OPERATIONAL DIRECTIVE

Enquiries to: Office of the Chief Medical Officer
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OD number: OD 0333/11
Date: 25 May 2011
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Subject: GUIDELINES FOR REFERRAL OF PATIENTS FOR MEDICAL REVIEW BY MEDICAL OFFICERS OR EMERGENCY NURSE PRACTITIONERS FROM TRIAGE AT NON-TERTIARY HOSPITALS

SCOPE
This policy applies to all WA public non-tertiary hospitals providing emergency services without 24 hour medical cover.
The policy excludes major disaster situations, community mental health services and community services.

BACKGROUND
WA Health bears a responsibility for the management of patients within its health care facilities. Triage is the first point of contact for any patient presenting to the Emergency Department. It aims to ensure that patients are treated in the order of clinical urgency and is central to the efficient and effective allocation of clinical resources in the Emergency Department. Furthermore, quality triage ensures the level of care provided is commensurate to the clinical need.
A variety of triage systems and training resources are available (outlined at close of policy). This circular does not attempt to re-state or capture these. The aim of this circular is to ensure that patients who merit medical review are thus identified and managed accordingly.

KEY POINTS
• All patients presenting to emergency departments must be triaged on initial presentation against the Australasian Triage Scale (ATS), by a registered nurse deemed competent in triage.
• The ATS categories define the urgency with which patients must be seen by or discussed with a doctor. Any patient who can not be seen in the ATS standard timeframes must be commenced on frequent observations on an Observation and Response Chart until a medical review can occur.
• The guidelines outline triage presentations where referral to a medical officer or ED nurse practitioner should occur. In addition, advice should be sought for any other concern relating to the health or safety of a patient, where the patient’s presenting complaint cannot be satisfactorily resolved or where the patient re-present with the same presenting complaint within 48 hours.
• Each area health service is to have documented escalation plan for medical review should an on-site medical officer not be available or available only for telephone consultation

The attached guidelines are to be read in conjunction with OD 0334/11.

Kim Snowball
DIRECTOR GENERAL
DEPARTMENT OF HEALTH WA

This information is available in alternative formats upon a request from a person with a disability.
GUIDELINES FOR REFERRAL OF PATIENTS FOR REVIEW BY MEDICAL OFFICERS OR EMERGENCY NURSE PRACTITIONERS FROM TRIAGE AT NON-TERTIARY HOSPITALS

BACKGROUND

WA Health bears a responsibility for the management of patients within its health care facilities. Triage is the first point of contact for any patient presenting to the Emergency Department. It aims to ensure that patients are treated in the order of clinical urgency and is central to the efficient and effective allocation of clinical resources in the Emergency Department. Furthermore, quality triage ensures the level of care provided is commensurate to the clinical need.

The triage assessment involves a combination of the presenting complaint and general condition of the patient. Although the intent of triage is not to reach a diagnosis, dependent upon the context, it may include pertinent physiological observations and the initiation of investigations. Generally however, the triage assessment should take no more than 2-5 minutes. Coupled with the range and breadth of presentations at any one time, triage is thus a process which requires specifically trained and experienced practitioners. There needs to be a clear distinction between triage and secondary assessment.

Closely weaved to the above theme is work by the Australian Commission of Safety and Quality in Healthcare on Recognising and Responding to Clinical Deterioration. The factors contributing to a failure to recognise and respond appropriately to unstable patients are complex and frequently compounded by the emergency environment. The principles underlying the RRCD project are relevant to patient triage. Although directed towards inpatients, the recognition of the deteriorating patient project has developed resources which are of use in emergency departments.

A variety of triage systems and training resources are available (outlined at close of policy). This circular does not attempt to re-state or capture these. The aim of this circular is to ensure that patients who merit medical review are thus identified and managed accordingly.

OD 0334/11 describes the guidelines for nurses performing triage in emergency at non-tertiary hospitals and should be referred to for additional reference.
SCOPE

This policy applies to all WA public non-tertiary hospitals providing emergency services without 24 hour medical cover. The policy excludes major disaster situations, community mental health services and community services.

KEY POLICY ITEMS

Regarding patient review

- All patients presenting to emergency departments must be triaged on initial presentation against the Australasian Triage Scale (ATS), by a registered nurse deemed competent in triage.
- The ATS categories define the urgency with which patients must be seen by or discussed with a doctor. This is outlined below.

<table>
<thead>
<tr>
<th>ATS CATEGORY</th>
<th>Treatment acuity (Maximum waiting time)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATS 1</td>
<td>Immediate</td>
</tr>
<tr>
<td>ATS 2</td>
<td>10 minutes</td>
</tr>
<tr>
<td>ATS 3</td>
<td>30 minutes</td>
</tr>
<tr>
<td>ATS 4</td>
<td>60 minutes</td>
</tr>
<tr>
<td>ATS 5</td>
<td>120 minutes</td>
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</tbody>
</table>

