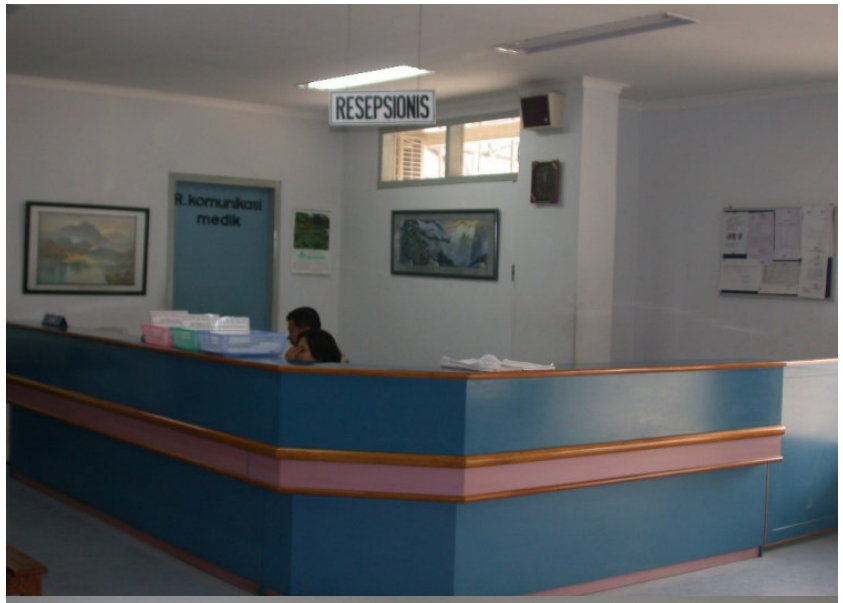
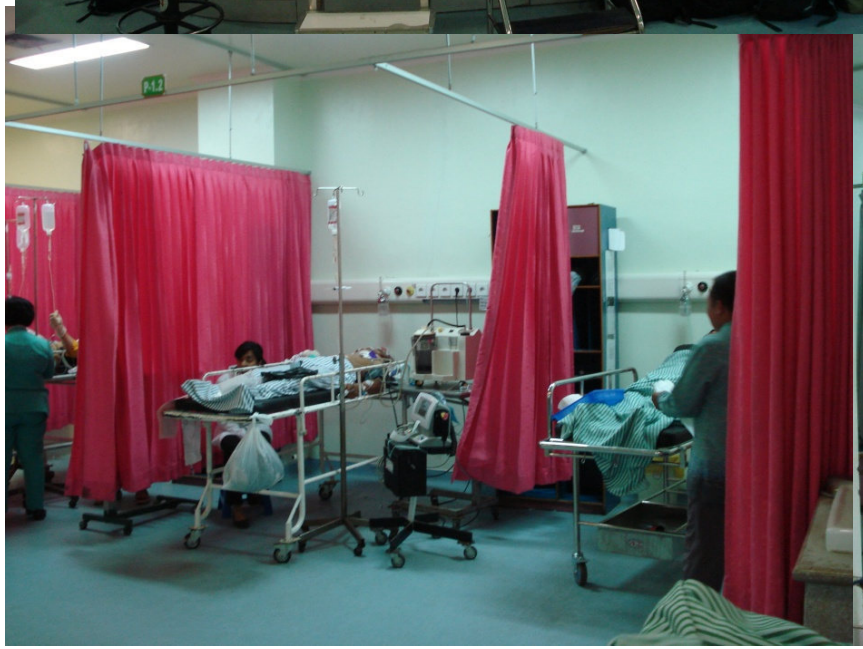
PERENCANAAN SISTEM TRIAGE IGD

PIT IV EM
Kshanti Adhitya

IGD RSSA MALANG: 2008



IGD RSSA MALANG SEKARANG



IGD RSUD Serang

Before

After

IGD RSUD DR. ISKAK TULUNGAGUNG

PELAYANAN DI IGD RSUD SUMBAWA?

TRIASE – RESPON TIME

Khon Kaen Hospital

Lerdsin General Hospital

GOALS OF TRIAGE

Rapidly identify patients with urgent, life-threatening conditions

Assess/determine severity and acuity of the presenting problem

Direct patients to appropriate treatment areas

Re-evaluate patients awaiting treatment

ADVANTAGES OF TRIAGE

Streamlines patient flow.

Reduces risk of further injury/deterioration.

Improves communication and public relations.

Enhances teamwork.

Identifies resource requirements.

Establishes national benchmarks.

TRIAGE ROLE

- To determine severity of illness or injury for each patient who enters the Emergency Department (ED).

TRIAGE

Patients should have a triage assessment within 10 minutes of arrival in the ED.

Accurate triage is the key to the efficient operation of an emergency department.

Effective triage is based on the knowledge, skills and attitudes of the triage staff.

TRIAGE PROCESS

Assess and determine the severity or acuity of the presenting problem.

Process the patient into a triage level.

Determine and direct the patient to appropriate treatment areas.

Effectively and efficiently assign appropriate human health resources.

TRIAGE ASSESSMENT

Chief complaint.

Brief triage history

Injury or illness (signs & symptoms)

General appearance.

Vital signs.

Brief physical appraisal at triage.

Triage is a dynamic process.

Reassessment & Reassessment .

A patient's condition may improve or deteriorate during the wait for treatment.

SISTEM TRIAGE DUNIA

Australasian Triage Scale (ATS)

Manchester Triage Scale (MTS)

Canadian Triage and Acuity Scale (CTAS)

Emergency Severity Index (ESI)

Australasian		*Manchester (United Kingdom)*		*Canadian*		*Emergency Severity Index*	
Level	Physician/ Staff Response Time (min)	Level	Physician/ Staff Response Time (min)	Level	Physician/ Staff Response Time (min)	Level	Physician/ Staff Response Time (min)
1 = Resuscitation	0 (Immediate)	1 = Immediate (Red)	0 (Immediate)	1 = Resuscitation	0 (Immediate)	1 = Unstable	0 (Immediate)
2 = Emergency	≤10	2 = Very Urgent (Orange)	≤10	2 = Emergent	≤15	2 = Threatened	Minutes
3 = Urgent	≤30	3 = Urgent (Yellow)	≤60	3 = Urgent	≤30	3 = Stable	≤60
4 = Semi-Urgent	≤60	4 = Standard (Green)	≤120	4 = Less Urgent	≤60	4 = Stable	Could be delayed
5 = Nonurgent	≤120	5 = Nonurgent (Blue)	≤240	5 = Nonurgent	≤120	5 = Stable	Could be delayed

CTAS

Level	Time to Primary RN assessment	Time to MD assessment	Reassessment Time
Level 1	immediate	immediate	continuous
Level 2	immediate	≤ 15 min	15 min
Level 3	≤ 30 min	≤ 30 min	30 min
Level 4	≤ 1 hour	≤ 1 hour	1 hour
Level 5	≤ 2 hour	≤ 2 hour	2 hours

The Canadian Association of Emergency Physicians
L'Association canadienne des médecins d'urgence

National Emergency Nurses Affiliation Inc.
L'affiliation nationale des infirmiers/infirmières d'urgence incorporée

L'association des Médecins d'urgence du Québec

The Canadian E.D. Triage and Acuity Scale

Patients should have an
*INITIAL TRIAGE ASSESSMENT WITHIN 10 MINUTES** of arrival

TRIAGE LEVEL I - *RESUSCITATION*

Time to NURSE Assessment
IMMEDIATE*

Time to PHYSICIAN Assessment
IMMEDIATE*

USUAL PRESENTATION	SENTINEL DIAGNOSIS
Code / Arrest	Traumatic Shock
Major Trauma	Pneumothorax - Traumatic / Tension
Shock States	Facial Burns with Airway Compromise
Near Death Asthma	Severe Burns > 30% TBS
Severe Respiratory Distress	Overdose with Hypotension / Unconscious
Altered Mental State (unconscious, delerious)	AAA
Seizures	AMI with Complications / CHF / Low BP
	Status Asthmaticus
	Head Injury - Major / Unconscious
	Status Epilepticus

TRIAGE LEVEL II - *EMERGENT*

Time to NURSE Assessment
IMMEDIATE*

Time to PHYSICIAN Assessment
15 MINUTES*

USUAL PRESENTATION	SENTINEL DIAGNOSIS
Head Injury (Risk Features ± Altered Mental State)	Head Injury
Severe Trauma	Trauma, Multiple Sites, Multiple Rib Fracture, Neck Injury / Spinal Cord
Altered Mental State (lethargic, drowsy, agitated)	
Chemical Exposure - Eyes	Alkaline / Caustic Occular Burns
Allergic Reaction (Severe)	Anaphylaxis
Chest Pain • Visceral, Non-Traumatic	AMI, Unstable Angina, CHF, Chest Pain NOS,
• ± Associated Symptoms	Gastroesophageal Reflux
Overdose (conscious), Drug Withdrawal	Unspecified Drug / Medicinal Overdose, "d.t.'s"
ABD Pain (Age >50) with Visceral Symptoms	AAA, Appendicitis, Cholecystitis
Back Pain (Non Trauma, Not MSK)	
GI Bleed with Abnormal Vital Signs	Gastrointestinal Bleed, Hypotension
CVA with Major Deficit	CVA
Asthma Severe (PEFR <40%)	Severe Asthma
Moderate / Severe Dyspnea / Diffuculty Breathing	COPD, Croup
Vaginal Bleeding • Acute, Pain scale >5	Spontaneous Abortion
• ± Abnormal Vital Signs	Ectopic Pregnancy / Rupture
Vomiting and/or diarrhea (with suspicion of dehydration)	
Signs of serious infection (purpuric rash, toxic)	
Chemotherapy or immunocompromised	
Fever (age ≤ 3 months) Temp ≥ 38.0 (rectal)	Epiglottitis, Meningitis, Sepsis
Acute Psychotic Episode / Extreme Agitation	Acute Psychotic Episode / Agitation
Diabetes: Hypoglycemia, Hyperglycemia	Hypoglycemia, Diabetic Ketoacidosis, Hyperglycemia
Headache (Pain Scale 8 - 10/10)	Migraine
Pain Scale 8-10 (CVA, Back, Eye)	Renal Colic, LBP / Strain (Disc), Keratitis, Iritis
Sexual Assault	
Neonate (≤ 7 days old)	

TRIAGE LEVEL III - *URGENT*

Time to NURSE Assessment
30 MINUTES*

Time to PHYSICIAN Assessment
30 MINUTES*

USUAL PRESENTATION	SENTINEL DIAGNOSIS
Head Injury, Alert, Vomiting	Head Injury
Moderate Trauma	Anterior Dislocated Shoulder, Tibia / Fibula Fracture, Bimalleolar, Trimalleolar Ankle Fracture
Abuse / Neglect / Assault	
Vomiting and/or diarrhea (≤ 2 years)	
Dialysis problems	
Signs of Infection	Pyelonephritis
Mild / Moderate Asthma (PEFR > 40%)	Asthma without Status / COPD
Mild / Moderate Dyspnea	Bronchiolitis / Croup, Pneumonia
Chest Pain • No Visceral Symptoms (Sharp/MSK)	Chest Pain NOS (MSK, GI, Resp)
• No Previous Heart Disease	
GI Bleed with Normal Vital Signs	GI Bleed, No complications
Vaginal Bleeding Acute, Normal Vital Signs	Spontaneous Abortion
Seizure, Alert on Arrival	Seizure
Acute Psychosis ± Suicidal Ideation	Acute Psychosis ± Suicidal Ideation
Pain Scale 8 - 10 / 10 with minor injuries	
Pain Scale 4 - 7 / 10 (Headache, CVA, Back)	Migraine, Renal Colic, LBP / Strain (Disc)

TRIAGE LEVEL IV - *LESS URGENT*

Time to NURSE Assessment
60 MINUTES*

Time to PHYSICIAN Assessment
60 MINUTES*

USUAL PRESENTATION	SENTINEL DIAGNOSIS
Head Injury, Alert, No Vomiting	Head Injury, Alert, No Vomiting
Minor Trauma	Colles Fracture, Ankle Sprain
ABD Pain (Acute)	Appendicitis, Cholecystitis
Earache	Otitis Media / Otitis Extema
Chest Pain, Minor Trauma or MSK, No Distress	Chest Pain NOS (MSK, GI, Resp), Gastroesophageal Reflux
Vomiting and diarrhea (>2 years/no dehydration)	
Suicidal Ideation / Depression	Suicidal Ideation / Depression
Allergic Reaction (Minor)	Urticaria
Corneal Foreign Body	Corneal Foreign Body
Back Pain (Chronic)	LBP /Strain
URI Symptoms	URI
Pain Scale 4 - 7	
Headache (Non Migraine / Not Sudden)	

