular changes = triage category 4
- How will you assess this boy's pain?
  - Child may be able to self-report using a simple scale
  - Rely on parental assessment
  - Find out from the grandfather how the boy would usually display pain and what calming strategies usually work with him
- Are there indicators in this presentation that provide clues to his pain?
  - Pallor, 'quiet', positioning and splinting of his arm
- What first aid should be provided at triage?
  - A sling to support his arm
  - Simple analgesics if not previously given.

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## Case study 8: Rash in an infant and parental concern

A 10-month-old girl presents to the ED with a fine red rash that appeared this morning. Her father says she has been unwell for about 3–4 days. Initially she just wasn't quite herself and then she developed a fever (about 38.9 °C). She showed no other symptoms other than a drop in her appetite. She continued to drink and this morning she had a small breakfast.

She is alert and smiling and her skin is pink and warm. She has a fine macular erythematous rash covering her torso and legs.

## Vital signs, case study 8

RR /min	HR /min	T °C
32	128	36.6

## Discussion points

- Review your local paediatric track-and-trigger observation charts to determine whether her vital signs are normal for her age:
  - Vital signs are within normal limits
- What triage category would you allocate and why?
  - Description suggests triage category 4
- What information would it be important to document in the triage notes?
  - Features that are negatively predictive for serious illness (for example, smiling, normal vital signs, blanching rash)
- Her father is extremely concerned and asking about meningitis. What do you think he is worried about?
  - He is likely to be concerned about meningococcal disease
  - How would you address his concerns?
  - Explain reassuring signs
  - Explain escalation pathway and signs of deterioration.

## Case study 9: Potential ingestion

A 2-year-old boy presents about 30 minutes after presumed ingestion of cetirizine syrup 1 mg/mL. His mother says she found the boy with his older sibling, a 4-year-old girl, with an empty bottle of the medication. She thought there may have been 20 mL of syrup left in the bottle when she last saw it. There was some on the carpet, and the 4 year old said her brother drank it, but that she didn't have any.

The boy is alert and his observations are within normal limits. The dose for a child aged 2–3 years is 2.5 mL/day and a concerning amount of cetirizine for a child of this age is about 10 mL.

## Discussion points

- What assumptions should you make and what recommendations would you make based on these factors?
  - Assumptions: boy ingested total amount possible – 20 mL, older sister is not telling the truth and consumed some or total volume
  - Recommendations: the older sister should also be triaged, based on the assumption that she has consumed some of the medication
- What category would you allocate to this presentation?
  - Descriptions suggests triage category 2
- What are likely overdose symptoms?
  - These include dizziness, agitation, tachycardia and possibly prolonged QT interval.

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## Case study 10: Vomiting and diarrhoea in a 2 year old

A 2-year-old girl has been unwell with vomiting and diarrhoea for five days. All the girl's family had the same symptoms. They were seen in the ED two days ago and have started to improve. While the girl initially responded to a trial of fluids on first presentation and at home, she has started vomiting again, but this time has no diarrhoea or fever.

Her parents are concerned because she hasn't improved like the other family members. Her parents have tried to give her fluids, like they did at the hospital, but she pushes the fluids away. They think her nappies haven't been as wet as usual, and she has been very sleepy, which is not like her.

On examination, she is sleepy but rousable. She appears pale and has normal work of breathing.

## Vital signs, case study 10

RR /min	SpO <sub>2</sub> %	HR /min	T °C	CRT secs
45	96	152	36.1	3

## Discussion points

- List the red flags in this presentation:
  - Re-presentation
  - Change in symptoms
  - Parents have tried first-line measures, which have not been successful
  - Parental concern
  - Decreased oral intake, resulting in a decreased urine output
  - Change in mentation (sleepy)
  - Pale and CRT 3 seconds
  - HR 152 (meets track-and-trigger criteria, especially concerning without fever)
  - RR 45 (raised)
  - Meets sepsis pathway criteria
- Which vital signs are abnormal and how can you account for them in this patient?
  - The patient has a high respiratory rate, which is the first vital sign to compensate in deterioration
  - Changes in mentation can also be an early warning sign of altered cerebral haemodynamics and hypoperfusion
  - An increased heart rate indicates haemodynamic compensation.

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## Case study 11: Reduced feeding in a neonate

The parents of a 14-day-old girl have brought her to ED because she has been feeding poorly over the past 12–16 hours. The baby is breastfed but falls asleep feeding after only about 5–10 minutes. She had a small feed last night at about 10 pm and didn't wake up again until about 5 am. She has usually been waking at about 2 am for a feed. Mum has been trying to feed her all morning, but she keeps falling asleep. It is now 10 am.

Baby is the first child, with nil sick contacts. She was born at 40 weeks +2 days, with a normal vaginal delivery lasting 26 hours. Mum was group B strep positive and had antibiotics. Baby has decreased wet nappies. RR 56 and irregular, with pauses but none more than 20 seconds.

## Vital signs, case study 11

RR /min	HR /min	T °C	CRT secs
56	175	35.7	4

## Discussion points

- Looking for the subtle signs of changes in behaviour when everything is so new is particularly difficult in a newborn. However, does the baby have any behavioural signs of concern?
  - Poor feeding and sleepiness are concerning signs
- Are any of the vital signs concerning?
  - Even though her respiratory rate is normal, or only slightly high, multiple pauses in breathing are concerning
  - The HR and CRT indicate poor perfusion, which could be due to sepsis
  - Remember, the very young (and very old) can present with low temperatures in sepsis
- Does the baby have any risk factors for sepsis?
  - Maternal infection during delivery
- Would this patient trigger your sepsis pathway?

## Case study 12: Endocrine emergency

A 3-year-old old boy with vomiting for 12 hours is brought in by his father. The boy is non-verbal and has a PEG tube. His father gave ondansetron at home about two hours ago, which has not reduced the vomiting. He also gave paracetamol as he felt the boy seemed distressed. The boy has no diarrhoea and no sick contacts.

The boy was due a feed about two hours ago, but the father was not able to give it. He has had the same amount of wet nappies. The father reports the boy seems sleepier than usual, and that he is normally pale and peripherally cool. The boy's history includes developmental delay and Addison's disease. The boy appears alert, but pale and cool to touch.

## Vital signs, case study 12

RR /min	SpO <sub>2</sub> %	HR /min	T °C	CRT secs
41	95	138	36.9	3

## Discussion points

- What red flags would you consider in the presentation?
  - A child with chronic illness and escalation by parents
  - Nil response to medications given at home
  - Decreased oral intake
  - Addison's disease reduces the stress response to injury and illness, and therefore the observations will not demonstrate signs of compensation. In this case, normal vital signs are not a reassuring sign
- What local process do you have to promote early intervention for a child presenting with endocrine emergencies requiring IM hydrocortisone?

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## Supporting resources

- Australian Commission on Safety and Quality in Health Care: [Diagnosis, Investigation and Management of Sepsis: Literature review](#)
- The Royal Children's Hospital Melbourne:
  - [Clinical practice guidelines](#)
  - [Paediatric Trauma Manual](#)
  - [Conversation with the experts podcasts: Managing Acute Behavioural Disturbance in the ED; Paediatric Sepsis](#)
- [Don't Forget the Bubbles](#), website with many resources
- [Australia and New Zealand Society for Paediatric Endocrinology and Diabetes](#)
- [Hormones Australia](#), consumer information and resources
- [Australian Addison's Disease Association](#), consumer information and resources

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# Chapter 8: Older people

## About this chapter

This chapter assumes knowledge of the physiology and anatomy of ageing and common presentations in older people.

In this chapter, older people are defined as those aged 65 years and over, or 50 years and over for First Nations people.

## Learning outcomes

After completing this chapter, you will be able to:

- Describe the physiological, cognitive, mental health and social factors that have an impact on how older people present to triage
- State the main physiological changes that occur in older people and explain how these changes influence the assignment of a triage category
- Apply strategies for communicating with the older person, their family and carers, including incorporating their preferences into care.

## Background

Older people present to ED more than any other age group, accounting for 21% of presentations to EDs.<sup>1</sup> Triage of older people can be challenging because they are more likely than younger people to have complex medical, psychological and social needs.<sup>2</sup> They present more often with symptoms that are non-specific<sup>3</sup>, hidden<sup>4</sup> and atypical.<sup>5</sup>

Older people are also more likely to be admitted to hospital – more than half of older people (52%) who present to ED are admitted to hospital compared to 28% for patients of all ages.<sup>1</sup>



### Key point

Older people who present to ED with vague presentations are sometimes labelled as having 'acopia' (inability to cope). Never use this term. It is ageist and judgemental and reduces the urge to investigate the underlying cause.<sup>6</sup>

Older people labelled as having acopia in ED have a high rate of acute medical illness and a high mortality rate.<sup>7</sup>

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## Common presentations

Knowledge of common presentations in older people will help to inform your assessment of urgency.

There are two main types of presentations in older people:

- Presentations that are more common in older people, such as chronic diseases like cancer and cardiovascular disease, and cognitive impairment, such as dementia and delirium
- Presentations that are affected by the ageing process, such as falls, trauma and infections.<sup>8</sup>

The leading reasons for emergency ambulance requests for older patients are falls, respiratory complaints and cardiac problems.<sup>8</sup>

## Delirium

Delirium is common in older people. Recognising the probability of delirium at triage is important because delirium increases the risk of a poor outcome in older people (38% higher mortality and 200% higher rate of institutionalisation after hospitalisation than older people who don't have delirium).<sup>9</sup>

There are three broad subtypes of delirium: hypoactive, hyperactive and mixed. Together the hypoactive and mixed forms of delirium are at least three times more common than the hyperactive form.<sup>10</sup>

Early identification of delirium at triage is important to start management strategies as soon as possible.<sup>10,11</sup>

People with dementia have a higher risk of developing delirium.<sup>11</sup> It is important to know whether the person is more confused than they usually are.<sup>10</sup>

## Mental health presentations

Older people have higher rates of depression and completed suicide than younger people, yet mental health conditions are frequently not detected in older people who present to ED due to a focus on physical health.<sup>12</sup> See **Chapter 5: Psychological distress and behavioural disturbance** for tips on assessing mental health conditions in older people.

## Approach

## Holistic approach to older people

Older people may feel vulnerable in the ED, especially if they are frail. Generally, older people want ED staff to:

- Involve them in decision-making<sup>2</sup>
- Include and respect their support person or decision-maker when they choose<sup>2</sup>
- Use holistic approaches that minimise their sense of vulnerability<sup>2</sup>
- Consider their personal healthcare priorities, including being aware of their advance care plans<sup>2</sup>
- Explain the reasons for a long wait and reassure them they can come back to you if they have concerns while waiting.<sup>13</sup>



## Key point

Older people often present without the typical symptoms seen in younger people, and they often have hidden symptoms (occult illness).<sup>4</sup> For example, appendicitis, diverticulitis and cholecystitis can be present without pain or abnormalities on examination.<sup>6</sup>

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## Communicating with older people

Communicating with older people at triage can be complex. Sensory or cognitive changes can affect how the older person perceives and describes their health status.<sup>8</sup> Age and cultural differences may also affect what an older person tells you at triage.<sup>8</sup>

Adjust your communication style if the person appears to have low health literacy or impairments in cognition, hearing and vision (for example, uses hearing aids or glasses).<sup>8</sup> Use hearing enhancement technology if available.

At first, try to communicate directly with the older person. If it is difficult to gather the information you need, adjust your style and involve the support person (if there is one). See **Chapter 3: Communication for triage** for practical tips on communicating with older people.



## Key point

When talking to an older person, face them and speak clearly. If they have hearing aids, make sure they are working, and that they are wearing their glasses if they have them.<sup>8</sup>

## Include and respect the support person

A support person, such as a family member or carer, can provide useful information about an older person's health history and preferences, as well as support them while they are in the ED. They are particularly valuable for older people with cognitive impairment who may be unable to communicate about their health status.<sup>13</sup> However, a support person may negatively impact your ability to communicate with patients if they take over and speak for an older person who is able to speak for themselves.<sup>14</sup>

Check with the older person who they want involved in their care, and give the older person the chance to talk before asking the support person.

*'We treat them like we can't ask them the question, we ask their son or daughter if they've been eating again, because we make assumptions on how old they look.'*<sup>14</sup>

– ED nurse

When communicating with an older person who has a support person with them at triage:<sup>8</sup>

- Ask the older person's consent to include their support person in communication
- Involve the older person when communicating with their support person
- Ensure that wherever possible, communication is between you and the patient.

*'The important thing was that she was taking notice of the fact that I said that my mother was very different, she was not her normal self.'*<sup>13</sup>

– A family member commenting on how an ED clinician responded to her input

*'After my dad had seizures, I was always left in the waiting room. I knew that when he started to talk, the things he would say would not be true. The ED staff often believed what he said even though I knew he was very confused.'*

– Son of older person in the ED

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## Red flags

You need to be on high alert for signs and symptoms in older people that indicate urgency. These signs and symptoms may not fit neatly into the common patterns you would see in young people.<sup>7</sup>

Red flags are harder to identify in older people because:

- The older person may be confused – don't assume this is usual for them, and consider delirium early in the patient journey
- Non-specific and subtle symptoms may be overlooked in a stressful setting like the ED, even though an acute, serious condition may be present in around half of these patients<sup>3</sup>
- There are vital sign variances due to chronic diseases and physiological changes in the response to injury and illness. Older people with serious illness may have apparently normal vital signs. For example, older people with shock may not have the expected tachycardia<sup>8</sup>, and shock may be present when blood pressure is within normal range (but low for the older person with baseline hypertension)
- Medications, including polypharmacy, have an impact on identifying deterioration. Absorption and clearance of medicines is reduced in older people.<sup>6</sup>



## Key point

Older people frequently present with vague complaints and are at risk of under-triage. Be on high alert for vague symptoms as they may be the only sign of urgent illness in older people.<sup>6</sup>

## Assessment

## Airway

## Physiological background

- Degenerative changes of the cervical spine.<sup>4</sup>

## Potential problems

- False teeth or teeth that are loose or damaged
- Fractures are more likely.<sup>4</sup>

## Breathing

## Physiological background

- Reduced chest wall muscle mass increases respiratory rate and effort
- Alveoli degeneration and reduced elasticity reduce oxygen diffusion.<sup>8</sup>

## Potential problems

- Respiratory rate will not be as high as in younger people and accessory muscles will tire, decreasing respiratory effort<sup>4</sup>
- Oxygen saturation levels should be considered as part of a respiratory assessment.<sup>4</sup>

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## Circulation

## Physiological background

- Degenerative changes to the structure of the heart lead to a delayed and reduced tachycardiac response and reduced capacity to maintain tachycardia<sup>8</sup>
- A normally higher systolic blood pressure can be expected due to hardening of the arterial walls, which will be compounded by disease processes such as atherosclerosis<sup>4</sup>
- Bleeding can be significant when impacted by the use of anticoagulants<sup>4</sup>
- Medicines that change the stress response, such as beta blockers and antihypertensives, affect compensatory mechanisms.

## Potential problems

- Decreased ability to maintain perfusion due to the effects of ageing on circulatory response<sup>4</sup>
- Circulatory compromise can be difficult to detect as it depends on the person's normal values and is affected by the type and timing of medications.<sup>4</sup>

'Remember, what is normal may not be normal for the patient – BP of 120/60 may be hypotensive for an elderly patient who is normally hypertensive.'

– Emergency clinical nurse consultant

## Disability

## Physiological background

- A decrease in neurons in the brain and spinal cord, brain atrophy and decrease in neurotransmitters affect cognition. The impact on cognition can be compounded by disease processes such as Alzheimer's disease, dementia and delirium<sup>8</sup>
- It's important to assess and understand an older person's baseline cognition to determine if any confusion is new or long-standing
- Brain atrophy can increase the risk of low-mechanism injuries rupturing cerebral blood vessels.<sup>4</sup>



## Key point

The simple question to ask a carer to screen for delirium in an older person is: 'Do you think [name of patient] has been more confused lately?'<sup>15</sup>

## Potential problems

- Increased risk of delirium
- Slower reaction time<sup>8</sup>
- Altered balance<sup>8</sup>
- Underlying cognitive impairment can complicate the assessment and the older person's ability to understand the assessment overall<sup>16</sup>
- Difficult to assess and localise pain (see [Assessing pain in older people](#))
- Pain can present as changes in behaviour and agitation.

'Family members and carers can tell you an older person's baseline cognition, e.g. – "Is mum normally forgetful, if yes, over what time period?"'

– Triage nurse educator

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## Assessing pain in older people

Older people, particularly those with cognitive impairment, are at risk of having their pain under-assessed and under-treated in the ED.<sup>17-19</sup> It is complex to assess pain in older people with cognitive impairment and provide timely analgesia.<sup>17,20</sup> Beliefs around not wanting to bother staff or that pain is an expected part of ageing may reduce reporting of pain.<sup>21</sup>

Tips for assessing pain in older people when self-report is not enough:

- Use observational pain assessment tools, such as Pain Assessment in Advanced Dementia (PAINAD), which are reliable ways to assess pain<sup>17,19</sup>
- Collaborate with family members and carers to assess pain.<sup>17</sup>

‘Older people might under-report pain because of a fear of going into hospital. Co-morbidities like cognitive impairment and type 2 diabetes can affect both pain response and ability to report.’

– Nurse educator

## Exposure

## Physiological background

- Reduced capacity to fight infection<sup>4</sup>
- Blunted or absent fever response to infection<sup>8</sup>
- Reduced muscle mass and skin thickness.<sup>4</sup>

## Potential problems

- Reduced acute response to infection<sup>4</sup>
- Reduced ability to maintain and increase heat as it is lost through skin and a decreased shivering response.<sup>4</sup>

## Focused assessment

There is no specific focused system assessment for older people – it will need to be appropriate for the presenting problem. When doing a focused system assessment for an older person, you need to consider the age-related changes to that system.<sup>22</sup>

## Other considerations

## Ask the paramedic

Paramedics are a source of information about the older person's home and living arrangements that can help your assessment. Paramedics can also detect signs of elder abuse, neglect and mistreatment.

The paramedic may be able to answer questions such as:

- Is the older person a carer for a person or an animal? If they are, consider early referral to support teams and services or escalate according to local processes
- What was the state of their house (for example, was there food in the fridge)?
- Could they move around their house?
- Were there Webster-paks or boxes of medicines in the house?

Answers to these questions may indicate if the older person's presentation is unusual and alert you to urgency in their presentation.



## Key point

Ask the older person if they are worried about anything, such as a person or pet at home. This worry can affect their decisions about their own care. It is also important to consider the safety of others at home.

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## Trauma

An older person is more likely to die from trauma compared to a younger person with an injury of the same severity.<sup>16</sup> Falls are the leading cause of trauma-related deaths in older people.<sup>16</sup> Despite this, older people with trauma are more likely to be under-triaged and less likely to receive trauma team activation compared to younger patients.<sup>27,28</sup> Triage audit data show that lack of assessment of the underlying cause of a fall can lead to under-triage.<sup>29</sup>



## Key point

Older people are more likely than younger people to sustain a serious injury from low-impact mechanisms or mechanisms with minor impact.<sup>16</sup>

When assessing older people with trauma, it is important to consider that:

- Physiological and anatomical changes of ageing increase trauma-related mortality<sup>27</sup>
- Low-mechanism trauma can result in serious injury
- Physical examination, including vital signs, can be deceiving due to changes in normal cardiovascular parameters and the older person's ability to compensate<sup>27</sup>
- A fall in an older person may be a symptom of underlying pathology rather than an isolated event.<sup>4</sup>

## End-of-life care

It is important to be aware of the patient's wishes and any advance care plans. For some older people, a higher triage category is needed to support rapid implementation of their advance care plan.

## Signs of possible elder abuse

ED staff are at the front line of identifying elder abuse<sup>23</sup>, which is any act (or lack of action) that causes harm or distress to an older person and is carried out by someone they know.<sup>24</sup> The abuse may be physical, sexual, financial, psychological, social and/or neglect.<sup>25</sup> All types of elder abuse are associated with increased mortality.<sup>26</sup> Be aware of mandatory reporting requirements.

To identify possible elder abuse, look for:

- Unexplained injuries, vague or strange explanations or denials
- Inconsistency between your observations and what the older person or suspected abuser tells you
- Frequent requests for care or treatment for minor conditions
- Delay in seeking care or reporting an injury
- History of injury, untreated injuries and multiple injuries, or the person being described as 'accident prone'
- Repeated ED attendances of older people from the same residential care setting.<sup>24</sup>

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**Take-home messages**

In summary, remember:

- Older people present to ED more than any other age group
- Triage of older people can be challenging because they are more likely to have complex medical, psychological and social needs
- Older people often present with vague, atypical and hidden symptoms
- Red flags are harder to identify in older people – vague symptoms may be the only sign of urgent illness
- Delirium is common in older people. It's important to assess and understand an older person's baseline cognition to determine if any confusion is new or long-standing
- Pain is under-assessed and under-treated in older people, especially in those with cognitive impairment. Use observational tools and information from the support person to assess the patient's pain
- Older people with trauma are at risk of under-triage: you need to have high suspicion of injury based only on mechanism, as vital signs can be deceiving
- Older people may feel vulnerable in the ED, especially if they are frail
- Older people want holistic care that includes them and their support person in decision-making.

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## Considerations for your site

Your role as an educator is to explain:

- Support services and referral pathways
- Appropriate location of care.

## Case studies

The case studies below highlight common presentations and low-frequency, high-risk presentations. Help learners consolidate their understanding by discussing the points below.

## Case study 1: A collapse

A 72-year-old woman collapsed in her garden while bending over and standing up to hang out the washing. Her husband saw her collapse from inside and called the ambulance. She lost consciousness for a short period. The woman landed on the brick edge of a garden path and fell onto her right side with her arm tucked underneath her.

She has pain and swelling to the distal ulna, and grazes and skin tears to her right knee and lateral aspect of the right ankle. She is underweight, alert and holding herself still. Pre-hospital care includes a temporary splint and IV morphine 5 mg. Her history includes hypertension and osteoporosis. Her neurovascular observations are intact.

## Vital signs, case study 1

RR /min	SpO <sub>2</sub> %	HR /min	BP mmHg	T °C
24 shallow	93	89	145/86	36.4

## Discussion points

- What are the red flags for this patient?
  - The mechanism is from standing, which is significant in older people. The fall on the brick garden edge increases the impact. The woman is underweight, reducing the amount of muscular protection on impact. Her history of osteoporosis increases the risk of fractures from a smaller mechanism
- What caused her fall?
  - Consider the questions you could ask to determine the underlying cause of the fall
- There is the possibility of shallow breathing due to rib pain. Is there an indication to check for pain on deep breathing or coughing or decreased air entry?
  - Yes, due to the mechanism of injury and respiratory rate
- How is her pain?
  - Assess her pain score (see **Chapter 2: Triage fundamentals**)
- Do you consider her a trauma patient?
  - While she may not meet most trauma criteria, in an older person, a fall from standing can be a significant mechanism that requires a high level of suspicion for serious underlying injuries.

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## Case study 2: A fall

Paramedics bring in a 92-year-old woman who was found on the floor in her aged care home. Injuries are a small laceration to the left temporal area and bruising to the left shoulder. Normally she is alert but not orientated to time and uses a four-wheeled walking frame.

## Discussion points

Consider these variations and how they might affect the triage category:

- Large blood loss on anticoagulant medication, HR 98, BP 98/72 and cold to touch
  - This would indicate circulatory compromise
- Glasgow Coma Scale (GCS) 13, eye open to voice and not orientated to time (assuming her normal GCS is 14)
  - As this was an unwitnessed fall, it is hard to say if there was a loss of consciousness, but it has to be highly suspected. Also consider the change in GCS from baseline and a history of anticoagulant medication. In this case, the combination of variations in vital signs and significant history might increase her urgency
- Variations in other vital signs.

## Case study 3: Man with abdominal pain

An 89-year-old man presents with generalised abdominal pain increasing over the past 6–8 hours, describing it as a 7/10. Paramedics gave him IV morphine 10 mg. On examination, he has non-specific abdominal pain and his abdomen is soft and tender. He had one episode of diarrhoea the previous day, but nil nausea, vomiting or urinary symptoms. He has a history of acute myocardial infarction, coronary artery bypass grafts, atrial fibrillation and hypertension.

## Vital signs, case study 3

RR /min	SpO <sub>2</sub> %	HR /min	BP mmHg	T °C
24	96	68	135/78	36.9

## Discussion points

- Consider the red flags in this presentation:
  - Age: increases risk factors for illness and decreases physical ability to cope with illness
  - Pain: not responding to a large dose of analgesia for his age
  - History of atrial fibrillation and significant abdominal pain: can be a risk factor for ischaemic gut.

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## Case study 4: Delirium

A teenager brings in his 86-year-old grandmother after finding her on the street. He said she didn't know where she was. His parents have been caring for her while her husband is in hospital. The woman is alert and interactive but can't tell you anything specific about her signs or symptoms. She has a wet cough and appears to have mild accessory muscle use. Her grandson is unsure about her history, but he tells you she has heart and lung problems and that his parents are on their way.

## Vital signs, case study 4

RR /min	SpO <sub>2</sub> %	HR /min	BP mmHg	T °C
26	93	115	110/65	38.4

## Discussion points

- Would you activate the sepsis pathway at triage?
  - Yes, she is likely to have sepsis. She has new onset confusion and breathing changes and at least two observations that would meet track-and-trigger criteria
- How could you support the grandson at triage?
  - You could let him know the ED staff will look after his grandmother and keep him informed.

## Case study 5: Older person observations

Paramedics bring in an 85-year-old man from home. He has had decreased oral intake for the past three days and developed lower abdominal pain the previous day. Carers told the paramedics that 'he doesn't seem himself'.

The patient says he feels unwell, has lower central cramping abdominal pain and urinary frequency. He is alert but falls back to sleep when you stop talking to him. His history includes Alzheimer's disease (he needs help with meals but is otherwise independent), hypertension, femoral popliteal bypass and gout. He usually takes metoprolol, clopidogrel and rivastigmine. The paramedics have brought his Webster-pak and it appears he has had his morning medication.

## Vital signs, case study 5

RR /min	HR /min	BP mmHg	T °C
22	95	105/65	37.9

## Discussion points

- Do you think this patient is possibly septic?
  - An older person has a significantly reduced ability to mount and maintain tachycardia and tachypnoea and to mount a fever. In this case, the patient also takes medication that will affect his ability to mount a compensatory tachycardia. This means his heart rate and fever may not reach track-and-trigger parameters
  - This patient also seems sleepy – a change in alertness is an early sign of deterioration. In this case, it is important to consider the observations in line with the patient's age and co-morbidities and have a high level of concern for starting him on the sepsis pathway.

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## Supporting resources

- [Acute geriatrics series, \*Emergency Medicine Australasia\*](#)
- [NSW Elder Abuse Toolkit, \*Identifying and Responding to the Abuse of Older People: The 5-step approach\*](#), NSW Elder Abuse Helpline & Resource Unit
- [Delirium Clinical Care Standard](#), Australian Commission on Safety and Quality in Health Care
- [Care of the Older Person in Emergency](#), Queensland Health
- [Older Person Trauma](#), Trauma Victoria

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# Chapter 9: Legal issues at triage

## About this chapter

This chapter assumes knowledge of child safety reporting requirements.

## Learning outcomes

After completing this chapter, you will be able to apply key legal concepts to triage nursing practice.

## Background

The triage role can present legal issues you may not routinely come across in general nursing practice. This chapter covers the key aspects of your legal responsibilities as a triage nurse and registered health professional.



### Key point

All nurses need to understand their obligations under the Nursing and Midwifery Board of Australia's *Code of Conduct for Nurses*.

## Professional standards

A nurse is a registered health professional. Practice is regulated through the Nursing and Midwifery Board and the Australian Health Practitioner Regulation Agency (Ahpra), which administer the *Health Practitioner Regulation National Law Act 2009* and complementary legislation in each state and territory (the National Law).

This means nurses must act in accordance with the *Code of Conduct for Nurses* issued by the Nursing and Midwifery Board.<sup>1</sup> All nurses need to be familiar with their obligations as registered health professionals under the *Code of Conduct*.

If a nurse does not meet professional standards, they can be disciplined for unsatisfactory professional conduct or, if very serious, professional misconduct. Under the National Law, unsatisfactory professional conduct is defined as when the 'knowledge, skill or judgement possessed, or care exercised, by the practitioner in the practice of the practitioner's profession is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience'.

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## Duty of care

Nurses have a duty to their patients to exercise reasonable skill and care in undertaking their professional responsibilities. The standard of reasonable care is that of the ordinary skilled person exercising and professing to have a particular specialised skill, for example, specialised skill as a triage nurse.

A breach of this standard level of care that results in injury to someone can constitute negligence. Failing to appropriately assess a patient for triage could raise the issue of negligence.<sup>2</sup>

## Elements required to establish negligence

Negligence laws vary between jurisdictions, but for negligence to be proven, all the following elements must be established within the healthcare context:

- The healthcare professional owed a duty of care to the patient
- The treatment provided fell below the standard of care reasonably expected from a healthcare professional
- The poor treatment resulted in the patient suffering an injury or harm
- The physical or psychological harm the patient suffered led to loss.

*'Remember, with negligence, the expectation is to practise as an average nurse would in similar circumstances. There will often be a lot of things happening at once, and no one expects you to be in two places at the same time.'*

– Triage nurse and educator

The first two elements of the law of negligence are directly relevant to nurses' consideration of their professional practice:

- **Duty of care:** A 'duty' is an obligation recognised by law. Health professionals, such as nurses, owe this duty to their patients. A nurse's duty is to provide the same level of care that would be provided by a nurse practising under the same, or similar, circumstances. Once you have engaged with the patient, you have a duty of care. As a triage nurse, you share responsibility with your hospital to offer people who present to your ED an appropriate assessment of their treatment needs and level of urgency.
- **Standard of care:** You are obliged to try to protect the patient from any foreseeable harm or injury, as part of ensuring a reasonable standard of care. This reasonable standard of care can be usefully informed by policies such as the College of Emergency Nursing Australasia's *Triage Nurse Position Statement*<sup>3</sup> and other documents such as the *Registered Nurse Standards for Practice*, published by the Nursing and Midwifery Board of Australia.

See [Case study 1](#) in educator resources for a discussion of fulfilling your responsibilities when limits on resources restrict the care that can be provided.



## Key point

Guidelines such as the ATS should guide triage decision-making – but remember you should not follow guidelines blindly. Critical thinking is vital in the triage role.

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## Privacy and confidentiality

The triage nurse has a responsibility to ensure the patient's privacy is respected during the triage assessment and while in the waiting room. Make sure you know your organisation's policy about privacy and the provisions of the *Code of Conduct for Nurses* that deal with this obligation.

Keeping a patient's information confidential is part of a triage nurse's duty of care. In some situations, other legal responsibilities override this – for example, mandatory reporting of a child at risk. The criteria for reporting vary across states and territories.

## Documentation

Healthcare records are an important channel of communication among healthcare team members and a formal record of events that take place in the care and treatment of a patient. They must be accurate, clear and succinct. Records should also be easily accessible and able to be understood.

The ACEM requirements for documentation of triage are:

- Date and time of triage assessment
- Name of the triage nurse
- Chief complaint/presenting problem
- Limited, relevant history
- Relevant assessment findings to justify the triage category
- Initial triage category allocated
- Re-triage category with time and reason, if applicable
- Assessment and treatment area allocated
- Diagnostics, first aid, analgesia or treatment initiated at triage.<sup>4</sup>

Remember, other health professionals who haven't seen the patient need to be assured from what you have written that the triage category is correct. Information that will give insight into the patient's state includes the presenting problem, pertinent history and assessment findings.

If the patient's condition changes or if you obtain new information before they are seen by the next clinician, you can re-triage and escalate using local pathways. You should clearly document any change in the patient's condition. This documentation should include the time and reason for the re-triage and who did the re-triage. Also see re-triage in **Chapter 2: Triage fundamentals**.

Documentation systems vary between organisations – make sure you understand the documentation system in your ED.

## Documentation pointers

- Complete documentation at the time of the event
- Be accurate, brief and objective – don't add interpretation
- Make sure your handwriting is legible or that your typing is accurate
- Avoid jargon and abbreviations, unless widely used and understood among healthcare professionals
- Make sure you write the documentation for the correct patient
- Only write what **you** did, heard or saw directly.

Source: *Emergency and Trauma Care for Nurses and Paramedics*<sup>2</sup>

## Your documentation may be used as evidence in court

Keep in mind that your documentation may be used as evidence in a court of law. There may also be a long delay between the event and the court case, so written records may be seen as more reliable than memory.<sup>2</sup>

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## Patients who want to leave before being seen

In Australian EDs, about 5% of patients who present don't wait to be attended to by a healthcare professional.<sup>5</sup> If the patient is a competent adult, you can't stop them from refusing treatment and leaving. However, you need to clearly advise the patient of the consequential risks of their decision and encourage them to return if they are concerned or if their condition worsens. You could also describe the changes that should trigger a return to the ED.

If a patient has told you they are leaving, you should:

- Document the information you gave about the risk of leaving and that you encouraged them to return if they were concerned or if their condition worsened
- Clearly advise the patient that they should seek urgent medical care if their condition worsens or they have any other concern about their condition
- Escalate the case in accordance with the relevant local protocol.



## Key point

At the end of the triage, take the opportunity to let the patient know they should talk to you if their condition deteriorates or if they are thinking about leaving.

People who are affected by cognitive impairment, drugs, alcohol or mental illness may not have capacity to understand the risks of leaving before being seen or before treatment is complete. You must be aware of local policies about your responsibility to prevent them from leaving in these situations.

## Consent

You need the patient's consent before directly or indirectly touching them and for major or minor treatment.<sup>2</sup> Consent can be given in writing, verbally or implied (for example, holding out an arm for taking a blood pressure reading).<sup>2</sup> You should always tell the patient what you are doing and explain how it may feel for them, even if consent is implied.

For consent to be valid:

- It must be given freely with no coercion
- The patient must be informed of the broad nature and effect of the treatment and its risks and benefits
- The patient must be competent to consent.<sup>2</sup>

To be competent to consent, the patient should:

- Be able to take in, retain and understand the information
- Believe the information they have been given (for example, some patients with anorexia may not believe they are unwell and are not considered competent for that reason)
- Be able to weigh up the risks and benefits of the treatment and communicate their decision.<sup>2</sup>

## Young people and consent

Under Australian common law, young people aged under 18 might be capable of giving informed consent if they are assessed as competent, although the clinician must consider the nature of the treatment and the ability of the young person to understand the treatment.<sup>6</sup>

Generally, if a young person is:

- Aged between 16 and 18, they are most likely able to consent
- Aged between 14 and 16, they are reasonably likely to be able to consent
- Under the age of 14, they may not have the capacity to consent, except for treatment that does not carry significant risk.

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Additional laws about the age for consenting to treatment apply in some states: in SA, people aged 16 and over can consent and in NSW, people aged 14 and over can consent if deemed capable.<sup>6</sup> The common law allows for younger people to consent in some cases in SA and NSW.<sup>6</sup>

Generally, consent from a parent or guardian is needed if the young person is aged 14 or under (unless the young person objects).<sup>6</sup> You should refer to your hospital's policy on consent to treatment by young people.

## Urgent treatment and consent

When a person cannot consent for whatever reason, urgent treatment without consent to save their life or prevent serious damage to their health is allowed, and state or territory law specifically provides for this.<sup>2</sup> However, in emergencies, providing treatment without consent is generally not permissible if it contradicts a valid prior refusal of treatment, such as an advance care plan.

You should be familiar with the policy in your organisation, which will articulate the relevant state or territory law about when treatment can be given without consent. If in doubt, escalate the case and seek advice.