- Any patient who cannot be seen in the ATS standard timeframes must be commenced on frequent observations on an age appropriate Observation and Response Chart until a medical review can occur.
- Some facilities providing emergency services do not have on site medical officers. In such instances, review may be undertaken by registered nurses deemed competent by the employing hospital who must ensure that the patient is seen by or discussed with medical officers or Nurse Practitioners where necessary so as to reach a diagnosis and management plan.
- A checklist of triage indicators which require review by or discussion with a doctor or emergency Nurse Practitioner follows by way of guidance. This list is not exhaustive and in addition to the items described, advice should be sought for any other concern relating to the health or safety of a patient.
• Where the patient’s presenting complaint cannot be satisfactorily resolved, referral to a doctor, emergency Nurse Practitioner is required.
• Patients who re-present with the same presenting complaint within 48 hours must be reviewed by a doctor, emergency Nurse Practitioner.
• Each area health service is to have documented escalation plan for medical review should an on-site medical officer not be available or available only for telephone consultation.
## Indicators for Review or Discussion with Medical Officer/ED Nurse Practitioner

<table>
<thead>
<tr>
<th>Airways/Breathing</th>
<th>Cardiovascular</th>
<th>Neuro-Sensory</th>
<th>Trauma</th>
<th>Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Respiratory rate &lt; 10, &gt; 30</td>
<td>• Systolic BP &lt; 100, &gt; 200</td>
<td>• Altered conscious state by &gt;2 of GCS, or response to pain only</td>
<td>• MVA</td>
<td>• Violent behaviour</td>
</tr>
<tr>
<td>• Oxygen saturation &lt;90%</td>
<td>• Heart rate &lt; 40, &gt; 120</td>
<td>• Altered visual acuity</td>
<td>• Any head and eye injury</td>
<td>• Extreme agitation</td>
</tr>
<tr>
<td>• Any patient on oxygen</td>
<td>• Chest pain</td>
<td>• Collapse or loss of consciousness</td>
<td>• Injury to chest, abdomen or neck</td>
<td>• Bizarre behaviour</td>
</tr>
<tr>
<td>• History of severe/anaphylactic allergic response and presenting with allergic reaction</td>
<td>• Capillary refill &gt; 2 seconds</td>
<td>• Sudden, severe headache</td>
<td>• Injury leading to deformity or needing sutures or with ongoing pain or with significant blood loss/concern of ongoing blood loss or with risk of neurovascular damage, burns</td>
<td>• Confusion/disorientation</td>
</tr>
<tr>
<td>• Use of respiratory accessory muscles</td>
<td>• Irregular pulse rate, that is not normal for the patient.</td>
<td>• First convulsion or sustained convulsions</td>
<td>• Alleged/ suspicion of physical and/or sexual assault</td>
<td>• Psychotic symptoms</td>
</tr>
<tr>
<td>• Asthma not relieved by actions outlined in the patient’s emergency / national asthma action plan</td>
<td>• Unexplained fall in urine output (&lt; 100ml in 3 hrs)</td>
<td>• Loss of sensation in any body part</td>
<td>• History meeting trauma team activation criteria</td>
<td>• Mood disturbance</td>
</tr>
<tr>
<td>• Stridor, audible wheeze, snoring in presenting complaint</td>
<td>• Presence of respiratory accessory muscles</td>
<td>• Decreased/loss of movement or weakness in any body part</td>
<td></td>
<td>• Situational crisis</td>
</tr>
<tr>
<td>• Threatened airway (swallowing/facial burns) or airway management required</td>
<td>• Respiratory accessory muscles</td>
<td>•</td>
<td></td>
<td>• Suicidal ideation</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Pediatrics</th>
<th>Infection</th>
<th>Medical History</th>
<th>Social History</th>
<th>Indicators from MR</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Hydration: &lt; 4 wet nappies in 24h, reduced skin turgor, sunken fontanelles, weight loss &gt; 4-5%, dry mucous membranes, no tears (need to get paediatric ED input into this)</td>
<td>• Fever &gt; 39 (work this to match rainbow)</td>
<td>• Exacerbation of chronic condition, where the patient’s care plan identifies need for medical review.</td>
<td>• Child protection issues</td>
<td>• ATS 1, 2, 3</td>
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<tr>
<td>• Petechial rash</td>
<td>• Peri-orbital involvement</td>
<td>• History of recent chemotherapy, radiotherapy, organ transplant or immunocompromise,</td>
<td>• No safe environment</td>
<td>• Any observation meeting criteria for review on adult or relevant paediatric observation chart</td>
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<tr>
<td>• All children &lt; 5 years with pyrexia</td>
<td>• Oedema of bony areas around facial sinuses</td>
<td>• History rheumatic fever or prosthetic valve</td>
<td>• To discharge patient to</td>
<td>• Any other reason for concern</td>
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<tr>
<td>• Decreased feeding - &lt;</td>
<td>• Hot swollen joints</td>
<td>• Re-presentation with similar or same symptoms within 48 h</td>
<td>• Patients under influence of drugs and/or alcohol</td>
<td>• Patients presenting as a worker’s compensation case</td>
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<td></td>
<td></td>
<td>• History of poisoning or envenomation</td>
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### Indicators From Midwifery or MO with Obstetric skills for secondary assessment

- Exclude ectopic pregnancy and prolapsed cord
- Symptoms of urinary tract infection or gastroenteric illness
- Pain score > 3
- Parenteral analgesic required
- Ocular pain
- Blood sugar level outside the normal range

**Withdrawn/Uncommnicative**: May 2017
ADDITIONAL REFERENCES AND RESOURCES

WACHS resources: update with link on WACHS intranet

Department of Health and Aging:
Emergency Triage Education Kit

Department of Health WA:

Australian Commission on Safety and Quality in Healthcare
Recognising and Responding to Clinical Deterioration

Australian College of Emergency Medicine:


