Title: Ministry of Health Emergency Department Triage Policy	
Policy Owner: Emergency Department	**Policy code: D-AE-001**
Section location: Administrative/General	**Effective date: 16/12/2021**
Applies to: Emergency Department of Hospitals and health care facilities of the Ministry of Health	**Revision dates: 16/12/2023**
Approvals:	**Signature/Date**
Approved by: Chairman of the Council of Emergency Medicine	
Approved by: MOH committee on hospital clinical services and polices	
Approved by: Director of technical affairs	
Approved by: Assistant undersecretary of technical affairs	
Notes:	

1.0 Policy Statement/Purpose:

1.1. This policy is established as a guide and framework to be implemented in all emergency departments (EDs) of the Ministry of Health (MOH) in Kuwait. It is intended to be utilized by all emergency healthcare providers (HCP), when triaging patients presenting to the ED. The objective of the triage process is to:

1.1.1. Rapidly identify patients with urgent, life-threatening conditions

1.1.2. Designate patients to the level of care they need in an efficient manner

1.1.3. Determine the most appropriate treatment area for the patients presenting to the ED

1.1.4. Reduce patient waiting times

1.1.5. Provide information to patients and families regarding services, expected care and waiting times

1.1.6. Provide a practical mechanism for ongoing patient assessment

1.1.7. Decrease congestion in the ED

1.2. The triage tool to be used will be the Canadian Triage and Acuity Scale (CTAS)

(The triage tool is subject to modification and/or change every 2 years upon revision of the policy, or sooner if the need arises)

2.0 Definitions

2.1 Triage - The process, by which patients are classified, evaluated and/or directed to the most appropriate area of the ED according to their disease acuity, presentation, and urgency of medical needs. Triage can be done by:

2.1.1 ED triage-trained nurse

2.1.2 ED physician (EDP)

2.2 Reorientation (triage-away) - A process of redirecting patients to an appropriate medical care facility/resource if the ED triage process indicates that situation is non-urgent or less urgent

and does not require immediate medical care/consultation/intervention

2.3 Priority - An established higher clinical urgency of a medical condition, presenting complaint, and/or patient risk factor profile

2.4 Acuity - The severity of an illness or injury

2.5 ED HCP

2.5.1 ED triage-trained nurse

2.5.2 EDP

3.0 General Principles

3.1 All patients are to be assessed at least visually as soon as possible after their arrival to the ED. The goal of triage is to rapidly identify patients with urgent or life-threatening conditions

3.2 All patients presenting to the ED will be assigned a triage score based on the Canadian Triage and Acuity Scale (CTAS)

3.3 Accurate assignment of triage score is based on:

3.3.1 CTAS predefined criteria and parameters (chief complaint, vital signs, etc.)

3.3.2 Clinical guidelines and protocols (international or local)

3.3.3 Clinical judgment

3.4 Only information required to assign a triage level shall be recorded (vital signs, chief complaint, vital signs, etc.)

3.4.1 Refer to the triage form

3.4.2 Full patient assessments shall ***not*** be done in the triage area

3.5 Patients may be re-triaged to an alternative triage level/care priority following reassessment or changes in the patient's vital signs and/or symptoms.

3.5.1 There shall be documentation of the initial triage as well as any changes

3.5.2 The initial documented triage level shall not be changed

3.5.3 New triage levels may be issued for the same patient (e.g., re-triage in the waiting areas)

3.5.4 Each ED will apply a context-appropriate patient assessment and re-triage system

3.6 All patients presenting to the ED shall be registered by registration personnel as per hospital-specific registration procedures

3.7 The decision to discharge patients at the point of triage shall be determined by the EDP (based on his/her triage assessment) - Please refer to reorientation in section 5.0

3.8 All documentation is to be signed by ED HCP (by hand or electronically as per the hospital specific documentation procedures)

4.0 CTAS Triage System

4.1 Time to assessment

4.1.1 After designation of the CTAS level, all patients will be assessed by a qualified EDP according to the following timelines:

4.1.1.1 CTAS Level 1: immediately

4.1.1.2 CTAS Level 2: within 10 minutes

4.1.1.3 CTAS Level 3: within 30 minutes

4.1.1.4 CTAS Level 4: within 60 minutes

4.1.1.5 CTAS Level 5: within 120 minutes

4.2 Definition of CTAS level~~s~~:

4.2.1 **Level 1: Resuscitation (Blue)**

4.2.1.1 Conditions that are threats to life or limb (or with imminent deterioration risk) requiring immediate aggressive intervention~~s~~

4.2.1.2 Examples of types of conditions, which would be Level 1 include but are not limited to: cardiac/respiratory arrest, major trauma, shock states, unconscious patients, severe respiratory distress

4.2.1.3 Time to physician assessment of patient is immediate

4.2.2 **Level 2: Emergent (Red)**

4.2.2.1 Conditions that are a potential threat to life, limb, or function, requiring rapid medical intervention or delegated actions

4.2.2.2 Examples of types of conditions, which would be Level 2 include but are not limited to: altered mental status~~es~~, head injury, severe trauma, neonates (less than 7 days), overdose, stroke, chemical exposures to eyes, myocardial infarction, unstable angina, pulmonary embolism, preeclampsia, testicular torsion

4.2.2.3 Time to physician assessment of patient is within 10 minutes

4.2.3 **Level 3: Urgent (Yellow)**

4.2.3.1 Conditions that could potentially progress to serious problems requiring emergency intervention. They may be associated with significant discomfort, affect the ability to function at work, and/or compromise activities of daily living