## Involuntary care

Legislation about involuntary care of people who are experiencing mental illness, or a crisis resulting in behaviour that is dangerous to themselves or other people, varies between states and territories.<sup>2</sup> An important principle underpinning legislation is to minimise any restriction on the patient's liberty and to minimise any interference with their dignity, rights and self-respect.<sup>2</sup>

## Detaining a patient

There may be certain circumstances when you identify a patient whose mental condition indicates they need to be detained for appropriate care and treatment because they pose a risk to themselves or others.

If you think a patient is experiencing a mental illness, disorder or condition and as a result poses a risk to themselves or others, and is likely to leave the ED, you should escalate through your local process.

Detaining or restraining a patient to provide necessary care or treatment is subject to individual state or territory law and is covered under local hospital policies. Make sure you know your hospital's policies on this issue.



## Key point

You should never put your own safety at risk to detain a patient.

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## Informed consent and involuntary care

Conducting a triage assessment for a patient who is in the ED against their will becomes challenging if they decline consent. In such cases, you might need to assign a higher triage category to enable an evaluation in a more secure setting, where additional staff members with the appropriate training can effectively handle the situation.

Patients who are brought to the ED involuntarily often feel scared, angry and disempowered. This can change the relationship between the triage nurse and patient; for example, they may not tell you the reason for presentation or answer your questions fully. Those with a past history of trauma may be particularly affected.

## Approach to care of patients brought to the ED involuntarily

- Treat the patient with respect
- Ask for consent before making physical contact
- Don't escalate the situation
- Triage to a higher category to allow a coordinated response if you can't adequately assess the patient alone.

## Preserving forensic evidence

As a triage nurse, you must know your hospital's procedures for preserving forensic evidence. These procedures should include liaison with police, as appropriate, with the patient's consent.

When a patient presents to the ED after being involved in a criminal offence, your first priority is to provide care.<sup>2</sup> For cases involving suspected sexual assault, follow your local policy.

Police are allowed to seize items if they suspect a serious offence has been committed.<sup>2</sup> One exception is Sexual Assault Investigation Kits, which police are entitled to seize only if the patient has signed the relevant documentation.<sup>2</sup> Police are also not allowed to seize or view medical records without following local policy for requesting access.

## Presentations involving violence

When a patient presents reporting assault, your role is to assess their need for care with a trauma-informed approach (See **Chapter 5: Psychological distress and behavioural disturbance**). You don't need to document the circumstances of the assault.

Patients who have experienced family violence may be hesitant to disclose this and may not present with obvious trauma.<sup>7</sup> Provide non-judgemental support, follow your local processes and consider assessment findings in light of the potential for deterioration when assigning a triage category.<sup>7</sup>

The police may also need to be notified if a person presents with serious injuries such as knife or gunshot wounds that suggest a crime may have been committed, even if the person does not report an assault or objects to police involvement. These cases should be escalated in accordance with your organisation's policies.

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## Mandatory reporting

## Children

If there is any suspicion that a child or children may need care or may be being maltreated, nurses have a legal responsibility to ensure it is reported to the relevant authorities. Although as the triage nurse you may not make the report yourself, you need to be aware of the legal requirements and of your organisation's procedures and documentation requirements for reporting.

If you are dealing with a child suspected of being the victim of an offence, or in need of care, attending to the child's injuries is the priority.<sup>2</sup> Don't try to get information from the child about the circumstances surrounding the injuries.<sup>2</sup> For example, don't ask 'Who did this to you?' Doing this could compromise court proceedings against the offender.<sup>2</sup> Trained staff from other authorities are responsible for gathering evidence from the child.<sup>2</sup>

## Other health practitioners

To protect the public from the risk of harm, registered health practitioners are required to make notifications about other health practitioners in some limited circumstances. See [Guidelines: Mandatory Notifications about Registered Health Practitioners](#) for information.<sup>8</sup>

## Take-home messages

In summary, remember that:

- You must act in accordance with the [Code of Conduct for Nurses](#)<sup>1</sup>
- Nurses have a duty to their patients to exercise reasonable skill and care in undertaking their professional responsibilities
- Record-keeping and associated documentation must be accurate, clear and succinct
- Justify your triage category in your documentation
- If a competent adult patient wants to leave before being seen, you cannot stop them; advise the patient of the risks of their decision, encourage them to return or seek urgent medical care if they are concerned or if their condition worsens, and document that you gave them this information
- People affected by cognitive impairment, drugs, alcohol or mental illness may not have the legal capacity to understand the risks of leaving before being seen or before treatment is complete – you must be aware of local policies about your responsibility to prevent them from leaving in these situations
- An important principle underpinning involuntary care legislation is to minimise restriction on the patient's liberty and to minimise interference with their dignity, rights and self-respect.

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## Educator resources

## Considerations for your site

Your role as an educator is to explain the organisation's processes and requirements for:

- Discharge of people who want to leave the ED before being seen, including who needs to be involved, assessment to be undertaken and where it is documented
- Holding a patient involuntarily – the triage nurse's role, including assigning a triage category to facilitate early medical officer assessment, escalation and calling for assistance
- What needs to be in place before police can leave (for example, security)
- Mandatory reporting
- Incident reporting.

## Discussion points

Help learners consolidate their understanding by discussing the points below:

- What legislation supports you to undertake an assessment of the patient under an involuntary order?
- What are the rights of the patient under involuntary care?

## Case studies

The case studies below illustrate key legal considerations at triage. Work through these cases with learners using the discussion points.

## Case study 1: Duty of care and meeting professional standards

Review your actions in the case below and consider whether the criteria for negligence apply.

## Presentation

A 24-year-old man presents with increasing shortness of breath over the past two days. He says he feels like he can't take a big enough breath but does not have pain. He has no infective symptoms. He has a broken leg, which was treated in the ED five days ago. He has a back slab plaster to his lower left leg and is on crutches. He is alert and speaking in full sentences.

## Vital signs, case study 1

RR /min	SpO <sub>2</sub> %	HR /min	BP mmHg
20	94	150	135/92

## Your actions

Due to his heart rate, you assign a triage category 2, alert senior medical staff and let the nurse in charge of the shift know. There are no beds available and you put him back into the waiting room with instructions to let staff know if his breathing changes or if he gets any new symptoms.

In line with your local procedures, the waiting room nurse reviews his condition regularly.

You see he has had an ECG, bloods collected and was seen by a medical officer while in the waiting room. At the end of your shift you hand over to the next triage nurse, stating your concern for his heart rate, before leaving.

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## The patient's deterioration

The next day, you are informed that during the night he was moved to a monitored bed, but on transfer he suddenly became acutely short of breath and was very quickly in pre-arrest. He was moved to resus, thrombolised for a large PE and is now intubated in ICU.

## Discussion points

Consider whether the criteria for breach of duty of care, or falling below satisfactory professional standards, applied in relation to your triage assessment of the patient:

- Were you acting in the course of your profession as a nurse? Yes, you were engaged as a nurse to carry out the specialised nursing role of triage assessment
- Did you owe a duty of care? Yes, you had a duty of care relationship with the patient
- Did you breach that duty of care, or otherwise fall below acceptable standards in relation to your triage assessment? No, you demonstrated the knowledge, skill and judgement and exercised the level of care in the undertaking of your role as a triage nurse to the standard reasonably expected of a nurse of an equivalent level of training or experience as a triage nurse.

Your triage assessment was complete and the triage category was appropriate at the time the assessment was made, based on available clinical information and having regard to relevant practice guidelines. Allocating the patient a monitored bed would have been best practice: you requested this, but you did not have control over bed availability. Your handover of care to the next shift was also appropriate.

The sudden deterioration of the patient the next day was not foreseeable at the time you made your triage assessment. The patient's presentation at the time of triage did not indicate a risk of sudden deterioration that could be detected during triage assessment.

While deterioration of a patient can be a risk, within the limits of the scope of a triage assessment, the patient's presentation at the time of triage did not indicate sudden deterioration. Your triage category was correct and you have not done anything, or omitted to do something, to cause foreseeable harm.

Consider other scenarios and what might have resulted in a breach of the duty of care, or failure to meet relevant professional standards:

- What if you gave a triage category of 3 instead of 2?
  - Based on the available clinical information at the time of presentation, this would be a breach of the reasonable standard level of care expected of a trained triage nurse, having regard to the ATS (category 2 descriptor, HR greater than 150)
- What if your documentation read: '24yr old male with shortness of breath increasing over the last 2 days, states he feels like he can't take a big enough breath but denies pain. He has a broken leg, which he was in the ED for 5 days ago. There is a back slab plaster on his lower left leg and he is on crutches. Nil history. SpO<sub>2</sub> 93%. Triage 4'
  - This would also show a breach of the standard level of care because it demonstrated that the assessment was not adequate to properly determine the appropriate triage category, and a trained triage nurse acting reasonably would have obtained further clinical information before arriving at an assessment
- What if you don't have a waiting room nurse in your organisation?
  - Discuss your local escalation process if the demands of triaging new patients don't allow for reassessment of patients in the waiting room in the recommended time frames.

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## Case study 2: Sexual assault

A 26-year-old patient presents reporting a sexual assault. The patient denies any injuries, pain or bleeding. There was no loss of consciousness or injury to neck or throat, and no other history. The patient is alert.

## Vital signs, case study 2

RR /min	SpO <sub>2</sub> %	HR /min	BP mmHg	T °C
20	97	78	118/72	36.7

## Discussion points

- What local policy or process might guide where this person would be allocated post-triage?
  - You should also consider whether the person feels safe in the waiting room
- What local processes, referrals and procedures are relevant in the case of alleged sexual assault presentations at triage?
  - Response teams, referrals or transfers
  - Social work
  - Evidence collection kits
- If the patient states there are periods of time they can't remember, what else should you consider?
  - The patient may have been strangled, which can result in amnesia or loss of consciousness; even without bruising or voice changes this would increase triage urgency
- If the patient tells you that children were present, what should you do?
  - Refer to local process for mandatory child reporting procedures.

## Case study 3: Documentation – shortness of breath in a child

## Documentation, case study 3

2yr old with cough and shortness of breath for 1 week. Did have a fever but none now. Nil runny nose. Cough non productive. Mild work of breathing, RR 35. Tolerating oral fluids. Normal wet nappies. Alert and interactive. Nil Hx IUTD.

## Discussion points

The A-E assessment tells us about alertness, mild respiratory effort and an assessment of overall hydration. We know that the child has presented with shortness of breath, and the other signs and symptoms that might be related to shortness of breath have been included or excluded.

- Are there any descriptors of the presenting problem missing?
- Do you have enough information to determine how sick this child is?

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Case study 4: Documentation – shortness of  
breath in an older person

## Documentation, case study 4

89yr old male BIBA with SOB and fevers, Hx COPD. Increased use of salbutamol. Still smokes. HR 95, SpO<sub>2</sub> 90%, 2LNP.

## Discussion points

We know that the patient has presented with fevers and shortness of breath requiring him to increase his use of salbutamol. It would also be useful to know how long this has been going on and if there is a productive cough that has changed colour, which would increase the risk of deterioration.

Next we need to understand the degree of shortness of breath. This is not described, so it would be difficult for the documentation provided to support any triage category given. Describing the patient's work of breathing, or ability to talk in phrases sentences or words, can give an understanding of the degree of his shortness of breath.

The history of COPD is important as it gives context to some of the assessment findings and also the patient's potential for deterioration. The information about the patient still smoking may be important in the overall ED work up, but does it impact the triage category allocation? Why might it have been included here?

## Supporting resources

- *No power to detain a patient just because it's good for them*, Blog post about detaining patients in ED, Australian Emergency Law

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# Chapter 10: Triage scenarios

## Development of the scenarios

Professor Marie Gerdtz, Head of Department of Nursing at The University of Melbourne, developed and validated the triage scenarios. See [Triage scenario development and validation methodology](#) for details.

The scenarios in this chapter achieved good to excellent inter-rater reliability in the validation process, and are suitable for assessment. [Additional scenarios](#), which achieved lower inter-rater reliability, are available for teaching purposes and discussion with experienced triage educators.

## How to use

Use the triage scenarios in this chapter to practise applying the knowledge you have learnt and the tools in chapters 1–9 of the ETEK. Consider the clinical details provided for each scenario and select the triage category you think is the most appropriate. Write notes in the box about why you selected the category. Discuss your answers and your reasoning with your educator or a triage nurse. Answers and justifications for the appropriate triage category are provided at the end of this chapter.

Some scenarios contain text in quotes – this is to simulate common ways patients and carers express information to the triage nurse.

### Note

[DOWNLOAD](#) and [SAVE](#) this chapter if you plan on writing your answers in the electronic document.

## Scenario 1

Joe is 47 years of age; he presents to the ED with a letter of referral from his local doctor. He has left flank pain radiating to his groin. His local doctor has given him oxycodone 5 mg with little effect. He has a history of left renal colic. His respiratory rate is 26 breaths per minute, his heart rate is 120 beats per minute and his blood pressure is 128/78 mmHg. His skin is cool and clammy. He rates his pain as 8/10.

Triage category?

1

2

3

4

5

Your reasons/comments?

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## Scenario 2

Albert, 44 years, was on his tractor this morning when a foreign body flicked into his eye. His eye is tearing, and he still has the sensation that 'something is there'. He says he has 'no pain', but the eye is 'uncomfortable'. His visual acuity is normal. There are no visible injuries to the eye.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 3

Shane is a 30-year-old man who presents to the ED reporting a frontal headache increasing in severity over the past few days. The patient states he has been thinking of harming himself, wants to 'get help' and is cooperative and does not seem agitated. If he cannot sort out his problems, he says he will 'go and jump off a bridge'. He has no previous neurological history and no previous suicide attempts.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 4

Dima is a 91-year-old woman of non-English speaking background. She is brought to the ED in her son's car after seeing her local doctor. You are called to assist her to get out of the car. Her son tells you she is 'very sick'. You note that she can transfer to a wheelchair with minimal assistance. According to her son, Dima tripped and fell three days earlier and has 'bruised her right hip'. She does not have any other injuries, she is able to walk, and her hip is very painful. She is not distressed when seated. Her respiratory rate is 20 breaths per minute, heart rate is 88 beats per minute and her blood pressure is 150/90 mmHg. You are unable to ascertain her exact level of pain, though she tells you she is 'all right'. The neurovascular status of her right foot is normal.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 5

Glen, 52 years, presents to the ED with 'bleeding haemorrhoids'. He has had this problem 'on and off for the past few months', but now it is 'getting worse'. He says he has considerable pain when he opens his bowels, normally every second day, and bleeds 'quite a bit' (about a spoonful at a time of bright blood for the last two days). He states that he needs to be seen by a doctor 'as soon as possible' as he considers his problem is 'an emergency'. His respiratory rate is 16 breaths per minute, heart rate is 78 beats per minute and his blood pressure is 132/78 mmHg.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 6

Rebecca is a 17-year-old girl who is brought to the ED by her friends following an all-night party, where she took two tablets of ecstasy. She cannot stop crying, and says she wants to die. She has had two previous attempted overdoses in the past year. Her heart rate is 112 beats per minute, respiratory rate is 24 breaths per minute and her temperature 37.6 °C.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 7

Laura is a 10-year-old girl who is brought to the ED at 11pm by her adult sibling saying that she has had abdominal pain for the last few hours. She indicates that the pain is across the centre of her stomach and that paracetamol has not helped. She complains of nausea and says that she has vomited once since the onset of pain. When asked, she states that she has had normal bowel motions. She is giving her own history while leaning over onto the desk, holding her abdomen, and moving very little. Her skin is pink, and she is not short of breath. Her respiratory rate is 22 breaths per minute and her heart rate is 98 beats per minute.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 8

Kylie, a 28-year-old woman, presents to triage with three days of fever and increasing shortness of breath. She is 28 weeks pregnant (G2P1) and has no medical history of note. She says she saw her local doctor yesterday and commenced oral antibiotics. Today she tells you she is having 'difficulty walking around the house' because of 'shortness of breath'. She has a productive cough with green sputum and is speaking in phrases. Her respiratory rate is 32 breaths per minute and SpO<sub>2</sub> is 90%. Her heart rate is 130 beats per minute; her skin is pale, hot, and moist to touch. Her GCS is 15/15, her temperature is 38.8 °C.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 9

Charlie is a 15-month-old boy who presents to the ED via ambulance at 2am following an episode of 'shaking and jerking' with loss of consciousness. The episode lasted approximately four minutes. The paramedics state that he had stopped fitting when they arrived, but he has been 'very drowsy' during transport. His mother states that he has never had an episode like this before. During the night, he had a fever and a runny nose. He has been sleeping poorly and is a little irritable. The child is flushed, his skin is warm, and his capillary refill is about 2 seconds. His heart rate is 153 beats per minute and his respiratory rate is 36 breaths per minute, his temperature is 38.6 °C. He has no use of accessory muscles or retraction. He is alert, crying and clinging to his mother. His mother says that he seems more alert now than before.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 10

Graham is a 55-year-old man who presents to the ED accompanied by his partner. He states that he has been 'bleeding from the back passage' since the previous night. He is very anxious about the bleeding and reports that it was 'bright' in colour and 'filled the toilet bowl' on two occasions. His blood pressure is 155/100 mmHg, heart rate is 102 beats per minute and his respiratory rate is 20 breaths per minute.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 11

Louisa is a 24-year-old woman who presents to the ED with her friend after 'fainting' in the toilet at home. She is reporting left sided abdominal pain, which she has had 'on and off' for several months. She previously attended the ED two weeks ago for the same problem. An abdominal ultrasound was performed at that time but identified no abnormalities. She rates her pain as 6/10. Her respiratory rate is 18 breaths per minute, heart rate is 82 beats per minute and her blood pressure is 112/64 mmHg. Her skin is cool and dry. She looks pale and uncomfortable.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 12

Nisha is a 67-year-old woman who was out shopping with her daughter when she slipped and fell on her outstretched hand, injuring her left wrist. She is not distressed by the pain and rates it as 3/10. Her wrist is tender, but not deformed. Radial pulse is present at 72 beats per minute. The neurovascular status of her left hand is normal. There are no other injuries.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 13

Kate is 18 years old. She attends triage at 12.30pm with a work colleague. Her hand is wrapped in a tea towel, and she appears pale and anxious. She tells you she has cut her hand with a carving knife. On examination you see a 4 cm laceration across her left palm. Tendons are on view and the wound is bleeding slowly. Kate tells you she is feeling quite nauseous and her pain is 7/10. Movement and sensation to her fingers are intact.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 14

Denise is a 34-year-old woman who is transferred to the ED on a 40 °C day via ambulance. According to bystanders she was attending an outdoor barbeque and 'collapsed in the heat'. Witnesses helped her to an upright position and she was then observed to have a 'fit' that lasted approximately two minutes. She was not incontinent, has no evidence of tongue trauma and regained consciousness when she was placed in the supine position. Her respiratory rate is 22 breaths per minute, heart rate is 112 beats per minute, blood pressure is 102/60 mmHg and her GCS is 15/15. Her skin is hot and moist.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 15

Kimberly is 32 years of age. She was sent to the ED following an accident at work. She was carrying a pot of hot oil and slipped, spilling it on her upper legs. She immediately removed her clothing and stood under a cool shower for 15 minutes. On arrival in the ED, Kimberly is in considerable pain (9/10). You estimate she has approximately 8% burns to her anterior thighs. Her heart rate is 110 beats per minute and her respiratory rate is 24 breaths per minute.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 16

Tom is a four-year-old boy who presents to the ED with his mother. She states that he fell from a tree. His older brother was the only witness to the fall and claims that Tom fell from about 2 m. Tom's mum found him lying on the ground and a little 'dazed'. Since the fall she says he seems 'drowsy' and he has vomited twice, once several minutes ago. Tom is now conscious and looking at you, but he is very quiet. His skin is pale and warm. He has no obvious injuries, is moving his neck and is not distressed.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 17

Justin is a 22-year-old man who comes to the ED concerned about a mole on his back. He says that his girlfriend advised he see a doctor and he is 'worried that it might be a melanoma'. The mole is large and irregular in shape; he says it is sometimes itchy.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 18

A young man is brought into the ED by ambulance after having been dragged unconscious and not breathing from the sea. He arrives with CPR in progress, and on arrival is noted to have red welts across his chest.

Triage category?

1	2	3	4	5
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Your reasons/comments?

## Scenario 19

Fred, an 84-year-old man, presents to triage reporting palpitations and central chest pain. He has a history of ischaemic heart disease, coronary artery by-pass grafts and atrial fibrillation. He takes his anti-arrhythmic medications regularly and normally manages well at home. Today his skin is pale, cool and moist. His respiratory rate is 26 breaths per minute, heart rate is 142 beats per minute and irregular and he reports chest pain of 4/10.

Triage category?

1	2	3	4	5
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Your reasons/comments?

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## Scenario 20

Michaela is a 3-week-old infant who is brought to the ED by her parents. She has been referred by her local doctor. The parents state that Michaela has been feeding poorly for several days and sleeping more than usual. The parents have not noticed a fever or other symptoms. The infant is sleeping in the mother's arms and her skin is pale. She is peripherally cool. Her capillary refill is 2–3 seconds and her heart rate is 172 beats per minute. Painful stimulus is required to wake the infant, who then wriggles and cries vigorously.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 21

Fabio is a 56-year-old man who was working in his vineyard when he encountered a snake, which reared up and struck him on the inner right thigh. He immediately summoned help and his wife, a nurse, applied a pressure-immobilisation bandage and splinted both legs. He was transferred to the ED in the back of a utility. On arrival he appears calm and states he has 'no pain'. His heart rate is 92 beats per minute, blood pressure is 130/86 mmHg, respiratory rate is 18 breaths per minute and his skin is cool and dry. He has no headache, and he is alert and orientated to time, place and person.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 22

Toby is an 18-month-old boy who presents to triage at 6pm with his parents. They state that he has been 'unwell' for two days. He started vomiting 48 hours ago, developed diarrhoea yesterday and has had seven loose stools today. He has had episodes of 'crying and drawing up his legs'. He is drinking small amounts. He appears lethargic and disinterested in his surroundings. He is pale and his capillary refill is approximately 3–4 seconds.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 23

Rae, a 24-year-old university student, comes to the ED with a friend. She has a four-hour history of generalised abdominal pain, now localised to the right iliac fossa. She has vomited twice and had one episode of diarrhoea about two hours ago. Her respiratory rate is 24 breaths per minute, heart rate is 92 beats per minute, blood pressure is 128/72 mmHg and her temperature is 38.2 °C. She rates her pain as 6/10.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 24

A father presents to the ED at 8pm with his three-and-a-half-year-old daughter, Savannah, stating that she has had a sore throat for 'a day or two'. It started with a runny nose and fever and then yesterday she began complaining of a sore throat. She is not eating as much but continues to drink and has normal urine output. She has no cough or stridor, demonstrates no shortness of breath and her skin is pink and warm. Her heart rate is 118 beats per minute and her respiratory rate is 24 breaths per minute. She is watching videos on her father's phone.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 25

A man states that his 3-week-old baby grandson, Kyle, is 'not breathing properly'. The baby is wrapped in a bunny rug in the grandfather's arms. On closer examination, the baby's eyes open and his face is noted to be white/grey. Respiratory effort is poor.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 26

Sarai is a 38-year-old woman with a history of asthma. She has required two admissions to the intensive care unit for her asthma in the past 18 months. She presents to triage at 8.30pm following a 22-hour history of wheeze and shortness of breath. She has been self-administering salbutamol at home but has had a minimal response to this despite three nebulisers in the past hour. On arrival her respiratory rate is 26 breaths per minute, she is speaking in three-word sentences and has an audible wheeze. Her oxygen saturation is 91% on room air.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 27

Neil is a 74-year-old man who presents to triage following trauma to his left arm after slipping on a wet floor. He describes tenderness at his wrist, elbow, and shoulder. He rates his pain as 3/10. No obvious deformity of the wrist is noted, but he has a decreased range of movement. His heart rate is 92 beats per minute. The neurovascular status of his left hand is normal.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 28

Harry is a 48-year-old man who regularly attends your ED for various complications associated with his poorly controlled type 2 diabetes. He has no GP, lives in supported accommodation and frequently sleeps out in a local park. Today he presents to triage complaining of a two-hour history of intermittent left sided chest pain that is 'heavy' in nature. On further questioning you establish that his pain came on at rest and radiates down both arms. His heart rate is 66 beats per minute and respiratory rate is 20 breaths per minute. His skin is cool and dry.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 29

Ernesto, 57 years, works for an energy company reading gas meters. On his rounds today he was attacked by a dog. He was bitten on the upper left leg. On inspection you note 6–7 cm<sup>2</sup> of skin loss. The wound is irregular, fat tissue is exposed, and it looks dirty; there is a small amount of blood loss. Ernesto says the injury is 'a bit painful' but he is not overtly distressed.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 30

Baz, 34 years, was installing a ceiling fan with the assistance of a mate in his own home. He received a 240-volt charge to his right hand. He was thrown back against the roof. His mate immediately switched the power off and called an ambulance. Baz was noted to have a brief period of loss of consciousness, but was alert when the paramedics arrived. His respirations are 20 breaths per minute, heart rate is 80 beats per minute and irregular, and his blood pressure is 116/68 mmHg. He states his chest aches. He has a 5 cm blackened area to his right hand. No exit wound is seen.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 31

Patrick is a 30-year-old man who is brought to ED by his parents, who found him hanging by his feet in the garage trying to 'drain the rays' from his brain. His parents describe a recent history of increasingly 'odd behaviour' in the context of long-term marijuana abuse. The patient believes that 'aliens' have landed a 'spaceship' in a tree in the neighbour's backyard, and that they are 'transmitting rays' to his brain. Although concerned about this, the patient is not overly distressed or agitated, is not expressing ideas of self-harm and is happy to wait to be seen. His observations are normal.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 32

Hannah is a 41-year-old woman who presents via ambulance with an altered conscious state following collapse. She is 30 weeks pregnant (G3P1) and is normally well. She was out shopping with a friend when she collapsed. Paramedics report a fluctuating conscious state. At the scene she tolerated an oropharyngeal airway but spat it out enroute. She is in a lateral position on the ambulance trolley with supplemental oxygen via a mask. Her respiratory rate is 10 breaths per minute. Her SpO<sub>2</sub> is 93% and her heart rate is 130 beats per minute. Her skin is pale, cool and moist. Her blood pressure is 190/110 mmHg. Her GCS is 10/15. Her temperature is 36.3 °C.

Triage category?

1	2	3	4	5
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Your reasons/comments?

## Scenario 33

Kira is a 7-year-old girl who presents with a schoolteacher, having fallen from play equipment onto tan bark. The teacher estimates the height of the fall as about 1 m. Her mother is on her way to the ED. She fell onto her right arm and has been complaining of pain around her wrist since. She 'did not hit her head' and does not complain of pain elsewhere. Her arm has been placed in a sling, but she has not received any analgesics. Kira is tearful but states that her arm is only 'a little bit sore'. There is a small amount of swelling around her distal forearm but no deformity and no neurovascular impairment. She demonstrates tenderness over her distal radius and has a limited range of movement of her wrist. She has no other signs of injury and is providing the details of her fall.

Triage category?

1	2	3	4	5
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Your reasons/comments?

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## Scenario 34

Vinh is a 74-year-old man who is brought to the ED by paramedics at 5.10am. He has acute shortness of breath and a history of left ventricular failure. His respiratory rate is 30 breaths per minute, with accessory muscle use. His SpO<sub>2</sub> is 89%, but the pulse oximetry display is giving a poor trace. Oxygen is being administered at 100% via bag-valve-mask. His heart rate is 112 beats per minute and irregular, and his blood pressure is 180/100 mmHg. Vinh is trying to remove the oxygen mask and is very agitated.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 35

Luka is a 9-year-old boy who presents to triage with his father at 3pm. He has an injured elbow due to a fall playing football. He is distressed and clutching his arm, which is in a sling. He tells you that his pain is 10/10. His left elbow is markedly swollen and deformed. He has a strong radial pulse and sensation distal to the injury is intact. He is pale, slightly diaphoretic and tachycardic (heart rate is 128 beats per minute). He has no other injuries.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 36

A mother presents at midday with her 9-month-old son, Connor. She describes three days of fever and poor oral intake. On the first evening he vomited once and has had two loose stools overnight, but has not had any since. He also has a 'runny nose'. He is bottle-fed and has had 180 mL of fluid this morning (his usual intake is about 320 mL). He has had a normal number of wet nappies. He was previously well and he is fully immunised. He has signs of a runny nose; no cough is heard, and he has no signs of increased work of breathing. His skin is slightly pale but warm and his mucus membranes are not dry. He is quiet, but looking around at his surroundings.

Triage category?

1	2	3	4	5
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Your reasons/comments?

## Scenario 37

Mr Brown, a 43-year-old man, presents to triage reporting generalised abdominal pains and vomiting. The pain commenced approximately four hours ago and has not been relieved by antacids. He has vomited three times and has no diarrhoea. He is a smoker and has a history of ischaemic heart disease. His normal medications include metoprolol, aspirin, and glyceryl trinitrate skin patches. His skin is pale, cool, and moist. He is doubled up in pain and says it is 'the worst pain I have ever had'. His respiratory rate is 24 breaths per minute and his heart rate is 72 beats per minute.

Triage category?

1	2	3	4	5
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Your reasons/comments?

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## Scenario 38

Iryn is a 10-week-old infant who presents with her parents. She has a two-day history of increasing lethargy and poor feeding. Her mother describes her becoming unsettled and less keen to feed over the last two days. She developed a fever yesterday and has had to be woken for feeds overnight, which is unusual. She was born at term, has had her first immunisation and has no other health problems. She does not demonstrate increased work of breathing but is slightly tachypnoeic. Her skin is pale and her legs are mottled to the knees. She is a little cool and demonstrates a capillary refill of 3–4 seconds. She is lethargic but responds to painful stimuli.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 39

Sebastian is a 16-year-old boy who is brought to the ED by a passer-by, who found him crying and banging his head against the footpath in a small laneway. After bringing Sebastian to triage the accompanying adult left the ED. He has superficial lacerations to both wrists, is dishevelled and unkempt. He is upset about having been brought to the ED, and is saying 'just leave me alone, why don't you just piss off'. He admits to trying to hurt himself and says that he will again as soon as he can. He appears agitated and has limited eye contact.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 40

Anne-Marie is a 22-year-old woman who is brought to the ED by her flatmates, who are concerned about her bizarre behaviour. She had been talking to herself for several days, turning the television off and on because it is sending her messages, yelling out at night, and not sleeping. Her flat mates are concerned that she will come to some harm without help. Anne-Marie does not make eye contact and answers questions with one-word answers. Her flatmates think she may take medication for a mental health diagnosis, but are unsure what it is.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 41

Roberto is a 50-year-old man who self presents to triage stating he 'cannot cope' since losing his job and feels like he is 'losing his mind'. He states that he has 'come to the end of his tether', cannot stand being alone, can't function properly, is tremulous, and is 'on the razors edge all the time'. He presents as tearful, anxious, wringing his hands and hyperventilating. He has no thoughts of self harm and states he wants help.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 42

Mohammed is a 24-year-old man who is brought to the ED by police. He is crying and lying rocking on the floor. He smells of alcohol and police say he is a refugee who has recently been released from a detention centre. He has committed no crime, but was apprehended 'directing traffic' in the middle of a busy city highway. He has had no previous contact with mental health services. Mohammed has very limited English and gives limited responses to questioning. His observations are within normal limits.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 43

Liz is a 40-year-old woman who presents to triage with mild fever and productive cough. She says she is not short of breath and does not complain of any pain. She is 18 weeks pregnant (G4P3) and is normally well. Her respiratory rate is 20 breaths per minute, her SpO<sub>2</sub> is 98% and her heart rate is 98 beats per minute; her skin is noted to be pale, warm and dry. Her GCS is 15/15. Her temperature is 37.8 °C.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 44

Damien is a 36-year-old man who is brought to the ED by his friend. The patient has had a recent marriage break-up, which has involved a lengthy custody and property court case. He has had symptoms of depression for several weeks, such as low mood, ruminations, poor sleep and appetite, feelings of hopelessness and agitation. Since receiving the outcome of the family court hearing three days ago, the patient has been using the amphetamine ice, and is now 'obsessed with plotting revenge' on his former spouse. The patient has been awake for more than 48 hours and presents as angry, rambling in speech, volatile and disordered in his thinking.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 45

David is a 40-year-old man who presents to triage reporting severe chest pain. David has difficulty with his speech and uses a communication board to tell you he thinks he is having a 'heart attack'. He says he has no history of cardiac problems, and his observations are within normal range. He appears highly anxious and is hyperventilating. Currently he says his pain is 10/10. His skin is warm and moist.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 46

Lionel, 68 years, is transferred to your ED from a nursing home. He has Alzheimer's disease and for the past two days has refused fluids. This morning his carer found him lying on the floor next to his bed. The cot-sides were up, but she thought that he had probably fallen because the blankets were also on the floor, and he had been incontinent of urine. Last week he was able to mobilise with a frame and take himself to the toilet, but for the past two days he has not had the energy to move at all and has needed assistance going to the toilet. Since the fall he cannot stand up and he seems to be guarding his right hip. On arrival, he is lying on the trolley groaning. His respiratory rate is 24 breaths per minute, heart rate is 122 beats per minute and his blood pressure is 110/70 mmHg.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 47

Marco is a 25-year-old man who is brought to the ED for assessment by ambulance after he was found by police sitting in his truck with the engine running and a hose connected to the exhaust pipe. An empty pack of temazepam (25 × 10 mg) was in the vehicle along with a half empty bottle of scotch (500 mL bottle). His wife and infant daughter are reported to have left him two weeks before. On arrival he is drowsy and smells of alcohol. When asked what he has taken Marco says 'nothing, I'll be OK'. His vital signs are within normal limits.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 48

Nicholas is a 3-year-old boy who presents with increasing wheeze and shortness of breath. His mother indicates that he has a history of asthma and has been in hospital before. He developed a cold two days ago and he became increasingly wheezy yesterday. His mother gave him prednisolone this morning and he has had hourly salbutamol at home. In the last two hours he has had three doses of salbutamol and the last dose was 15 minutes ago. He has a tight cough and increased work of breathing. His skin is pale but warm. He is distressed and restless.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 49

Harry, an 81-year-old man, presents to triage having been transported via ambulance from a smaller country hospital. He has type 2 diabetes and a two-day history of reduced oral intake, fever and lethargy. He has had 1000 mL of 0.9% saline. He is tachycardic (120 beats per minute) and hypotensive (90/60 mmHg). He has a provisional diagnosis of 'sepsis of unknown origin'.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 50

Frankie is a 21-month-old boy who presents to the ED with his mother by ambulance at 6.30am. He has a barking cough. His mother describes a recent cold. He woke this morning at 5am with the cough and seemed distressed. His mother says that his breathing was 'fast and noisy'. He does not have a stridor but does have a barking (croup-like) cough and mild increase in work of breathing. His respiratory rate is 32 breaths per minute. His skin is pink and warm, and he is settled on the ambulance trolley watching something on a phone.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 51

A mother presents with her 5-month-old baby boy, Jon. She is concerned about a rash that has appeared this morning all over his body. She states that he has had a fever and was 'a bit unsettled' for several days but he seemed 'better last night and this morning, except for this rash'. He is otherwise well, immunised and has no allergies. He is not showing signs of respiratory distress and is not coughing and has no stridor. His skin is pink and warm, and he is smiling. He has a fine red macular rash which blanches over his torso and limbs.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 52

Parents present with a 13-month-old child, Oliver, who has a history of diarrhoea and vomiting. They state that he has been unwell for 'about six days'. It started with vomiting which persisted for 2–3 days but has since stopped. He developed diarrhoea on the second day and that continues. He is willing to drink and has had about his usual amount to drink today. He has passed two loose stools today. He shows no shortness of breath, his skin is pink and warm and his mucus membranes are not dry. He is grabbing at your ID badge.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 53

A restless 24-year-old man is shouting in the ED waiting area. He says, 'God says everyone here is a sinner'. He stands up and kicks the seats, his fists are clenched, he is red in the face and breathing hard. He turns to face the waiting patients with his fists raised aggressively.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 54

Wei is a 30-year-old woman who presents to the ED accompanied by her husband and 4-month-old baby. She has suddenly stopped eating, has insomnia, and has been very withdrawn in the past 'two weeks'. According to her husband she is 'neglecting the care of her baby'. She avoids making eye contact and does not want to hold the baby.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 55

Mr Carver, an 87-year-old man, was brought to your ED in the early hours of the morning with acute shortness of breath. He is sitting upright on the ambulance trolley with a simple face mask in situ. He is receiving 8 L of oxygen per minute. His respiratory rate is 32 breaths per minute, heart rate is 116 beats per minute and irregular, and blood pressure is 170/90 mmHg. His jugular veins are visible and elevated. Skin is moist and pale. He is unable to talk, but he nods when asked if he has pain in his chest.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 56

A father presents at 6.30pm with his 22-month-old son, Jackson, who has cut his forehead about 90 minutes ago. He was playing at home and tripped and fell against the coffee table. He cried straight away but has a large cut on his forehead. The child is not distressed and squirms away when attempts are made to examine his wound. He has a haematoma on the left side of his forehead and a full thickness laceration of 1–2 cm on the left side of his forehead over his eye. His skin is pink and warm and there are no signs of other injuries.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 57

Mr Smith, an 86-year-old man, is brought to your ED following a fall in which he sustained a five-minute loss of consciousness. He was transported from a residential aged care facility to your hospital via ambulance. He has a past medical history including dementia and ethanol misuse. Since the fall he has become restless and agitated and is trying to get off the ambulance trolley. His respiratory rate is 22 breaths per minute, heart rate is 76 beats per minute and his GCS is 12/15. His blood glucose level is 6.6 mmol/L.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 58

Ranjit, a 7-year-old boy, is brought into the ED by his dad. About three hours ago the child fell from his bike, striking his head on the pavement. He was not wearing a helmet. The incident was observed by an older sibling (9 years old) who reported that the boy lay on the ground for some time following the fall and did not move (for 'maybe five minutes'). The child then got up and since the event has vomited twice. He is quiet and closes his eyes while sitting but opens them and responds slowly with one-word answers when asked a question. His GCS is 14/15.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 59

Sunil, a 56-year-old man, was opening a tin of paint stripper with a knife. Some of the chemical splashed up into his right eye. He put his eye under the tap for 15 minutes, before his partner drove him to the ED. At triage he appears very uncomfortable. The eye is closed and there is blistering to the skin surrounding the right orbit.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 60

Rachael is an 18-year-old woman who presents to triage reporting one day of right leg pain. She is 24 weeks pregnant (G1P1) and is normally well. She tells you that she woke up with calf pain and that her pain is worse when she walks. Her calf appears slightly swollen, although she tells you that both legs often swell since she became pregnant. She has no other symptoms. Her respiratory rate is 16 breaths per minute and SpO<sub>2</sub> is 98%. Her heart rate is 94 beats per minute. Her skin is pink, warm and dry. Her GCS is 15/15. Her temperature is 37.8 °C. She says her pain is about 4/10.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 61

Wendy is a 24-year-old woman who presents to triage reporting chest pain. She tells you she has had pain for two days, but it is 'worse today' and she feels 'dizzy'. She is 24 weeks pregnant (G1P0) and is normally well. Her respiratory rate is 24 breaths per minute and her SpO<sub>2</sub> is 95%. Her heart rate is 118 beats per minute. Her skin is pale, cool and dry. Her GCS is 15/15. Her temperature is 36.8 °C. She rates her pain as 7/10.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 62

Stephanie is a 36-year-old woman who presents to triage via ambulance with collapse and abdominal pain. Paramedics tell you she has had intermittent left upper quadrant pain for four days, but today 'the pain became worse' and is now 'constant'. She is 33 weeks pregnant (G2P0) and is normally well. Her respiratory rate is 24 breaths per minute. Her SpO<sub>2</sub> is 98%. Her heart rate is 125 beats per minute. You note her skin is pale, cool and dry. Her blood pressure is 100/R. Her GCS is 15/15 and her temperature is 36.8 °C. When questioned she rates the pain as 8/10.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 63

Rosemary is a 40-year-old woman who presents to triage reporting abdominal pain. She is 36 weeks pregnant (G5P3) and is normally well. She tells you she has had pain 'on and off' for a week but it has become more severe in the last day. The pain seems to be in the right upper quadrant but is difficult for the patient to be precise about the location. She says, 'it is worse after eating' and today she has vomited twice. She says this pain 'does not feel like labour pains'. Her respiratory rate is 22 breaths per minute, SpO<sub>2</sub> is 98% and heart rate is 106 beats per minute. Her skin is pale, warm and dry. Her GCS is 15/15. Temperature is measured at 37.8 °C. She rates her pain as 7/10. She tells you that she has had no PV loss.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 64

Paul is a 47-year-old man. He has a painful left shoulder. He received treatment in ED for the same problem two days ago. There is no history of injury but Paul tells you his shoulder is stiff and keeps 'seizing up'. He tells you that he was prescribed some pain killers that worked initially but the pain is back and is 'much worse now'. He is crying in pain. His left hand is pale and cool; a week radial pulse is noted. His right hand is pink and warm.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 65

Hyojin is a 22-year-old woman who is brought to the ED from a nearby netball stadium. She reports that she fell and twisted her ankle. She is unable to weight bear and is in a wheelchair. At a glance, you note that her ankle is obviously deformed, and she is crying with the pain. You are not able to assess her pedal pulse due to the ice pack and bandaging that are in place, but her friend tells you that the 'bone is sticking out'.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 66

Ted, a 78-year-old man, is brought to the ED via ambulance. Ted attended the ED last night with a vague story of feeling dizzy and unwell – he was diagnosed with a viral illness and sent home. Throughout the night he was woken by heavy chest pains that ‘came and went’. He used his glyceryl trinitrate spray, which did not relieve the pain. Now he is short of breath. His respiratory rate is 24 breaths per minute, heart rate is 92 beats per minute and his blood pressure is 160/90 mmHg.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 67

Gillian is a 26-year-old woman who presents via ambulance with palpitations. She is 34 weeks pregnant (G1P0) and is normally well. She tells you that she was out shopping when her palpitations started. She does not have any associated chest pain or shortness of breath. Her respiratory rate is 20 breaths per minute. Her SpO<sub>2</sub> is 98%. Her heart rate is 108 beats per minute and regular, and her blood pressure is 120/80 mmHg. Her skin is pale, warm and dry. Her GCS is 15/15.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 68

Macey is a 38-year-old woman who presents to the ED with an injured right leg. She is brought to the triage desk in a wheelchair by her father who tells you she has multiple sclerosis. Today she was found by her father after tripping and falling four steps at the front of her home. Normally she can walk with a walking stick, but since the fall she has not been able to walk at all. On examination you note her right ankle is swollen; a right pedal pulse is palpable. She tells you that she has 'no pain' now and is happy to wait to see the doctor. Her vital signs are within normal limits.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 69

Thuy, a 44-year-old woman, presents to the ED with back pain. She has had the problem on and off for many years. This current episode was brought on after lifting a light shopping bag from her car four hours ago. She has taken ibuprofen with little improvement. Currently she has no GP as he moved to a different practice and so she 'didn't know where else to go when the pain happened'. Her vital signs are within normal limits (respiratory rate 16 breaths per minute, blood pressure 110/68 mmHg, heart rate 68 beats per minute) and she is not sure how to rate her pain but says it is 'very bad'. She has normal movement and sensation in her legs and feet. She is moving tentatively and appears to be in pain.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 70

Lilly is a 15-year-old female who presents to triage with her friend following a paracetamol overdose. She is six weeks pregnant (G1P0) and has not been able to tell her parents. Her boyfriend does not want anything to do with her or the baby and she tells you she wants to die. Her friend tells you she took 24 tablets one hour ago. Her respiratory rate is 18 breaths per minute, SpO<sub>2</sub> is 99% and her heart rate is 76 beats per minute. Her skin is pink, warm and dry. Her temperature is 36.8 °C. She is alert and orientated.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 71

A solidly built man of about 40 years and smelling strongly of alcohol starts shouting at another patient in the waiting room. He says he wants to see a doctor but before you can establish what is wrong he stands up and begins to threaten the other patients who are waiting with a knife.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 72

Rae is a 22-year-old woman who presents to the ED. You have received notification about her via a referral from the local mental health clinic. She is brought into ED by her parents. The patient is currently detoxing from amphetamines and is visibly restless. The clinic referral letter states that the patient is 'actively suicidal'. She states she has no plans to harm herself and she is asking for help.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 73

Patty is a 53-year-old woman who presents to triage reporting right-sided abdominal pain. She states that the pain has been constant for two days. She has not had any nausea or vomiting. She tells you that the pain is worse when she is sitting still. She states that she has had this pain before and her local doctor thought it might be gall stones. Prior to coming to the ED, she took two paracetamol tablets with minimal effect. She rates the pain as 5/10. Her respiratory rate is 18 breaths per minute, heart rate is 96 beats per minute and her blood pressure is 145/84 mmHg. Her temperature is 36.4 °C.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 74

Galen is a 9-year-old boy who presents to the ED with his father. He has a past history of asthma. Today he developed wheezing while playing soccer, which has only been partially relieved by salbutamol. He is able to speak in short sentences, but sits in the tripod position on a chair while you assess him and he shows severe increase in work of breathing. The onset of the attack occurred four hours ago and since then he has taken three doses of salbutamol. He also takes a preventer for his asthma and his father states that he normally manages well. His heart rate is 142 beats per minute and his respiratory rate is 26 breaths per minute.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 75

Emil is a 5-year-old boy with a 5-day history of diarrhoea and vomiting. He presents to the ED with his mother, and she says that he has been unable to keep anything down today. He has not eaten since becoming sick but was having sips of water yesterday. He is pale and quiet but alert. His heart rate is 124 beats per minute and his respiratory rate is 26 breaths per minute. His urine is darker in colour and his capillary refill is less than 3 seconds. His mother is unsure if he has had a fever at home and his temperature is 36.6 °C.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 76

Lee is a 20-year-old woman who presents to the ED with her mum. Her mother reports that she has had paranoid ideas that her food has been poisoned and since yesterday has not had anything to eat or drink. She states that the reason for not drinking is because she believes that there are 'spiders and poison around'. This has never happened before.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 77

Tomas, an 8-year-old boy, presents to the ED with his mother. Mum was called to the school to pick up Tomas today. While playing at recess he was involved in a fight which resulted in him being hit in the face with a plastic cricket bat. Mum says the school called her because he was inconsolable after the event, and he didn't want to go back to the classroom. There was no loss of consciousness reported and he has not vomited, felt dizzy or complained of headache since, but he has a 3 cm laceration to his left cheek.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 78

Harley is an 18-month-old boy who was brought to the ED via ambulance. He was found face down in a swimming pool. His parents administered cardio-pulmonary resuscitation at the scene and called the ambulance. On arrival the child is breathing spontaneously and receiving 100% oxygen via bag-valve-mask. His heart rate is 140 beats per minute and his respiratory rate is 14 breaths per minute. The child has his eyes closed and is lying still on the trolley. He is responding to painful stimuli.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 79

Candy, a 3-month-old girl, presents to the ED with her mother. She has been referred by the maternal child and health nurse. She has been 'crying a lot' according to her Mum and she has 'bad colic'. The baby was born prematurely at 36 weeks and delivered by emergency caesarean section due to pre-eclampsia. Since birth, the baby has gained weight and mum says other than the colic 'is doing OK'. When you go to examine the baby you note green/yellow bruising and some red welts on the upper arms. The infant is alert, shows no increase in work of breathing and her skin is pink and warm.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 80

Ahmad is a 39-year-old man who walks to the triage desk. He slipped and fell onto his shoulder in his driveway and now has left shoulder pain. On examination the shoulder is very swollen and painful on movement. His arm is already in a sling. His left hand is warm, and a radial pulse is present. He rates his pain as 2/10 when not moving.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 81

Laurie, a 66-year-old man, has been referred to the ED from his local doctor on a Monday morning. He complains of increasing upper abdominal pains, associated nausea and constipation over the weekend. He had a loose bowel action this morning. His appetite is normal, his pain is sharp in nature, and he rates it as 8/10. His respiratory rate is 22 breaths per minute, heart rate is 86 beats per minute, blood pressure is 142/82 mmHg and his temperature is 37.8 °C.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 82

Bianca is 24 years old. She has a history of a perianal abscess that underwent drainage two days ago. She continues to have pain (4/10) and was seen by her local doctor today. She has taken paracetamol with no relief and is on oral antibiotics. Her respiratory rate is 20 breaths per minute, heart rate is 92 beats per minute and her temperature 37.6 °C.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 83

Ned, a 28-year-old jockey, attends the ED after being kicked in the abdomen by a horse. He was assisting a colleague to guide the animal into a float when it reared up and then kicked him. Ned was thrown some 2 m and fell to the ground. He did not lose consciousness but was 'winded from the kick'. At triage, Ned appears pale and distressed. He tells you that he has pain and points to his left upper quadrant. His respiratory rate is 26 breaths per minute, his heart rate is 128 beats per minute and his skin is cool and moist.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 84

Homer, 21 years, twisted his right knee playing basketball. His knee is very swollen, and he is unable to weight bear. The injury occurred about two hours prior to his arrival in the ED and an ice pack has been applied. The neurovascular status of his right foot is normal. He rates his pain as 2/10 if he doesn't try to walk on it.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 85

A 52-year-old man presents to triage. He has a diagnosis of schizophrenia. He is currently on medications for this, but cannot recall the name of the medication or the name of his case manager. He says that he has been having suicidal thoughts and that 'there are voices' urging him to 'step in front of a train'. He has lost his medication and is asking for help; he makes eye contact and is not agitated.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 86

A 29-year-old woman presents to the ED with a friend. She states that she is depressed and feels like harming herself. She has superficial lacerations on her forearm that look to be 4–7 days old. When asked if she would be able to wait a short time, she says that she feels safe to wait and finds her friend supportive. She has a history of depression and self-harm, but is not currently on any medications.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 87

Ranju presents to the ED with generalised abdominal pain. She has been brought in by a work colleague. When questioned she complains of six days of constipation. She is booked in for a colonoscopy at a private clinic tomorrow. She is on no medication but is bent over and crying in pain. Her respiratory rate is 16 breaths per minute. Her heart rate is 92 beats per minute and blood pressure is 105/60 mmHg. Her temperature is 36.8 °C. She rates her pain as 6/10.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 88

While playing volleyball, Gary, a 47-year-old, hurt his left wrist. He has a good range of movement although he has pain when you ask him to rotate his left hand. The neurovascular status of his hand is normal, and his pain is 1/10 when not moving.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 89

Marcia, a 48-year-old woman with a history of epilepsy, comes to the ED because she has occasional pain radiating up her leg and chest causing tightness. On arrival she is pain-free but complains of nausea and lethargy. She is short of breath, her respiratory rate is 16 breaths per minute, SpO<sub>2</sub> is 97% and her heart rate is 68 beats per minute. She is afebrile.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 90

Bryan, 23 years, attends the ED because he has noticed a sore on his penis. He tells you the sore is about 3 cm and is oozing clear fluid. He says he feels 'embarrassed', and that he has 'never had this problem before', but he had to get help because it is 'painful'. He rates the pain as 5/10. He is afebrile.

## Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 91

Liam is a 23-year-old man who presents to triage after being seen by a locum doctor. He is currently back-packing around Australia and has been staying in a boarding house a few doors down from the hospital. His partner has brought him to the ED. He has a six-hour history of fever and lethargy. He has been vomiting and complains of a headache. The doctor gave him an ondansetron wafer, with some effect. His temperature is 38.4 °C; his partner points out a fine petechial looking rash on his torso. He is drowsy but orientated to time, place and person. His respiratory rate is 26 breaths per minute and his heart rate is 102 beats per minute.

## Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 92

Ashley, a 23-year-old university student, fell off her push bike two days ago and was seen in another ED. She is reporting stiffness and pain to her left wrist. Her left hand is swollen but she has full range of movement, the left hand is pink and warm. She rates her pain as 2/10.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 93

Hamish is an 18-year-old man who is sent to the ED from his local doctor with a sudden onset of right testicular pain. He has a history of partial testicular torsion two weeks ago and states that the pain is the same as it was then. He is doubled over in pain at the triage desk.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 94

Remo is a 43-year-old man who presents with a two-week history of right renal stones. He now has pain, which he describes as colicky in nature. He rates the pain as 4/10. He has had no pain relief today. His respiratory rate is 22 breaths per minute, heart rate is 67 beats per minute and temperature is 37.6 °C.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 95

Linda is a 35-year-old woman with a history of hepatitis B. Today she presents with right-sided abdominal pain. The pain has been getting worse over the past week and is currently 4/10. She has no vomiting and her skin is pink and warm. Her respiratory rate is 18 breaths per minute and her heart rate is 74 beats per minute. Her blood pressure is 126/72 mmHg and her temperature is 37.8 °C.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 96

Thiam, a 29-year-old, was painting a roof. He lost his footing and fell approximately 2 m, landing on his feet. His work mate was able to assist him into a car and transported him to hospital and is interpreting for him now as Thiam's English is limited. On arrival he is unable to weight bear at all. He has pain, which he says is 8/10. Both feet and ankles are swollen. His respiratory rate is 20 breaths per minute and his heart rate is 102 beats per minute. He has pins and needles in both feet and pulses are present.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 97

Cassandra, a 15-year-old, was riding her horse in the bush some 60 km away from town when the animal was startled and threw her about 3 m. She was wearing a helmet, but her head struck a tree, and the helmet broke in half. Her companions noted an initial loss of consciousness, after which she was drowsy and vomiting. She did not appear to have any injuries elsewhere and did not complain of neck pain when asked. She was transferred to your ED in the back of a utility. On arrival she has a GCS of 8/15. Her respiratory rate is 24 breaths per minute and her heart rate is 62 beats per minute.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 98

Luke, a 27-year-old, wants to travel to India next week. He attends the ED for advice about the sorts of vaccinations he might need.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 99

Mrs Y is a 49-year-old woman who complains of pain in the upper abdomen and states that she has been vomiting. She hands you a local doctor's letter that reads: 'Dear Dr, Herewith Mrs Y a 49-year-old woman 12/12 past history of hypertension and back pain. Early this morning she developed epigastric pain, described as coming in waves and vomiting, no diarrhoea. Yours Sincerely, Dr A.' Her respiratory rate is 16 breaths per minute and her heart rate is 92 beats per minute. Her blood pressure is 116/68 mmHg, temperature is 37.2 °C and her skin is warm and dry. She rates her pain as 6/10.

Triage category?

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Your reasons/comments?

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## Scenario 100

Pete, aged 28 years, presents to the ED at 9pm on a Sunday night requesting a workers' compensation certificate for a day off work the previous week. He was seen at the hospital five days ago with a sprained wrist and had been given the certificate for one day off work. He has lost the certificate. He tells you that he is 'prepared to wait' as his boss has told him to get a new certificate by Monday morning or he would be 'in big trouble'. His wrist is no longer painful, and he says he 'feels fine'.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 101

Jane is in her 20s and presents to the triage desk with her friend. The friend states Jane has taken 15 × 50 mg sertraline tablets and some diazepam tablets (unsure how many) and some wine. As you begin talking to her friend, Jane begins to vomit, appears confused, falls to the floor and becomes unresponsive. You summon help and staff arrive, they lift her onto a trolley and take her into the ED.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 102

Jane is a 17-year-old girl who was sent to the ED by her local doctor. On her way home from school her boyfriend noticed her to be drowsy, 'she kept asking where she was and appeared disoriented'. She was seen by her local doctor who told her to 'go straight to the ED'. He did not provide her with a letter of referral. Her respiratory rate is 14 breaths per minute, heart rate is 62 beats per minute and her blood pressure is 106/58 mmHg. Her skin is pink, warm, and dry. Her GCS is 14/15.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 103

Djawa, 34 years of age, has an abscess under his tooth. He presents to the ED at 1.30am. He is in pain (6/10) despite taking regular paracetamol and ibuprofen. He has an appointment with his dentist tomorrow but has not been able to sleep because of the pain. He is afebrile.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 104

Mario, a 67-year-old man, was putting some pesticides on his vegetable patch and he accidentally spilt it on his clothing. He had a shower at home immediately after the accident but has come to the ED some two hours later because he is nauseous, vomiting and has developed excessive sweating. His respiratory rate is 28 breaths per minute and his heart rate is 122 beats per minute. He says he is not sure of the name of the chemical he was exposed to as he has had it in his shed for 'many years'.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 105

Hugh is a 54-year-old man who was seen in the ED with a fractured right radius and ulna four days ago. He presents today because he says the cast is too loose and needs to be replaced. He has no pain, and his right hand is pink and warm.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 106

Joanne is a 34-year-old woman who walks to the triage desk at 10.50am. When you ask her what is wrong, she says 'I can't go to the toilet'. When questioned she says that she has not passed urine today but said she 'did last night and it was not painful' to void. Her pain is currently 4/10. Her respiratory rate is 16 breaths per minute, heart rate is 72 beats per minute and temperature is 36.2 °C.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 107

Mrs Zhang is assisted to the triage desk by her daughter around midday. She has limited English proficiency, so her daughter tells you her history. Last night Mrs Zhang had an episode of palpitations and complained of nausea and feeling lethargic. Today 'the palpitations are back'. She has a history of coronary artery bypass grafts. When asked if she has chest pain, she says she is 'very sick'. Her respiratory rate is 26 breaths per minute and her heart rate is 108 beats per minute. Her skin is pale, cool and moist to touch.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 108

Madhu is a 32-year-old woman who presents via ambulance complaining of 'palpitations'. She is 30 weeks pregnant (G3P1) and is normally well. She was doing the vacuuming when her palpitations started. She complains of mild chest pain that is dull in nature and mild shortness of breath. Her respiratory rate is 24 breaths per minute and SpO<sub>2</sub> is 98%. Her heart rate is 162 beats per minute. Her skin is pale, cool and dry. Her blood pressure is 90/R. Her GCS is 15/15. Her temperature is 36.3 °C.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 109

Kerry is a 36-year-old woman who presents to the ED via ambulance with sudden onset of headache. She tells you that she is 31 weeks pregnant (G3P1) and has been 'keeping well'. Her husband tells you she was making lunch when she suddenly complained of a severe occipital headache. Her respiratory rate is 20 breaths per minute and SpO<sub>2</sub> is 98%. Her heart rate is 124 beats per minute. Her skin is pale, cool and dry. Ambulance officers report a blood pressure of 160/100 mmHg and a GCS of 14/15 (eyes open to voice). Her temperature is 36.3 °C. When asked to score her level of pain out of 10, she tells you it is 9/10.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 110

At 5.30am a mother presents with her 18-month-old daughter, Jasmine, describing one or two days of cough. She had been seen at another ED earlier in the night but discharged home. The mother states that the child is 'an asthmatic' and that they have been giving her four-hourly salbutamol. The last dose was given at midnight. The child is leaning against her mother, but looking around, and her skin is pink. Her cough is moist, and she is showing moderate use of her accessory muscles. Her respiratory rate is 32 breaths per minute and on auscultation has an expiratory wheeze and decreased air entry to both bases. Her heart rate is 168 beats per minute and her SpO<sub>2</sub> is 92%.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 111

Josie is 39 years of age. She walks to the triage desk complaining of pain in her legs. When asked, she says, 'my feet and legs are swollen and sore'. She has a history of intravenous drug use, heavy alcohol intake and hepatitis C. Currently she is on no medications and is alert and orientated. Her respiratory rate is 18 breaths per minute, heart rate is 74 beats per minute and temperature is 36.7 °C.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 112

Manaaki is 28 years of age. He attends the ED with his partner at 5.30pm. He has abdominal pain radiating to his right loin, urinary frequency and dysuria. He saw his GP yesterday who said he 'might have kidney stones'. The pain is worse now (7/10) and he noted some blood in his urine last time he voided. His respiratory rate is 16 breaths per minute and his heart rate is 102 beats per minute. His temperature is 37.2 °C.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 113

Dylan is a 20-year-old man who is brought to the ED in police custody. He has a history of intravenous drug use and hepatitis C. He presents with a two-day history of right upper quadrant pain. When asked about his pain he states that his liver is 'playing up'. His respiratory rate is 16 breaths per minute, heart rate is 82 beats per minute, temperature is 37.2 °C and pain is 2/10.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 114

Police escort a 19-year-old distressed woman to the ED. The police tell you quietly that Helen has been repeatedly raped and bashed in a domestic dispute. Helen cannot speak to you as she is shaking and crying. She is sitting in a wheelchair with a blanket wrapped around her. She has bruising to her face and a large peri-orbital haematoma is evident to her left eye. You approach Helen to try to assess her but she starts screaming and hitting out.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 115

A 5-year-old boy is rushed into your ED by his parents one hot summer day. He has been holidaying with his family in far north Queensland and was wading in the sea. He has a raised red welt on his right leg. He is in severe pain and is crying. He has a heart rate of 128 beats per minute and a blood pressure of 130/70 mmHg.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 116

Aida, a 17-year-old girl, presents to the ED complaining of a sore throat. She has a hoarse voice and her friend states she also has muscular pain to her neck, shoulders and back. She has been unwell for a few days but has come to the ED today because she is having trouble swallowing. You ask her to open her mouth and note that her breath is foul smelling. Her tonsils appear to be covered in pus. Her respiratory rate is 22 breaths per minute, heart rate is 98 beats per minute, blood pressure is 116/78 mmHg and her temperature is 38.4 °C. She is speaking in full sentences and able to swallow, although it is painful.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 117

Benny, a 52-year-old, has recently received chemotherapy (two treatments), the last of which was two days ago, for small cell lung cancer. He was told to come straight back to hospital should he develop a fever. He now has a temperature of 38.7 °C and is pale and sweating. His respiratory rate is 28 breaths per minute and his heart rate is 98 beats per minute.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 118

Reese, a 31-year-old, suffers from migraines. Today she has come to the ED with her sister. She has had an eight-hour history of a global headache, vomiting and visual disturbance, which she says is typical of her migraine pain. She has taken her usual medication (sumatriptan), but says it is 'not working'. Her heart rate is 96 beats per minute and her respiratory rate is 28 breaths per minute. She is afebrile and rates her pain as 7/10.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 119

India is a 9-year-old girl who arrives to the ED via a taxi; she is accompanied by her mother. She fell while playing netball, injuring her right foot. She is transferred to the triage desk in a wheelchair as it is painful for her to weight bear. Her ankle is moderately swollen, but there is no deformity and her toes are pink and warm. She has no other injuries but agrees to a dose of paracetamol.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 120

A mother presents with her 6-month-old baby who she says won't wake up. The child is breathing, but is floppy, unrousable and has pin-point pupils.

Triage category?

1	2	3	4	5
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Your reasons/comments?

## Scenario 121

Paddy is a 32-year-old man who presents to triage stating that he has vomited bright red blood twice in the last six hours. He describes dark bowel motions, for the last three days. He tells you that he normally drinks '12 stubbies of beer per day'. His respiratory rate is 20 breaths per minute, heart rate is 108 beats per minute and his blood pressure is 106/68 mmHg. His skin is pale, warm and dry. He doesn't have any pain, but does complain of nausea.

Triage category?

1	2	3	4	5
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Your reasons/comments?

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## Scenario 122

Trinh is a 22-year-old woman who presents to the ED at 11pm complaining of a 24-hour history of a sore throat and feeling generally unwell. She had been attending a party nearby and decided to call in to the hospital to get some antibiotics. She has no other symptoms, looks well and is afebrile. Her vital signs are within normal limits.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 123

You are called to assist a young woman help her boyfriend out of the car that is pulled up in the ambulance bay. She tells you that Matt 'shot up' 30 minutes ago. On examination, Matt appears to have vomited and is centrally cyanosed. He has irregular grunting respirations of six breaths per minute.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 124

Elliot is 27 years old. He injured his back yesterday lifting a heavy box at work. He has been managing his pain at home; however, today it is 'much worse'. He was unable to get an appointment with his local doctor so has come to the ED. He rates his pain as 5/10 and has taken two paracetamol and two ibuprofen tablets in the last hour.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 125

Over the past four weeks Gregory, a 56-year-old, has attended your ED 14 times. Today he says he has a problem with a tattoo that was applied 'by a mate' two weeks ago. The wound looks red and is oozing pus. Gregory has a history of intravenous drug and alcohol misuse, hepatitis C and type 2 diabetes. His vital signs are within normal limits.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 126

Khee, 62 years, stubbed his right great toe on the corner of a fireplace. The nail has lifted off and the toe is now covered in a blood-soaked tea-towel. He walks into the ED assisted by his son. He tells you that he takes warfarin, so 'thought it best to come to hospital rather than see the local doc'. His son tells you that the tea-towel has not been changed since the injury, but there was 'blood all over the floor'. His respiratory rate is 16 breaths per minute, heart rate is 88 beats per minute and blood pressure is 132/78 mmHg. He rates his pain as 4/10.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 127

Carole, a 48-year-old woman, is brought to the ED by her husband. She is vomiting and has severe epigastric pain. She ate at a local restaurant and told you she thinks that she has 'food poisoning'. Her respiratory rate is 26 breaths per minute, her heart rate is 98 beats per minute and her temperature 37.8 °C. Her skin is pale and moist to touch. She says that the pain comes and goes, she rates it as 8/10 at the worst point, and 2/10 at the lowest point. She says that she has vomited semi-digested food more than six times in the last hour. Now the vomit is clear fluid.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 128

Paramedics arrive without prior notice with a woman aged 26 years. She was a front seat passenger from a single motor vehicle crash that involved multiple rollovers. The paramedics state that the patient was walking around at the scene, intoxicated, abusive, complaining of abdominal pains and reluctant to come to hospital. On examination the patient is centrally cyanosed and not breathing.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 129

Ron, the 50-year-old coach of a visiting interstate football team, presents to triage at 7pm on Saturday night. His anti-hypertensive medications have run out and his GP has previously warned him that it would be dangerous for him to stop his medications. Ron says that he realises that it is 'not completely appropriate' for him to attend the ED for a prescription but says he doesn't know any GPs in the city and is quite prepared to wait for his prescription. His GCS is 15/15. His skin is pink, warm and dry. He has no headache or pain elsewhere.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 130

Noel, a 29-year-old man, is driven to the ED by friends following a fight at his cousin's party. You are called to retrieve Noel from the ambulance bay. While getting Noel out of the car you learn that he was stabbed in the left side of his chest with a carving knife and see a 2 cm laceration below his left nipple. His skin is cool, pale, and moist. He has a weak carotid pulse and a GCS of 9/15.

Triage category?

1	2	3	4	5

Your reasons/comments?

## Scenario 131

Harriet, 90 years of age, presents to the ED via ambulance in an acutely confused state. She lives in a low-level care facility and is normally independent with activities of daily living. Today, the visiting nurse found her in another resident's room rummaging through their drawers. When she was approached, she hit out at the nurse, which 'is unlike her'. She has a history of hypertension and mild dementia. She is mildly febrile (37.6 °C), her heart rate is 86 beats per minute and her respiratory rate 20 breaths per minute. She is picking at the sheets and seems agitated. Her GCS is 14/15.

Triage category?

1	2	3	4	5

Your reasons/comments?

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## Scenario 132

An obviously pregnant woman presents to triage stating that she is in labour and that she thinks that there is something hanging down between her legs. On examination you see under her dress is what appears to be an umbilical cord.

Triage category?

1	2	3	4	5
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Your reasons/comments?

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## Answers

Scenario	Category	Rationale
1	2	Airway and breathing are intact. The patient is cool and clammy and reporting very severe pain post-analgesia.
2	3	Airway, breathing and circulation are intact. Foreign body in the eye with no change to visual acuity and no pain.
3	3	Airway, breathing and circulation are intact. The underlying problem is the pain, and this must be investigated thoroughly. Suicidal ideation is expressed but it should be noted that Shane is seeking help. This patient should be under close observation.
4	4	Airway, breathing and circulation are intact. Her hip is causing pain on movement, but she can weight-bear. She will require assessment within one hour.
5	4	Airway, breathing and circulation are intact. He has a mild haemorrhage. Pain only occurs when bowels are opened. This patient should be assessed within one hour.
6	3	Airway, breathing and circulation are intact. She has severe symptoms of depression. Rebecca should also be under close observation and should wait no longer than 30 minutes for a medical assessment.
7	3	There is no compromise to the primary survey. Pain has not been relieved by oral analgesia and there is a moderate level of distress associated with the pain.
8	2	Airway is intact. There is severe respiratory distress with potential risk to the foetus (SpO <sub>2</sub> 90%). Sepsis is suspected. Kylie should be medically assessed within 10 minutes.
9	3	Airway, breathing and circulation are intact. History of fever and possible febrile convulsion. This child should wait no longer than 30 minutes.
10	3	There is no compromise to airway or breathing. From the history it appears that the blood loss is moderate. The heart rate is mildly elevated but there is no haemodynamic instability.
11	3	There is no compromise to airway, breathing or circulation. She is pale. Her pain is moderate to severe and is causing distress.
12	4	Airway, breathing and circulation are intact. Mild pain with no circulatory compromise. This patient should wait no longer than one hour for medical assessment.
13	3	Airway, breathing and circulation are intact. Blood loss is mild, but pain is severe. Kate should wait no longer than 30 minutes for assessment of her wound.

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Scenario	Category	Rationale
14	3	Airway, breathing and circulation are intact. History suggests heat stroke and seizure. Patient has normal neurological functioning now. This patient should be medically assessed within 30 minutes.
15	2	Airway and breathing are intact and circulation is stable with slight tachycardia. Burns of this nature cause severe pain. Analgesia should be given and treatment should commence within 10 minutes of arrival.
16	2	Airway and breathing are intact. His skin is pale and he is drowsy post a fall of significant height. Reported change to conscious state with some neurological symptoms. He should not wait more than 10 minutes to be seen.
17	5	Airway, breathing and circulation are intact. This is not an urgent problem; however, the lesion does need to be checked. This patient should be seen within two hours.
18	1	Cardiopulmonary arrest. Possible jelly fish envenomation. Immediate assessment and resuscitation is required.
19	2	Airway is intact with tachypnoea. Chest pain is potentially cardiac in nature. This patient should be assessed and treated within 10 minutes.
20	2	The airway is clear and there is no compromise to breathing. The child shows signs of circulatory compromise including lethargy and drowsiness and should therefore be assessed within 10 minutes of arrival.
21	2	Primary survey is intact. Known snake bite with effective first aid; however, this is a significant/dangerous envenomation. Assessment and treatment should commence within 10 minutes.
22	2	Airway and breathing are not compromised. Multiple signs and symptoms of dehydration are evident, including lethargy and poor capillary refill. The child also appears to be in pain and very distressed with his illness. He needs to be assessed and commence treatment within 10 minutes of arrival.
23	3	Airway, breathing and circulation are not compromised. She has pain and likely intra-abdominal pathology as evident by localising pain, fever and vomiting. Rae should wait no more than 30 minutes for assessment and treatment.
24	4	Airway, breathing and circulation are intact. Savannah is experiencing some discomfort from her condition and should therefore be assessed and commence treatment within an hour.
25	1	Neonate with potential airway compromise and abnormal breathing. Kyle requires resuscitation and immediate medical assessment.
26	2	Airway is intact. Significant level of respiratory distress in the context of history of previous severe asthma requiring ICU admissions. This patient should be assessed and treated within 10 minutes.