TRIAGE LEVEL V - *NON URGENT*

Time to NURSE Assessment
120 MINUTES*

Time to PHYSICIAN Assessment
120 MINUTES*

USUAL PRESENTATION	SENTINEL DIAGNOSIS
Minor Trauma, Not Necessarily Acute	LBP / Strain
Sore Throat, No Resp Symptoms	URI
Diarrhea alone (no dehydration)	Gastroenteritis
Vomiting alone normal mental status (no dehydration)	Vomiting
Menses	Disorders of Menstruation
Minor Symptoms	Dressing Changes
ABD Pain (Chronic)	Cast Changes
Psychiatric complaints	Constipation
Pain Scale < 4	Symptoms / Neurotic, Personality and Nonpsychotic Mental Disorders
	Unspecified Superficial Laceration(s)

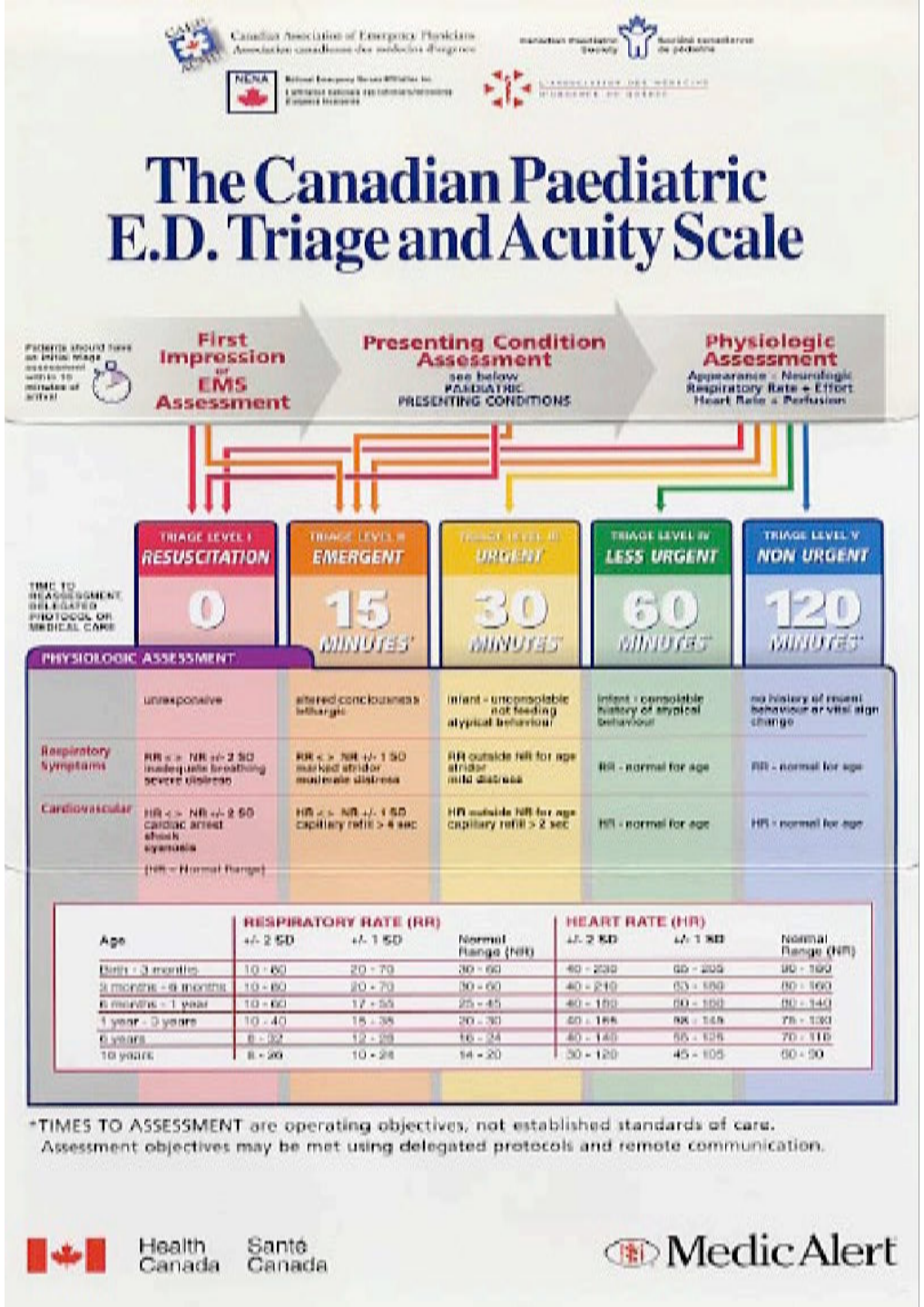
* *TIMES TO ASSESSMENT* are operating objectives, not established standards of care. Facilities without onsite

PEDIATRIC TRIAGE PCTAS

There are three things that must be assessed and documented on all pediatric patients:

- Respiratory rate.
- Heart rate.
- Capillary refill.

Pediatric CTAS Poster Pocket Card



The Canadian Paediatric E.D. Triage and Acuity Scale

First Impression or EMS Assessment

Presenting Condition Assessment see below PAEDIATRIC PRESENTING CONDITIONS

Physiologic Assessment Appearance + Neurologic Respiratory Rate + Effort Heart Rate + Perfusion

	TRIAGE LEVEL I RESUSCITATION	TRIAGE LEVEL II EMERGENT	TRIAGE LEVEL III URGENT	TRIAGE LEVEL IV LESS URGENT	TRIAGE LEVEL V NON URGENT
TIME TO REASSESSMENT DELEGATED PROTOCOL OR MEDICAL CARE	0	15 MINUTES*	30 MINUTES*	60 MINUTES*	120 MINUTES*
PHYSIOLOGIC ASSESSMENT	unresponsive	altered consciousness lethargic	infant - unconsolable not feeding atypical behaviour	infant - consolable history of atypical behaviour	no history of recent behaviour or vital sign change
Respiratory Symptoms	RR < > NR +/- 2 SD inadequate breathing severe distress	RR < > NR +/- 1 SD marked stridor moderate distress	RR outside NR for age stridor mild distress	RR - normal for age	RR - normal for age
Cardiovascular	HR < > NR +/- 2 SD cardiac arrest shock cyanosis	HR < > NR +/- 1 SD capillary refill > 4 sec	HR outside NR for age capillary refill > 2 sec	HR - normal for age	HR - normal for age

(HR = Normal Range)

Age	RESPIRATORY RATE (RR) +/- 2 SD	+/- 1 SD	Normal Range (NR)	HEART RATE (HR) +/- 2 SD	+/- 1 SD	Normal Range (NR)
Birth - 3 months	10 - 60	20 - 70	30 - 60	60 - 220	85 - 205	90 - 190
3 months - 6 months	10 - 60	20 - 70	30 - 60	60 - 210	85 - 190	90 - 180
6 months - 1 year	10 - 60	17 - 55	25 - 45	60 - 180	80 - 160	80 - 140
1 year - 3 years	10 - 40	15 - 35	20 - 30	60 - 165	80 - 145	75 - 130
3 years	8 - 32	12 - 28	16 - 24	60 - 140	85 - 125	70 - 110
10 years	8 - 28	10 - 24	14 - 20	50 - 120	45 - 105	60 - 90

*TIMES TO ASSESSMENT are operating objectives, not established standards of care. Assessment objectives may be met using delegated protocols and remote communication.

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MedicAlert

EMERGENCY SEVERITY INDEX

	ESI-1	ESI-2	ESI-3	ESI-4	ESI-5
Stability of vital functions (ABCs)	Unstable	Threatened	Stable	Stable	Stable
Life threat or organ threat	Obvious	Reasonably likely	Unlikely (possible)	No	No
Requires resuscitation	Immediately	Sometimes	Seldom	No	No
Severe pain or severe distress	Yes	Yes (sufficient, but not necessary for this category)	No	No	No
Expected resource intensity	Maximum: staff at bedside continuously; mobilization of outside resources	High: multiple, often complex diagnostic studies; frequent consultation; continuous (remote) monitoring	Medium: multiple diagnostic studies; or brief period of observation; or complex procedure	Low: one simple diagnostic study; or one simple procedure	Low: examination only
Physician/staff response	Immediate team effort	Minutes	Up to 1 hr	Could be delayed	Could be delayed
Expected time to disposition	1.5 hr	4 hr	6 hr	2 hr	1 hr
Examples	Cardiac arrest, intubated trauma patient, severe drug overdose	Most chest pain, stable trauma (mechanism concerning), elderly pneumonia patient, altered mental status, behavioral disturbance (potential violence)	Most abdominal pain, dehydration, esophageal food impaction, hip fracture	Closed extremity trauma, simple laceration, cystitis, typical migraine	Sore throat, minor burn, recheck

PRIMARY AND SECONDARY PEDIATRIC TRIAGE SURVEY

	Primary		Secondary
A = Airway	✔ Patency, positioning for air entry, audible sounds, airway obstruction (blood, mucus, edema, foreign body)	F = Find	Find out underlying history of current illness or injury
B = Breathing	✔ Increased or decreased work of respiration, quality of breath sounds; nasal flaring; use of accessory muscles; pattern; quality; rate	G = Get vital signs	Obtain vital signs, obtain orthostatic vital signs if condition warrants
C = Circulation	✔ Color and temperature of skin; capillary refill; strength and rate of peripheral pulses	H = Head-to-toe assessment	Perform a head-to-toe assessment for a complete and thorough examination
C = Cervical collar	Placement of a cervical collar when indicated	I = Initiate	Initiate the Triage Documentation Record
C = Consciousness	✔ Level of consciousness (Glasgow Coma Scale); response to environment; muscle tone; pupil response	I = Isolate	Assess patient for rashes, communicable diseases, or immunosuppression, and place in appropriate isolation
D = Dextrose	✔ Serum glucose level in patients with altered mental status	I = Intervention	Perform triage interventions (first aid, medication administration, diagnostic studies)
E = Expose	Expose patient by undressing to identify underlying injuries	J = Judgment	Make appropriate triage classification of patient acuity

PENGENALAN KEGAWATAN PEDIATRIK

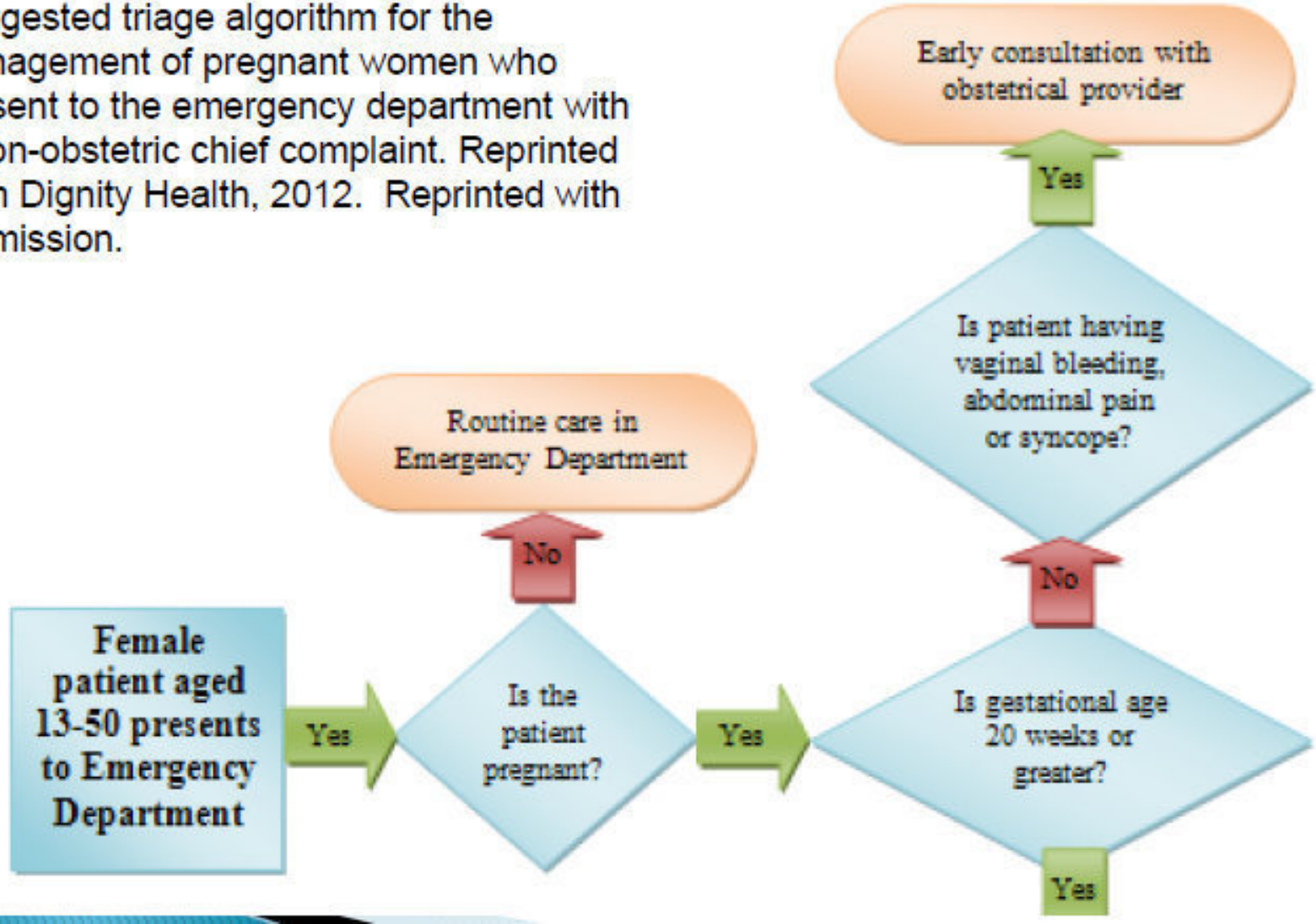
observe

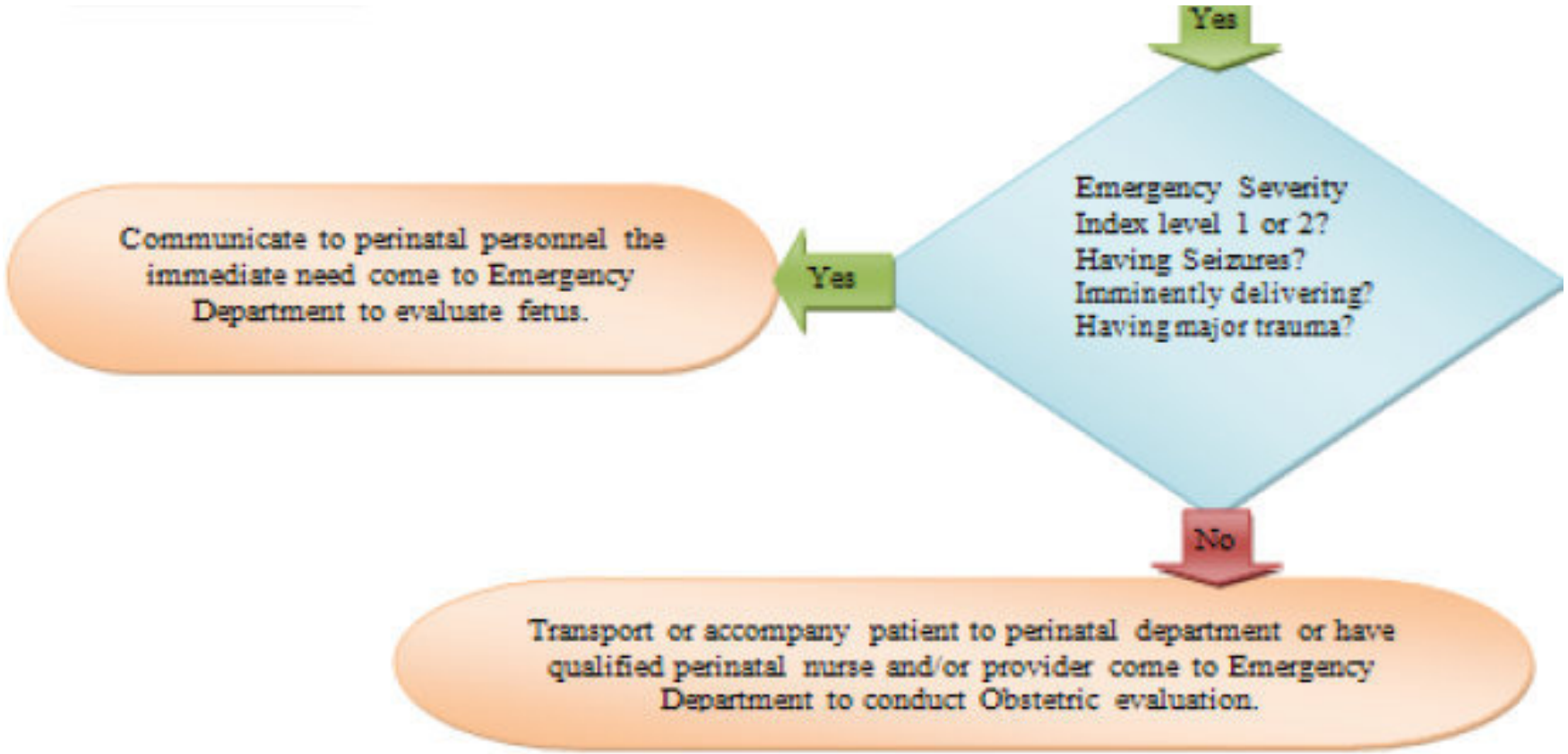
Skin	Mottled? Cyanotic? Petechiae? Pallor?
Activity	Needs assistance/ Not ambulating? Responsive?
Ventilation	Retractions? Head bobbing? Drooling? Nasal flaring? Slow rate? Fast rate? Stridor? Wheezing?
Eye Contact	Glassy stare? Fails to engage/focus?

Abuse	Unexplained bruising/injuries? Inappropriate parent?
Cry	High pitched, cephalic? Irritable?
Heat	High fever (>41°)? Hypothermia (36°)?
Immune System	Sickle cell? AIDS? Corticosteroids?
Level of Consciousness	Irritable? Lethargic? Pain only? Convulsing? Unresponsive?
Dehydration	Hollow eyes? Capillary refill? Cold hands, feet? Voiding? Severe diarrhea? Vomiting: projectile, bilious, persistent? Dry mucous membranes?

PENGENALANAN KEGAWATAN OBSTETRIK

Suggested triage algorithm for the management of pregnant women who present to the emergency department with a non-obstetric chief complaint. Reprinted from Dignity Health, 2012. Reprinted with permission.




Yes
Emergency Severity Index level 1 or 2?
Having Seizures?
Imminently delivering?
Having major trauma?
Yes
Communicate to perinatal personnel the immediate need come to Emergency Department to evaluate fetus.
No
Transport or accompany patient to perinatal department or have qualified perinatal nurse and/or provider come to Emergency Department to conduct Obstetric evaluation.

INTERVENTION CALLING SCORE

Physiological marker	Score 0	Score 1	Score 2	Score 3
Ventilatory frequency	≤19	20–21	≥22	
Pulse	≤101	≥102		
Systolic blood pressure	≥100		≤99	
Temperature	≥35.3			<35.3
Oxygen saturation in air	96 to 100	94 to <96	92 to <94	<92
AVPU	Alert			Other

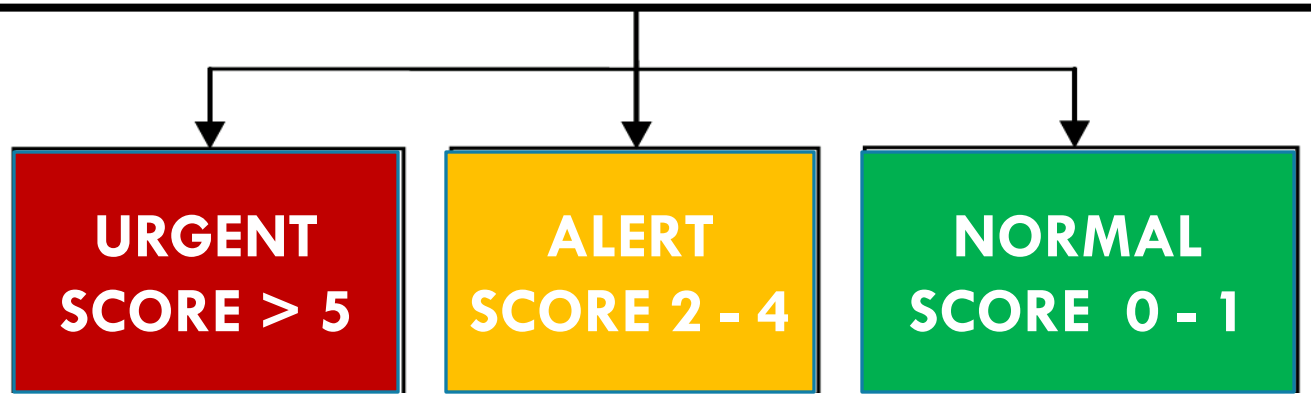
URGENT
SCORE > 5

ALERT
SCORE 2 - 4

NORMAL
SCORE 0 - 1

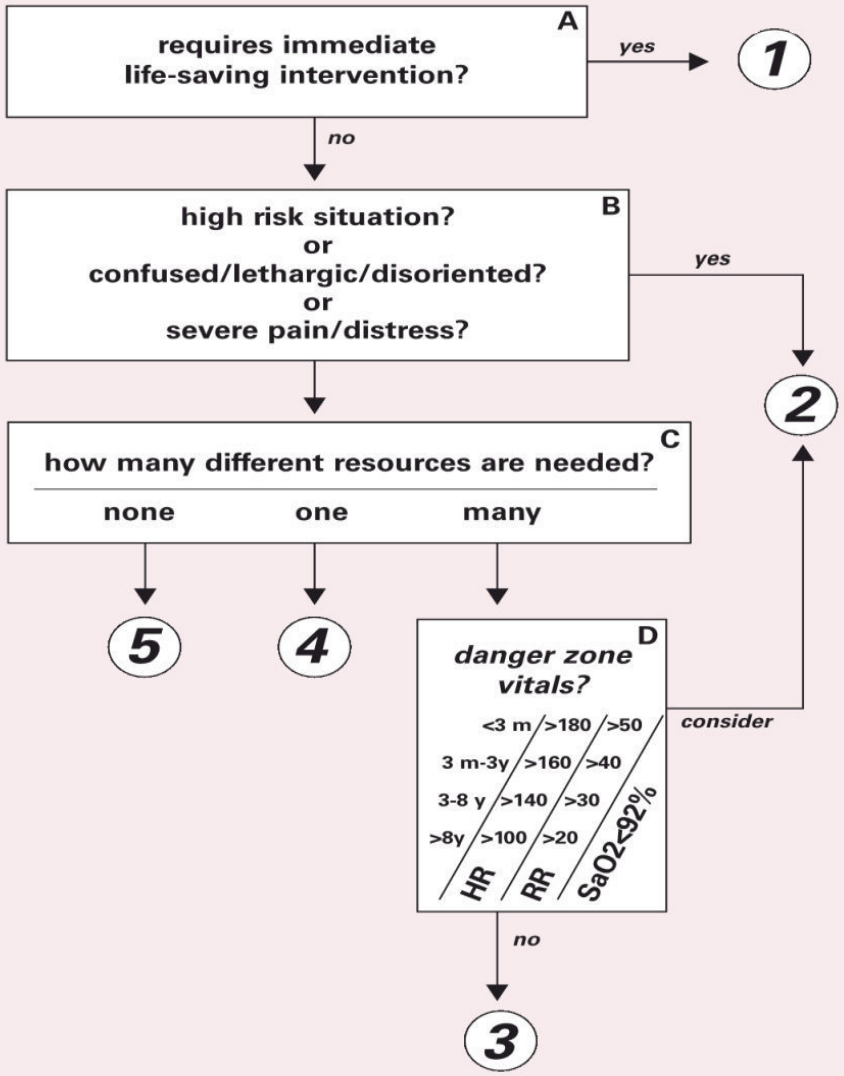
MODIFIED EARLY WARNING SCORE

Score	3	2	1	0	1	2	3
Respiratory rate (min^{-1})		≤8		9–14	15–20	21–29	>29
Heart rate (min^{-1})		≤40	41–50	51–100	101–110	111–129	>129
Systolic BP (mmHg)	≤70	71–80	81–100	101–199		≥200	
Urine output (ml/kg/h)	Nil	<0.5					
Temperature (°C)		≤35	35.1–36	36.1–38	38.1–38.5	≥38.6	
Neurological				Alert	Reacting to voice	Reacting to pain	Unresponsive



ESI TRIAGE ALGORITHM

Figure 2-1a. ESI Triage Algorithm



A. Immediate life-saving intervention required: airway, emergency medications, or other hemodynamic interventions (IV, supplemental O2, monitor, ECG or labs DO NOT count); and/or any of the following clinical conditions: intubated, apneic, pulseless, severe respiratory distress, SPO_2<90, acute mental status changes, or unresponsive.

Unresponsiveness is defined as a patient that is either:
(1) nonverbal and not following commands (acutely); or
(2) requires noxious stimulus (P or U on AVPU) scale.

B. High risk situation is a patient you would put in your last open bed.

Severe pain/distress is determined by clinical observation and/or patient rating of greater than or equal to 7 on 0-10 pain scale.

C. Resources: Count the number of different types of resources, not the individual tests or x-rays (examples: CBC, electrolytes and coags equals one resource; CBC plus chest x-ray equals two resources).

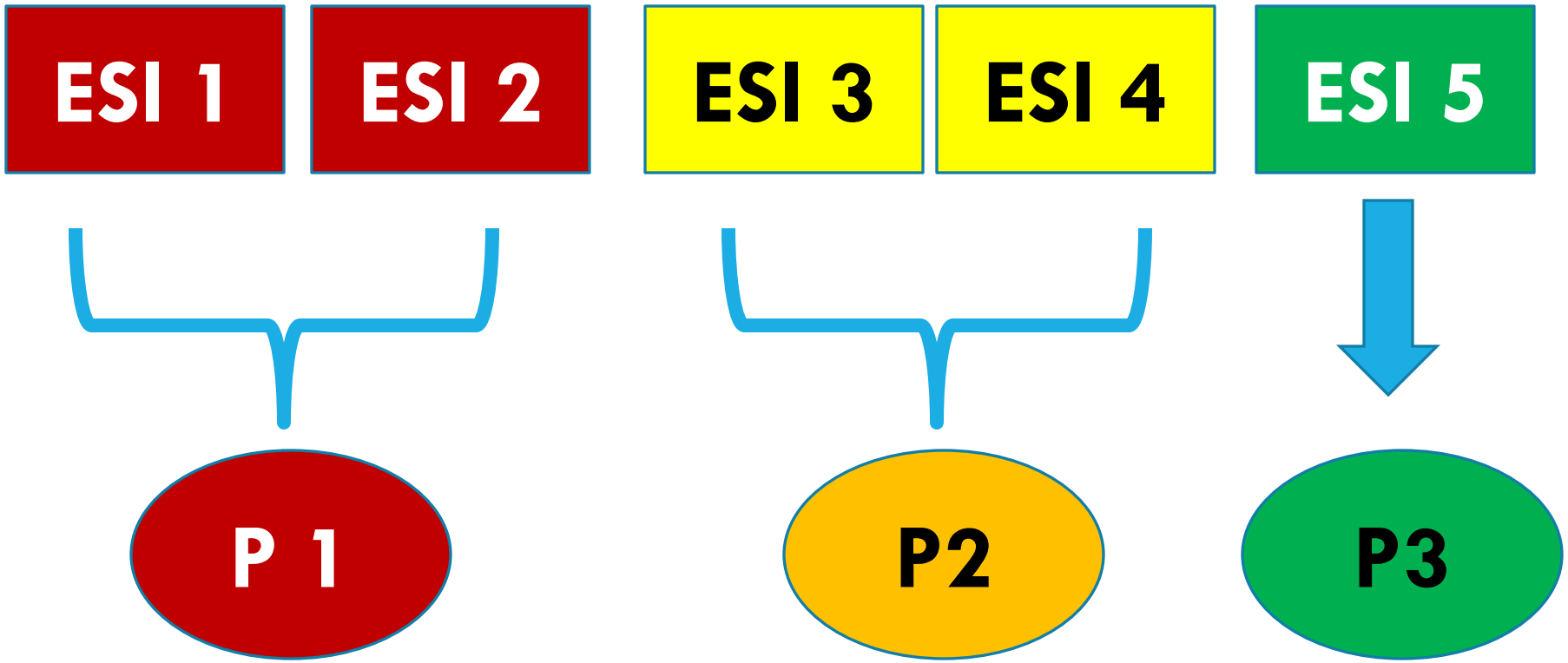
Resources	*Not Resources*
• Labs (blood, urine) • ECG, X-rays • CT-MRI-ultrasound-angiography	• History & physical (including pelvic) • Point-of-care testing
• IV fluids (hydration)	• Saline or heplock
• IV or IM or nebulized medications	• PO medications • Tetanus immunization • Prescription refills
• Specialty consultation	• Phone call to PCP
• Simple procedure =1 (lac repair, foley cath) • Complex procedure =2 (conscious sedation)	• Simple wound care (dressings, recheck) • Crutches, splints, slings

D. Danger Zone Vital Signs
Consider uptriage to ESI 2 if any vital sign criterion is exceeded.

Pediatric Fever Considerations
1 to 28 days of age: assign at least ESI 2 if temp >38.0 C (100.4F)

1-3 months of age: consider assigning ESI 2 if temp >38.0 C (100.4F)

3 months to 3 yrs of age: consider assigning ESI 3 if: temp >39.0 C (102.2 F), or incomplete immunizations, or no obvious source of fever


ESI 1
ESI 2
ESI 3
ESI 4
ESI 5
P 1
P2
P3

PACS

SINGAPORE EMERGENCY PATIENT'S CATEGORISATION SCALE

TRIAGE CATEGORY	DEFINITION OF LEVEL OF ACUITY	TYPICAL PRESENTING COMPLAINT	INITIAL PROVISIONAL DIAGNOSIS
1	Resuscitation & Critically Ill Patients	Cardiac Arrest Trauma arrest Major Trauma Shock States Near-Death Asthma Severe Respiratory Distress Unconscious patients Active Seizures Major Limb Amputations Head Injury with Altered Mental State Chest Pain – Likely to be AMI/Unstable Angina Gastrointestinal Bleed with Shock/Impending Shock Other Presentation of Acute Coronary Ischaemia Syndrome	Traumatic Shock Pneumothroax – Traumatic/Tension Facial Burns with Airway Compromise Head Injury with Unconsciousness Open wound of Chest Hypoglycemia Tricyclic Overdosage Leaking Abdominal Aortic Aneurysm Dissecting Aneurysm AcuteMyocardial Infarction with/without Complications Status Asthmaticus Status Epilepticus Multiple Major Trauma Grade 4 Heart Failure Shock of Whatever Cause Unstable Angina Pectoris Acute Stroke with Altered Mental State.

TRIAGE CATEGORY	DEFINITION OF LEVEL OF ACUITY	TYPICAL PRESENTING COMPLAINT	INITIAL PROVISIONAL DIAGNOSIS
2	Major Emergencies (Non-Ambulant)	Chest Pain – Unlikely to be AMI Drug Overdosage – Conscious Severe Abdominal Pains Gastrointestinal Bleed with Normal vital signs Acute Vaginal Bleed with Normal Vital Signs Altered Mental States – Not Unconscious and Normal Vital Signs Moderate Trauma – Non-Ambulant Severe Painful states Head Injury, Alert + Vomiting Mild/Moderate asthma Seizures – Alert on arrival Chest Infection with Breathlessness Persistent Vomiting - ?Cause	Hyperosmolar Non-Ketotic Diabetes Diabetic Ketoacidosis Multiple Rib Fractures Neck/Spinal Cord Injury Ocular Burns Chest Pain – Cause Not Obvious Epiglottitis Ectopic Pregnancy Major Limb Fractures Major Joint Dislocation Major Vertebrogenic Syndromes Bronchial Asthma Acute Appendicitis Perforated Viscus Acute Ureteric Colic Acute Urinary Retention Bronchopneumonia Gastrointestinal Bleed – Normal Vital Signs Cholecystitis Severe Sepsis without Shock Acute Psychotic States Acute Cerebrovascular Accident but Alert Acute Pyelonephritis Cancers with Complications Intestinal Obstruction Drug Overdosage with Alert Mental State Acute Exarcebation of Peptic Ulcer

TRIAGE CATEGORY	DEFINITION OF LEVEL OF ACUITY	TYPICAL PRESENTING COMPLAINT	INITIAL PROVISIONAL DIAGNOSIS
3	Minor Emergencies (Ambulant)	Head Injury, Alert, No Vomiting Minor acute Trauma Acute Ankle Sprain Abdominal Pains – Not Severe Headaches Earache/Acute Ear Discharge Foreign Bodies in Orifices and Eyes Mild to Moderate Pains Missed Abortion	Head Injury, alert, No Vomiting Colles Fracture Clavicular Fracture Ankle Sprain Other Minor Fractures Migraine and Similar Headaches Otitis Media/Externa Gastrointestinal Reflux Foreign Bodies of Ear, Nose, Throat, Eyes and Extremities Dysmenorrhoea Symptoms Acute Gastroenteritis Vomiting All Sprains Insect Stings and Snake and Animal Bites Superficial Injuries Hyperpyrexia Urticaria

TRIAGE CATEGORY	DEFINITION OF LEVEL OF ACUITY	TYPICAL PRESENTING COMPLAINT	INITIAL PROVISIONAL DIAGNOSIS	
4	Non-Emergencies	Old Trauma with Residual Disability Sore Throat with Absence of Respiratory Problems Minor Upper Respiratory Illnesses Non-Urgent Surgical Procedures Chronic weakness of Body Non-Urgent Eye Conditions Non-Urgent ENT Conditions Minor Ill-Defined Conditions Requests for Non-Urgent Treatment Request for Certification and General Check-ups Cold Gynecological Cases Non-Urgent Skin Problems	Old Scars Deformities of Bones, Limbs or Spine Joint Contractures Old Fractures <u>Non-Urgent Operations</u> : Request for Removal of Metal Plates, Screws Old Unreduced Dislocations Chronic Discharging Wounds Chronic Sprains Cold Lumps and Bumps in the Body Varicose Veins Cyst Requests for Circumcision Patching of Earlobe Removal of Tattoo Removal of Corns, Warts Removal of Keloids <u>Weakness of Body</u> : Cerebral Palsy, Spastics Cervical Spondylosis Post Polio Old Hemiplegias, old Strokes Old Paraplegia Osteoarthritis Knees	<u>Non-Urgent Eye Conditions</u> : Refractive Disorders of the Eye, Spectacles Pterygium Cataract Defective Vision Squints <u>Non-Urgent ENT Conditions</u> Chronic Rhinitis Defective Hearing Nasal Polyp Wax in Ears <u>Ill Defined Conditions</u> Chronic vague Symptoms Like Tiredness, Dyspepsia Upper Respiratory Infections Without Fever Chronic Cough Social Problem – Requests Admission Psychosomatic Problems Chronic Headaches On and Off Insomnia

WPSS

Physiological marker	Score 0	Score 1	Score 2	Score 3
Ventilatory frequency	≤19	20–21	≥22	
Pulse	≤101	≥102		
Systolic blood pressure	≥100		≤99	
Temperature	≥35.3			<35.3
Oxygen saturation in air	96 to 100	94 to <96	92 to <94	<92
AVPU	Alert			Other

Total score	Intervention
Total score 0–1	Normal
Total score 2–4	Alert
Total score ≥5	Urgent

AVPU, Alert, Voice, Pain and Unconsciousness score.

MAKLUMAT TRIAGE

CONCLUSION

1. Multiple portals of entry → telephone contact, ambulance contact, and direct patient entry to hospital developing integrated care services.
2. The challenge for the future is to develop effective triage systems → focus the response using a sensitive and specific system, in order to use limited resources most effectively
3. The health burden on emergency services → increasing demand, increasing financial pressures, limitations on staff