4.2.3.2 Examples of types of conditions, which would be Level 3, include but are not limited to: moderate trauma, asthma, GI bleed, vaginal bleeding in pregnancy, acute psychosis, suicidal thoughts

4.2.3.3 Time to physician assessment of the patient is within 30 minutes

4.2.4 **Level 4: Less Urgent (Green)**

4.2.4.1 Conditions that are related to patient age, distress, or potential for deterioration or complications and would benefit from intervention

4.2.4.2 Examples of types of conditions, which would be Level 4, include but are not limited to: headache, corneal foreign body, vomiting, chronic back pain

4.2.4.3 Time to physician assessment of the patient is within 60 minutes

4.2.5 **Level 5: Non-Urgent (White)**

4.2.5.1 Conditions that may be acute but non-urgent as well as conditions that may be part of a chronic problem with or without evidence of deterioration. The investigation or interventions for some of these illnesses or injuries could be delayed or even referred to other areas of the hospital or health care system

4.2.5.2 Examples of types of conditions which would be considered Level 5 include but are not limited to: sore throat, upper respiratory infection, chronic/recurring mild abdominal pain (without peritoneal signs), and normal vital signs, isolated resolved non-bloody non-bilious vomiting, isolated non-bloody diarrhea, medication refill request, general check up, physical exam for work/school

4.2.5.3 Time to physician assessment of the patient is within 120 minutes

5.0 <u>Documentation</u>

5.1 Please refer to the attached MOH official triage form

5.2 Triage shall be done by the ED HCP according to the ED local policy and regulations

6.0 <u>Reorientation/Triage-Away</u>

6.1 Any patient presenting with signs of instability or CTAS 1, 2, or 3 CANNOT be reoriented/triaged away

6.2 If the triage evaluation indicates that the patient's condition is non-urgent or less urgent and does ***not*** require immediate further medical investigation and/or intervention, the EDP can reorient/triage away the patient to a more appropriate healthcare facility (primary care, other specialized)

6.3 The decision to reorient patients at the point of triage and their recommended orientation shall be determined and documented by the EDP

6.4 Indications for reorientation/triage away include, **<u>but are not limited to</u>**:

6.4.1 Patient with a stable/chronic condition that has no acute change and does not mandate urgent medical attention

6.4.2 Flu-like symptoms in otherwise stable patients

6.4.3 Prescription renewal/refill

6.4.4 Medical form/note completion request (for school or work)

6.4.5 General physical exam request without specific acute issues

6.4.6 Vaccines (except tetanus booster only when acutely indicated)

6.4.7 Referral for routine investigations (whether from government or private sector)

6.4.8 Referral for elective admission (should be arranged directly between referring physician and the admitting service, ***not*** through the ED)

6.4.9 Non-urgent focal dermatological conditions

6.4.10 Referral/request for routine change of indwelling urinary catheter, nasogastric tube, or any other indwelling medical devices without any acute complications

6.4.11 Routine daily dressing

6.4.12 Suture removal

6.4.13 Sexually transmitted infection testing and treatment request

6.4.14 Isolated tooth pain

6.4.15 Tooth extraction request

6.4.16 Referral from dentist for specialized dental care

6.4.17 Referral for non-urgent injections (medications, mineral, vitamins, etc.) or transfusions (whether from government or private sector)

6.4.18 Patients with existing outpatient follow-up appointments (polyclinic, specialist department) within 7-10 working days and who have no new active medical/surgical issues necessitating urgent clinical assessment prior to the pre-existing outpatient appointment

6.4.19 Gastroenteritis in otherwise stable patients with no risk factors

6.4.20 Chronic atraumatic musculoskeletal pain (without new or progressive neurological symptoms)

6.4.21 First time referrals from polyclinic with any of the above mentioned cases/scenarios

6.5 The above criteria should be used in conjunction with appropriate clinical judgment

6.6 Patients with symptoms that may necessitate early but non-urgent imaging or investigative procedures may be redirected with their referral letters to the index hospital respective department the following morning to follow up and triage for early outpatient appointments as applicable and appropriate. Examples include but are not limited to:

- 6.6.1 Chronic headache (4-12 weeks' duration) with no acute change and no neurologic deficit
- 6.6.2 Isolated chronic, stable cough
- 6.6.3 Isolated chronic, non-progressive shortness of breath
- 6.6.4 Isolated chronic, stable fatigue without any clinical red flags
- 6.6.5 Slow non-intentional weight loss without any clinical red flags
- 6.6.6 Second time referrals from polyclinic with the same complaint or pathology

7.0 References

7.1 Canadian Triage Acuity Score (CTAS 2008)

7.2 MOH Emergency department admission policy [code: A-Adm-002 (2019)]

7.3 Canadian Emergency Department Informatics system (CEDIS) 2008 Chief Complaint list

7.4 The Canadian Triage and Acuity Scale: Education manual (2012)

7.5 CTAS National Working group

7.6 Canadian Association of Emergency Physicians

7.7 St. Mary's Hospital\Policies and Procedures\Emergency\Triage Guidelines Policy

7.8 Nursing reorientation from triage in adults emergency departments/ McGill University Health Center (2018)

7.9 Triage process in emergency department, Hamad Medical Corporation (2017)

8.0 Attachments

8.1 Color coding triage

8.2 MOH Triage form