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Scenario	Category	Rationale
27	4	Airway, breathing and circulation are intact. No circulatory compromise to the injured limb. Pain is reported to be mild.
28	2	Airway, breathing and circulation are intact. Chest pain of likely cardiac nature. Diabetes is a co-morbid factor. The patient should receive assessment and treatment within 10 minutes.
29	4	Airway, breathing and circulation are intact. Blood loss is mild. Pain is reported as mild. This patient needs to receive treatment for his injury within one hour.
30	2	Airway, breathing and circulation are intact. Likely full thickness burn from electrocution indicates severe localised trauma, with possible systemic involvement. This patient should wait no more than 10 minutes to commence treatment.
31	3	Primary survey is intact. The patient demonstrates signs of acute thought disorder and requires assessment within 30 minutes.
32	1	Immediate risk to airway, breathing and circulation. Hannah requires immediate assessment and resuscitation.
33	4	Airway, breathing and circulation are intact. Injured wrist/forearm with no circulatory impairment. Pain is mild. This child should commence treatment within one hour.
34	2	Airway is currently clear; however, there is severe respiratory distress. There is acute shortness of breath and a mild tachycardia. These signs and symptoms are possibly due to acute left ventricular failure. Vinh should be assessed and commence treatment within 10 minutes.
35	2	Airway, breathing and circulation are intact. There is severe pain, and the child should wait no more than 10 minutes to commence treatment.
36	4	Airway, breathing and circulation are intact. He is alert with mildly decreased oral intake. This child should receive treatment within one hour.
37	2	His airway is intact, his respiratory rate is elevated and he is pale. His pain is severe. He should wait no longer than 10 minutes to commence treatment
38	1	Tachypnoea, pale and mottled skin with delayed capillary refill are signs of severe shock. The patient responds to pain only. She requires immediate simultaneous assessment and treatment.
39	2	Airway, breathing and circulation are intact. The patient has attempted self-harm. His comments indicate that he may be at high risk of absconding. He should commence treatment within 10 minutes of arrival in the ED.

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40	3	Airway, breathing and circulation are intact. There are signs of acute thought disorder as well as bizarre and agitated behaviour. Anne-Marie requires assessment within 30 minutes.
41	3	Airway, breathing and circulation are intact. The patient is very distressed and has a situational crisis. He should wait no longer than 30 minutes to be seen.
42	3	Primary survey is intact. The patient is experiencing a situational crisis and should wait no longer than 30 minutes for medical assessment.
43	4	Airway, breathing and circulation are intact. The patient is febrile and is likely to have an infection. She should wait no longer than one hour.
44	2	Airway, breathing and circulation are intact. There is extreme agitation and possible threats of harm to others. This patient should commence treatment within 10 minutes.
45	2	Airway is intact. This patient reports severe pain and has some risk factors for heart disease. Investigations must be conducted to rule out cardiac causes for his pain and he should wait no longer than 10 minutes before treatment is commenced.
46	3	Airway is intact; heart rate and respiratory rate are elevated. There is a possibility of a fractured hip and given his cognitive impairment, pain is difficult to assess. This patient is likely to be in pain and discomfort from the injury. He should wait no longer than 30 minutes for treatment.
47	2	Significant sedative ingestion and potential exposure to toxic fumes. Risk of self-harm. This patient requires monitoring of airway, breathing and circulation and should be medically assessed within 10 minutes.
48	2	Airway is clear, though there is marked increased work of breathing. The child is distressed and restless. He should wait no longer than 10 minutes.
49	2	Airway and breathing are intact. His tachycardia with hypotension demonstrates circulatory compromise and the patient has indicators to meet suspected sepsis. He should wait no longer than 10 minutes.
50	3	Airway is clear, though there is increased work of breathing. This child should wait no longer than 30 minutes for treatment.
51	4	Primary survey is intact. He should wait no longer than one hour.
52	4	Airway, breathing and circulation are intact. The child is alert and active. He should wait no more than one hour.

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Scenario	Category	Rationale
53	1	Severe behavioural disorder with imminent threat of dangerous violence. This patient requires immediate assessment and simultaneous management.
54	3	The primary survey is intact. The patient shows signs of distress and being withdrawn and is post-partum.
55	2	Airway is clear. The patient has severe respiratory distress and shows signs of acute left ventricular failure. He also has pain in the chest. He should wait no more than 10 minutes for treatment.
56	4	Airway, breathing and circulation are intact. The child is not distressed and he did not lose consciousness. He should wait no longer than one hour for treatment.
57	2	Airway, breathing, and circulation are intact. He has had a loss of consciousness and his GCS is less than 13. He should wait no longer than 10 minutes.
58	2	The primary survey is intact. Significant head injury and possible other trauma with ongoing changes to cognition. He should wait no longer than 10 minutes.
59	2	Airway, breathing and circulation are clear. He has a chemical burn to the eye with changed visual acuity. This patient should receive treatment within 10 minutes.
60	4	Primary survey is intact. There is moderate pain with some risk features. She should wait no longer than one hour.
61	2	Airway is intact, slight elevation in respiratory rate and heart rate with chest pain. This patient should wait no longer than 10 min to be medically assessed.
62	2	Airway is intact, increase respiratory rate and early signs of circulatory compromise. She also has very severe pain. Pregnancy is a complicating factor. She should wait no more than 10 minutes
63	3	Airway, breathing and circulation are intact. The patient has moderate to severe pain and should wait no longer than 30 minutes for treatment.
64	2	Airway, breathing, and circulation are intact. Neurovascular assessment indicates a limb-threatening condition. The patient is experiencing severe pain and so should wait no longer than 10 minutes to commence treatment.
65	2	Airway, breathing and circulation are intact. The patient is in very severe pain and the description of the injury suggests severe localised trauma. Hyojin should be assessed and commence treatment within 10 minutes of arrival.

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Scenario	Category	Rationale
66	2	His airway is clear and he is short of breath. Chest pain of likely cardiac nature. Ted should be assessed and commence treatment within 10 minutes of arrival.
67	3	Airway, breathing and circulation are intact. The heart rate is mildly elevated and the patient is experiencing palpitations. She should wait no longer than 30 minutes to commence treatment.
68	4	Airway, breathing and circulation are intact. There is an injury to the ankle and possible fracture. The patient should wait no longer than one hour for assessment and treatment.
69	3	Airway, breathing and circulation are intact. The patient has moderate pain and should wait no longer than 30 minutes to be assessed and commence treatment.
70	2	Primary survey is intact. The patient presents with a significant toxic ingestion compounded by pregnancy. She is also experiencing a significant situational crisis and verbalising suicidal thoughts. Assessment and treatment should commence within 10 minutes of arrival.
71	1	Immediate threat of physical violence using a weapon. Simultaneous security and clinical response to aggression is required.
72	3	Primary survey is intact. The patient is agitated and should wait no longer than 30 minutes to be seen.
73	4	Airway, breathing and circulation are intact. The patient has abdominal pain with no associated nausea or vomiting. Symptoms are moderate, and treatment should commence within one hour.
74	2	Airway is intact. There is severe respiratory distress and the patient should wait no longer than 10 minutes.
75	3	Airway is intact and there is no respiratory distress. The patient is mildly tachycardic. He should wait no longer than 30 minutes for treatment.
76	3	Airway, breathing and circulation are intact. The presence of psychotic symptoms (paranoid ideas) indicates that treatment should commence within 30 minutes.
77	4	Airway, breathing and circulation are intact. There has been no loss of consciousness, nonetheless the child is distressed and should receive treatment within one hour.
78	1	Near drowning with respiratory arrest. Respiration and circulation are now re-established. The child should be assessed and commence treatment immediately.
79	3	Airway, breathing and circulation are intact. A number of risk factors suggest this child is at risk of abuse; accordingly, the child should wait no longer than 30 minutes for assessment.

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Scenario	Category	Rationale
80	4	Airway, breathing and circulation are intact. There is an acute injury causing mild pain, but there is no circulatory compromise to the affected limb. The patient should wait no longer than one hour before commencing treatment.
81	2	Airway, breathing and circulation are intact. The patient has severe pain and abdominal symptoms and is over the age of 65. He should commence treatment within 10 minutes.
82	4	Airway, breathing and circulation are intact. Pain is due to an acute infection which is being treated. The patient has taken analgesia but continues to experience a mild level of pain. The patient should wait no longer than one hour.
83	2	Airway is clear and the patient is tachypnoeic and tachycardic. Significant blunt trauma to the abdomen (possible liver injury) and the patient is showing signs of shock. This patient should commence treatment within 10 minutes.
84	4	Airway, breathing and circulation are intact. The patient has mild pain due to an acute limb injury. He should wait no more than one hour for treatment.
85	3	Airway, breathing and circulation are intact. There is evidence of psychotic symptoms (command hallucinations) and suicidal ideation. The patient should be under close observation in the ED waiting room and should receive treatment within 30 minutes.
86	4	Primary survey is intact. The patient has support and is willing to wait. She should wait no longer than one hour for assessment.
87	3	Airway, breathing and circulation are intact. Abdominal pain is causing moderate discomfort. This patient should wait no longer than 30 minutes to commence treatment.
88	5	Airway, breathing and circulation are intact. The main problem is pain – the patient is experiencing mild to moderate pain and minor limb trauma. The patient should receive treatment within two hours.
89	3	Airway, breathing and circulation are intact. Pain currently resolved but needs investigation as it could be cardiac in nature. The patient should wait no longer than 30 minutes.
90	4	Airway, breathing and circulation are intact. The patient reports mild to moderate pain with some risk features. He should wait no longer than one hour.
91	2	Airway, breathing and circulation are intact. The patient has suspected sepsis and signs of meningococcaemia and needs to commence treatment within 10 minutes.

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Scenario	Category	Rationale
92	5	Airway, breathing and circulation are intact. This injury occurred 48 hours ago and was treated at that time. Function of the limb is not impaired and there are no high-risk features in this presentation. Pain is mild. This patient should receive treatment within two hours.
93	2	Airway, breathing and circulation are intact. The patient has severe pain with possible torsion of testes. He should receive treatment within 10 minutes.
94	4	Airway, breathing and circulation are intact. The pain is likely to be due to renal calculi. Pain is mild to moderate and there are no high-risk factors. This patient should be seen within one hour.
95	4	Airway, breathing and circulation are intact. Mild pain is the main problem for this patient, and she should commence treatment within one hour.
96	2	Airway and breathing are intact. He has an elevated heart rate and significant mechanism with changes to limb function and sensation. He has severe pain. He should wait no longer than 10 minutes for treatment.
97	1	GCS 8/15 is an immediate airway risk. Patient responding only to pain. Requires immediate assessment and emergency treatment.
98	5	This is a non-urgent problem; however, the patient still requires advice about vaccinations given he is travelling overseas in the next week. He can wait for up to two hours for assessment and treatment.
99	3	Primary survey is intact. Moderately severe abdominal pain without high-risk features. This patient should be seen within 30 minutes.
100	5	This is a non-urgent problem and the patient can wait up to two hours for assessment and treatment.
101	1	Immediate risk to airway, requires immediate assessment and intervention.
102	3	Airway, breathing and circulation are intact. The history is unclear and there is an altered conscious state. The patient should wait no longer than 30 minutes for treatment.
103	4	Airway, breathing and circulation are intact. The main problem is pain, possibly due to infection. Pain is at a moderate level and treatment should commence within one hour.
104	2	Airway intact, tachypnoeic with tachycardia and excessive sweating, nausea and vomiting, possibly due to toxic exposure to organophosphate. This patient should wait no more than 10 minutes for treatment.
105	5	This is a non-urgent problem. However, the plaster needs to be assessed as it was applied in the ED and if it is loose will not effectively immobilise the fracture.

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Scenario	Category	Rationale
106	4	Airway, breathing and circulation are intact. Acute urinary symptoms and discomfort with mild pain. The history is a little unclear; however, this patient should wait no longer than one hour.
107	2	Airway is intact but she has palpitations/tachycardia with possible chest pains. History is suggestive of a cardiac event with some signs of increased sympathetic activity (pallor and diaphoresis). This patient should wait no longer than 10 minutes for treatment.
108	2	Airway is intact. The patient has mild tachypnoea and haemodynamic compromise. This patient should wait no longer than 10 minutes for treatment.
109	2	Airway and breathing are intact; hypertensive in the context of pregnancy with sudden severe onset of headache and altered conscious state. This patient should wait no longer than 10 minutes for treatment.
110	2	Airway is intact. The patient is showing signs of severe respiratory distress. She should wait no longer than 10 minutes for treatment.
111	4	Airway, breathing and circulation are intact. The patient has pain and no history of injury. She has significant co-morbid factors and should be seen within one hour.
112	3	Airway, breathing and circulation are intact. Pain is moderate to severe and the patient should receive treatment within 30 minutes.
113	4	Airway, breathing and circulation are intact. Two-day history of mild pain. History increases risk factors. The patient should wait no longer than one hour for treatment.
114	2	Airway, breathing and circulation are intact. The patient experienced significant mechanism of injury and is visibly distressed. She should not wait longer than 10 minutes for assessment and treatment.
115	2	Possible marine envenomation. Rapid heart rate and elevated blood pressure associated with pain indicate that treatment should commence within 10 minutes.
116	3	Airway, breathing and circulation are intact. Moderately severe pain. The patient has signs of infection but is not septic. Treatment should commence within 30 minutes.
117	2	Airway is intact. Elevated respiratory rate with fever and recent chemotherapy would meet criteria for febrile neutropenia. He should wait no longer than 10 minutes for medical assessment and treatment.
118	3	Airway, breathing and circulation are intact. The patient is experiencing moderately severe pain and should wait no longer than 30 minutes for treatment.

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Scenario	Category	Rationale
119	4	Airway, breathing and circulation are intact. Moderate pain will require investigation and treatment should commence within one hour.
120	1	Airway is unstable and cardiopulmonary arrest is imminent. The child requires immediate simultaneous assessment treatment.
121	3	While airway, breathing and circulation are currently within normal parameters, this patient is at significant risk of a sudden and large gastrointestinal blood loss. He should not wait longer than 30 minutes for medical assessment and treatment.
122	5	This is a non-urgent problem, and the patient can wait two hours to see a doctor.
123	1	Grunting respirations and central cyanosis indicate that this patient has an airway obstruction and requires immediate assessment and treatment.
124	4	Airway, breathing and circulation are intact. The patient has mild to moderate pain. Adequate analgesia has been administered prior to arrival. This patient should wait no longer than one hour to see a doctor.
125	4	Airway, breathing and circulation are intact. The patient has an infection of the skin and has several co-morbid conditions. He should commence treatment within one hour.
126	4	Airway, breathing and circulation are intact. There is moderate blood loss and a clean, firm dressing needs to be applied to the wound. The patient should wait no longer than one hour for treatment; however, close observation of the dressing needs to occur, and re-triage should be performed if the bleeding cannot be adequately controlled.
127	3	Airway, breathing and circulation are intact. Pain is the problem, and it is reported to be severe. The patient should wait no longer than 30 minutes.
128	1	Respiratory arrest requires immediate assessment and simultaneous treatment.
129	5	This is a non-urgent presentation and this patient can wait up to two hours to see a doctor.
130	1	Cardiopulmonary arrest is imminent. Immediate assessment and resuscitation are required.
131	3	Airway and breathing are intact. She has a new behavioural change and a low-grade fever. She should wait no longer than 30 minutes for treatment.
132	1	Birth is imminent. The patient should receive immediate simultaneous assessment and treatment.

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ATS category	Response	Description of category	Clinical descriptors (indicative only)
1 	<b>Immediate simultaneous assessment and treatment</b>	<b>Immediately life-threatening</b> Conditions that are threats to life (or imminent risk of deterioration) and require immediate aggressive intervention	<ul style="list-style-type: none"> <li>■ Cardiac arrest</li> <li>■ Respiratory arrest</li> <li>■ Immediate risk to airway – impending arrest</li> <li>■ Respiratory rate &lt;10/min</li> <li>■ Extreme respiratory distress</li> <li>■ BP &lt;80 (adult) or severely shocked child/infant</li> <li>■ Unresponsive or responds to pain only (GCS &lt;9)</li> <li>■ Ongoing/prolonged seizure</li> <li>■ IV overdose and unresponsive or hypoventilation</li> <li>■ Severe behavioural disorder with immediate threat of dangerous violence</li> </ul>

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ATS category	Response	Description of category	Clinical descriptors (indicative only)
2	<p><b>Assessment and treatment within 10 minutes</b></p> <p>(assessment and treatment often simultaneous)</p>	<p><b>Imminently life-threatening</b></p> <p>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 10 minutes of arrival</p> <p><b>OR</b></p> <p><b>Important time-critical treatment</b></p> <p>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</p> <p><b>OR</b></p> <p><b>Very severe pain</b></p> <p>Humane practice mandates the relief of very severe pain or distress within 10 minutes</p>	<ul style="list-style-type: none"> <li>■ Airway risk – severe stridor or drooling with distress</li> <li>■ Severe respiratory distress</li> <li>■ Circulatory compromise:                             <ul style="list-style-type: none"> <li>– Clammy or mottled skin, poor perfusion</li> <li>– HR &lt;50 or &gt;150 (adult)</li> <li>– Hypotension with haemodynamic effects</li> <li>– Severe blood loss</li> </ul> </li> <li>■ Chest pain of likely cardiac nature</li> <li>■ Very severe pain – any cause</li> <li>■ Suspected sepsis (physiologically unstable)</li> <li>■ Febrile neutropenia</li> <li>■ Fever with signs of lethargy (any age)</li> <li>■ BSL* &lt;3 mmol/L</li> <li>■ Drowsy, decreased responsiveness any cause (GCS &lt;13)</li> <li>■ Acute stroke</li> <li>■ Acid or alkali splash to eye – requiring irrigation</li> <li>■ Suspected endophthalmitis post-eye procedure (post-cataract, post-intravitreal injection), sudden onset pain, blurred vision and red eye</li> <li>■ Major multi trauma (requiring rapid organised team response)</li> <li>■ Severe localised trauma – major fracture, amputation</li> <li>■ Suspected testicular torsion</li> <li>■ High-risk history:                             <ul style="list-style-type: none"> <li>– Significant sedative or other toxic ingestion</li> <li>– Significant/dangerous envenomation</li> <li>– Significant pain or other feature suggesting PE, aortic dissection/AAA or ectopic pregnancy</li> </ul> </li> <li>■ Behavioural/psychiatric:                             <ul style="list-style-type: none"> <li>– Violent or aggressive</li> <li>– Immediate threat to self or others</li> <li>– Requires or has required restraint</li> <li>– Severe agitation or aggression</li> </ul> </li> </ul>

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\* BSL = BGL

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<p><b>3</b></p> 	<p><b>Assessment and treatment start within 30 minutes</b></p>	<p><b>Potentially life-threatening</b></p> <p>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 30 minutes of arrival</p> <p><b>OR</b></p> <p><b>Situational urgency</b></p> <p>There is potential for adverse outcome if time-critical treatment is not commenced within 30 minutes</p> <p><b>OR</b></p> <p><b>Humane practice</b> mandates the relief of severe discomfort or distress within 30 minutes</p>	<ul style="list-style-type: none"> <li>■ Severe hypertension</li> <li>■ Moderately severe blood loss – any cause</li> <li>■ Moderate shortness of breath</li> <li>■ Seizure (now alert)</li> <li>■ Persistent vomiting</li> <li>■ Dehydration</li> <li>■ Head injury with short LOC – now alert</li> <li>■ Suspected sepsis (physiologically stable)</li> <li>■ Moderately severe pain – any cause – requiring analgesia</li> <li>■ Chest pain likely non-cardiac and moderate severity</li> <li>■ Abdominal pain without high-risk features – moderately severe or patient age &gt;65 years</li> <li>■ Moderate limb injury – deformity, severe laceration, crush</li> <li>■ Limb – altered sensation, acutely absent pulse</li> <li>■ Trauma – high-risk history with no other high-risk features</li> <li>■ Stable neonate</li> <li>■ Child at risk of abuse/suspected non-accidental injury</li> <li>■ Behavioural/psychiatric:                             <ul style="list-style-type: none"> <li>– Very distressed, risk of self-harm</li> <li>– Acutely psychotic or thought disordered</li> <li>– Situational crisis, deliberate self-harm</li> <li>– Agitated/withdrawn</li> <li>– Potentially aggressive</li> </ul> </li> </ul>

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4	Assessment and treatment start within 60 minutes	<p><b>Potentially serious</b></p> <p>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><b>OR</b></p> <p><b>Situational urgency</b></p> <p>There is potential for adverse outcome if time-critical treatment is not commenced within hour</p> <p><b>OR</b></p> <p><b>Significant complexity or severity</b></p> <p>Likely to require complex work-up and consultation and/or inpatient management</p> <p><b>OR</b></p> <p><b>Humane practice</b></p> <p>mandates the relief of discomfort or distress within one hour</p>	<ul style="list-style-type: none"> <li>■ Mild haemorrhage</li> <li>■ Foreign body aspiration, no respiratory distress</li> <li>■ Chest injury without rib pain or respiratory distress</li> <li>■ Difficulty swallowing, no respiratory distress</li> <li>■ Minor head injury, no loss of consciousness</li> <li>■ Moderate pain, some risk features</li> <li>■ Vomiting or diarrhoea without dehydration</li> <li>■ Eye inflammation or foreign body – normal vision</li> <li>■ Minor limb trauma – sprained ankle, possible fracture, uncomplicated laceration requiring investigation or intervention – normal vital signs, low/moderate pain</li> <li>■ Tight cast, no neurovascular impairment</li> <li>■ Swollen 'hot' joint</li> <li>■ Non-specific abdominal pain</li> <li>■ Behavioural/psychiatric:                             <ul style="list-style-type: none"> <li>– Semi-urgent mental health problem</li> <li>– Under observation and/or no immediate risk to self or others</li> </ul> </li> </ul>

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5	Assessment and treatment start within 120 minutes	<p><b>Less urgent</b></p> <p>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><b>OR</b></p> <p><b>Clinico-administrative problems</b></p> <p>Results review, medical certificates, prescriptions only</p>	<ul style="list-style-type: none"> <li>■ Minimal pain with no high-risk features</li> <li>■ Low-risk history and now asymptomatic</li> <li>■ Minor symptoms of existing stable illness</li> <li>■ Minor symptoms of low-risk conditions</li> <li>■ Minor wounds – small abrasions, minor lacerations (not requiring sutures)</li> <li>■ Scheduled revisit (e.g. wound review, complex dressings)</li> <li>■ Immunisation only</li> <li>■ Behavioural/psychiatric: <ul style="list-style-type: none"> <li>– Known patient with chronic symptoms</li> <li>– Social crisis, clinically well patient</li> </ul> </li> </ul>

Source: *Guidelines on the Implementation of the Australasian Triage Scale in Emergency Departments*, ACEM 2023

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# Mental Health Triage Tool

Triage category	Description	Typical presentation	General management principles*
<p style="text-align: center;"><b>1</b></p>  <p style="text-align: center;"><b>Immediate</b></p>	<p><b>Definite danger to life (self or others)</b></p> <p>ATS<sup>†</sup> states:</p> <p>Severe behavioural disorder with immediate threat of dangerous violence</p>	<p><b>Observed</b></p> <ul style="list-style-type: none"> <li>■ Violent behaviour</li> <li>■ Possession of a weapon</li> <li>■ Major self-harm in the ED</li> <li>■ Extreme agitation or restlessness</li> <li>■ Bizarre/disoriented behaviour</li> </ul> <p><b>Reported</b></p> <ul style="list-style-type: none"> <li>■ Verbal commands to do harm to self or others, that the person is unable to resist (command hallucinations)</li> <li>■ Recent violent behaviour</li> </ul>	<p><b>Supervision</b></p> <ul style="list-style-type: none"> <li>■ Continuous visual surveillance‡ 1:1 ratio</li> </ul> <p><b>Action</b></p> <ul style="list-style-type: none"> <li>■ Alert ED medical staff immediately</li> <li>■ Alert mental health triage or equivalent</li> <li>■ Provide a safe environment for patient and others</li> <li>■ Ensure adequate personnel to provide restraint/detention based on local legislation</li> </ul> <p><b>Consider</b></p> <ul style="list-style-type: none"> <li>■ Calling security +/- police if staff or patient safety compromised, may require several staff to contain patient</li> <li>■ 1:1 observation</li> <li>■ Intoxication by drugs and alcohol may cause an escalation in behaviour that requires management</li> </ul>

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\* Management principles may differ according to individual health service protocols and facilities

† Australasian Triage Scale

‡ Observation definition: Continuous visual surveillance – person is under direct visual observation at all times

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Triage category	Description	Typical presentation	General management principles*
<p><b>2</b></p>  <p><b>Emergency</b></p>	<p><b>Probable risk of danger to self or others, and/or</b></p> <ul style="list-style-type: none"> <li>Client is physically restrained in ED, and/or</li> <li>Severe behavioural disturbance</li> </ul> <p>ATS states: Violent or aggressive (if):</p> <ul style="list-style-type: none"> <li>Immediate threat to self or others</li> <li>Requires or has required restraint</li> <li>Severe agitation or aggression</li> </ul>	<p><b>Observed</b></p> <ul style="list-style-type: none"> <li>Extreme agitation/restlessness</li> <li>Physically/verbally aggressive</li> <li>Confused/unable to cooperate</li> <li>Hallucinations/delusions/paranoia</li> <li>Requires restraint/containment</li> <li>High risk of absconding and not waiting for treatment</li> <li>Unable to wait safely</li> </ul> <p><b>Reported</b></p> <ul style="list-style-type: none"> <li>Attempt at self-harm/threat of self-harm</li> <li>Threat of harm to others</li> </ul>	<p><b>Supervision</b></p> <ul style="list-style-type: none"> <li>Continuous visual surveillance<sup>†</sup></li> </ul> <p><b>Action</b></p> <ul style="list-style-type: none"> <li>Alert ED medical staff immediately</li> <li>Alert mental health triage</li> <li>Provide safe environment for patient and others</li> <li>Use defusing techniques (oral medication, time in quieter area)</li> <li>Ensure adequate personnel to provide restraint/detention based on local legislation</li> <li>Prompt assessment for patient recommended under Section 9 or apprehended under Section 10 of the <i>Mental Health Act 2000</i></li> </ul> <p><b>Consider</b></p> <ul style="list-style-type: none"> <li>If defusing techniques ineffective, re-triage to category 1 (see above)</li> <li>Security in attendance until patient sedated, if necessary</li> <li>Intoxication by drugs and alcohol may cause an escalation in behaviour that requires management</li> </ul>

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<p><b>3</b></p>  <p><b>Urgent</b></p>	<p><b>Possible danger to self or others</b></p> <ul style="list-style-type: none"> <li>■ Moderate behaviour disturbance</li> <li>■ Severe distress</li> </ul> <p>ATS states:</p> <ul style="list-style-type: none"> <li>■ Very distressed, risk of self-harm</li> <li>■ Acutely psychotic or thought-disordered</li> <li>■ Situational crisis, deliberate self-harm</li> <li>■ Agitated/withdrawn</li> <li>■ Potentially aggressive</li> </ul>	<p><b>Observed</b></p> <ul style="list-style-type: none"> <li>■ Agitation/restlessness</li> <li>■ Intrusive behaviour</li> <li>■ Confusion</li> <li>■ Ambivalence about treatment</li> <li>■ Not likely to wait for treatment</li> <li>■ Hallucinations/delusions/paranoia</li> <li>■ Thought disorder</li> <li>■ Bizarre/agitated behaviour</li> <li>■ Severe symptoms of depression</li> <li>■ Withdrawn/uncommunicative and/or anxiety</li> <li>■ Elevated or irritable mood</li> </ul> <p><b>Reported</b></p> <ul style="list-style-type: none"> <li>■ Suicidal ideation</li> <li>■ Situational crisis</li> </ul>	<p><b>Supervision</b></p> <ul style="list-style-type: none"> <li>■ Close observation<sup>†</sup></li> <li>■ Do not leave patient in waiting room without support person</li> </ul> <p><b>Action</b></p> <ul style="list-style-type: none"> <li>■ Alert mental health triage</li> <li>■ Ensure safe environment for patient and others</li> </ul> <p><b>Consider</b></p> <ul style="list-style-type: none"> <li>■ Re-triage if evidence of increasing behavioural disturbance, i.e.                             <ul style="list-style-type: none"> <li>– Restlessness</li> <li>– Intrusiveness</li> <li>– Agitation</li> <li>– Aggressiveness</li> <li>– Increasing distress</li> </ul> </li> <li>■ Inform security that patient is in department</li> <li>■ Intoxication by drugs and alcohol may cause an escalation in behaviour that requires management</li> </ul>

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\* Management principles may differ according to individual health service protocols and facilities

† Observation definition: Close observation – regular observation at a maximum of 10-minute intervals

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<p style="font-size: 2em; text-align: center;">4</p> <div style="background-color: #004a87; width: 40px; height: 20px; margin: 0 auto;"></div> <p style="text-align: center;">Semi-urgent</p>	<p><b>Moderate distress</b></p> <p>ATS states:</p> <ul style="list-style-type: none"> <li>■ Semi-urgent mental health problem</li> <li>■ Under observation and/or no immediate risk to self or others</li> </ul>	<p><b>Observed</b></p> <ul style="list-style-type: none"> <li>■ No agitation/restlessness</li> <li>■ Irritable without aggression</li> <li>■ Cooperative</li> <li>■ Gives coherent history</li> </ul> <p><b>Reported</b></p> <ul style="list-style-type: none"> <li>■ Pre-existing mental health disorder</li> <li>■ Symptoms of anxiety or depression without suicidal ideation</li> <li>■ Willing to wait</li> </ul>	<p><b>Supervision</b></p> <ul style="list-style-type: none"> <li>■ Intermittent observation<sup>†</sup></li> </ul> <p><b>Action</b></p> <ul style="list-style-type: none"> <li>■ Discuss with mental health triage nurse</li> </ul> <p><b>Consider</b></p> <ul style="list-style-type: none"> <li>■ Re-triage if evidence of increasing behavioural disturbance, i.e.                             <ul style="list-style-type: none"> <li>– Restlessness</li> <li>– Intrusiveness</li> <li>– Agitation</li> <li>– Aggressiveness</li> <li>– Increasing distress</li> </ul> </li> <li>■ Intoxication by drugs and alcohol may cause an escalation in behaviour that requires management</li> </ul>

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\* Management principles may differ according to individual health service protocols and facilities

† Observation definition: Intermittent observation – regular observation at a maximum of 30-minute intervals

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<p><b>5</b></p> <p></p> <p><b>Non-urgent</b></p>	<p>No danger to self or others</p> <ul style="list-style-type: none"> <li>No acute distress</li> <li>No behavioural disturbance</li> </ul> <p>ATS states:</p> <ul style="list-style-type: none"> <li>Known patient with chronic symptoms</li> <li>Social crisis, clinically well patient</li> </ul>	<p><b>Observed</b></p> <ul style="list-style-type: none"> <li>Cooperative</li> <li>Communicative and able to engage in developing management plan</li> <li>Able to discuss concerns</li> </ul> <p><b>Reported</b></p> <ul style="list-style-type: none"> <li>Known patient with chronic psychotic symptoms</li> <li>Pre-existing non-acute mental health disorder</li> <li>Known patient with chronic unexplained somatic symptoms</li> <li>Request for medication</li> <li>Minor adverse effect of medication</li> <li>Financial, social, accommodation, or relationship problems</li> </ul>	<p><b>Supervision</b></p> <ul style="list-style-type: none"> <li>General observation†</li> </ul> <p><b>Action</b></p> <ul style="list-style-type: none"> <li>Discuss with mental health triage</li> <li>Refer to treating team if case-managed</li> </ul>

\* Management principles may differ according to individual health service protocols and facilities

† Observation definition: General observation – routine waiting room check at a maximum of one-hour intervals

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# Abbreviations and glossary

## Abbreviations

Abbreviation	Complete term
ACEM	Australasian College for Emergency Medicine
ACEN	Australian College of Emergency Nursing
ADHD	attention deficit hyperactivity disorder
ATS	Australasian Triage Scale
BP	blood pressure in mmHg
BGL	blood glucose level in mmol/L
CENA	College of Emergency Nursing Australasia
CRT	capillary refill time (also known as capillary refill rate)
ED	emergency department
GCS	Glasgow Coma Scale, a tool used to assign a patient a score
HR	heart rate in beats per minute
NP	nasal prong
RR	respiratory rate in breaths per minute
SpO <sub>2</sub>	oxygen saturation (percentage)
T	temperature in degrees Celsius (°C)

## Glossary

Term	How it is used in this document
<b>Australasian Triage Scale</b>	A five-category scale for rating the clinical urgency of a patient's presentation to an emergency service
<b>complexity</b>	The difficulty of a patient's medical, social, psychological and environmental issues that impact the level of resources needed to find a solution <sup>1</sup>
<b>child</b>	Anyone aged under 18 years
<b>disposition</b>	Allocation of a patient to an area after triage
<b>infant</b>	A child aged over 28 days and under 1 year
<b>escalation pathway, clinician-led</b>	A system clinicians can use to call for help with a patient who is acutely deteriorating <sup>2</sup>
<b>escalation pathway, patient-led</b>	A system that patients and their support people can use to call for help – independently of the team that is directly providing care – if they are worried that the person of concern is acutely deteriorating <sup>3</sup>

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Glossary (continued)

Term	How it is used in this document
<b>First Nations people</b>	Aboriginal and Torres Strait Islander people
<b>front-end team</b>	Clinical and non-clinical staff who work in the triage area, waiting room, registration area and, if relevant, ED models of care areas where patients are rapidly assessed before returning to the waiting room or moving to their next care location
<b>model of care</b>	The way care is delivered to support the safe and timely treatment of patients through the ED, e.g. streaming to fast track, acute care or resuscitation <sup>4,5</sup>
<b>neonate</b>	A child aged under 4 weeks
<b>neurodiverse</b>	Having neurological differences compared with neurotypical people, due to conditions such as autism spectrum disorder and attention deficit hyperactivity disorder (ADHD)
<b>older people</b>	Those aged 65 years and over, or 50 years and over for First Nations people
<b>over-triage</b>	Assignment of a higher urgency triage category than the patient's presentation merits
<b>parent</b>	In the ETEK, the term 'parent' includes other carers who might accompany a child to the ED
<b>person-centred care</b>	Care that respects and responds to the preferences, needs and values of patients and their families

*Continued over...*

Term	How it is used in this document
<b>pregnant woman</b>	A person who is pregnant. We have used the words 'woman' and 'women' as this is the way most people who are pregnant will identify. Using these words is not intended to exclude those who give birth and do not identify as women
<b>support person</b>	Anyone accompanying and providing support to the patient in their ED presentation. This includes the patient's parents, other family, partner, friends, First Nations liaison officers and paid and unpaid carers
<b>triage</b>	Determining the order in which patients are treated in the ED, based on their need for urgent care to prevent deterioration or further pain and suffering
<b>trauma-informed care</b>	Care that recognises the possible effects of past or continuing psychological trauma on health and behaviour, and avoids re-traumatisation. <sup>6</sup> It is based on the principles of trust, collaboration, safety, choice and empowerment <sup>7</sup>
<b>under-triage</b>	Assignment of a lower urgency triage category than the patient's presentation merits
<b>urgency</b>	The need for time-critical intervention <sup>8</sup> – that is, how quickly a patient needs to be seen to prevent deterioration or further pain and suffering <sup>1</sup>

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