HEALTH HOLDING

HAFER ALBATIN HEALTH CLUSTER
MATERNITY AND CHILDREN HOSPITAL

Department:	Emergency Room		
Document:	Multidisciplinary Policy and Procedure		
Title:	Triage – Prioritization of Care		
Applies To:	All Emergency Room Staff		
Preparation Date:	January 05, 2025	**Index No:**	ER-MPP-001
Approval Date:	January 19, 2025	**Version :**	2
Effective Date:	February 19, 2025	**Replacement No.:**	ER-MPP-001 (1)
Review Date:	February 19, 2028	**No. of Pages:**	17

1. PURPOSE:

1.1 To provide a standardized system whereby patients seeking medical care in the Emergency Room are seen by a physician in order of priority based upon their acuity level.
1.2 To provide guidelines for patient assessment.
1.3 To assess priorities of care in critical situations and highly pressured environment.
1.4 To identify the needs of patients in establishing the priorities required during emergency situations.
1.5 To perform technical and advanced skills in providing emergency care.

2. DEFINITIONS:

2.1 **Triage** – a process of assessing patient's degree of required promptness of care in determining management priorities; the system of care classifications applied in prioritizing the delivery of care.

3. POLICY:

3.1 All patients coming to the emergency room of Maternity and Children Hospital, Hafer Al Batin will go a rapid evaluation and decision making process.
3.2 The triage system is according to the Canadian Triage and Acuity Scale.
3.3 The patients coming to the ER will be first screened in the visual triage.
- 3.3.1 The assigned staff in the visual triage will perform the following duties.
  - 3.3.1.1 Perform patient assessment.
  - 3.3.1.2 Reassess patients who are waiting.
  - 3.3.1.3 Initiate emergency treatment if necessary.
  - 3.3.1.4 Manage and communicate with patients in waiting room.
  - 3.3.1.5 Provide education to patients and families when necessary.
  - 3.3.1.6 Sort patients into priority groups according to guidelines.
  - 3.3.1.7 Transport patients to appropriate treatment areas.
  - 3.3.1.8 Communicate status of patients to physician and nurses.

3.4 As per MERS – CoV guidelines, the patients from visual triage with the score of >4; they are diverted to the respiratory triage area colored light blue or isolation room. Even the cases of communicable diseases are admitted to isolation room.
- 3.4.1 In respiratory triage patients are assessed as:
  - 3.4.1.1 Adults (>14 y/o):
    - 3.4.1.1.1 Acute respiratory illness with clinical or radiological, evidence of pulmonary parenchymal disease (pneumonia or ARDS).
    - 3.4.1.1.2 A hospitalized patient with healthcare associated pneumonia based on clinical and radiological evidence.
    - 3.4.1.1.3 Upper or lower respiratory illness within 2 weeks after exposure to a confirmed or probable case of MERS – CoV infection.
    - 3.4.1.1.4 Unexplained acute febrile (38°C) illness and body aches, headaches, diarrhea or nausea and vomiting, with or without respiratory symptoms, and leucopenia (WBC <3.5x10/L) and thrombocytopenia (platelets150xloL).

3.4.1.2 Pediatrics (≤14 y/o):
3.4.1.2.1 Meets the above case definition and has at least one of the following:
3.4.1.2.1.1 History of exposure to a confirmed or suspected MERS – CoV 14 days prior to the onset of symptoms.
3.4.1.2.1.2 History of contact with camels or camel products 14 days prior to the onset of symptoms.
3.4.1.2.1.3 Unexplained severe pneumonia.
3.4.1.2.1.4 Signs and Symptoms:
3.4.1.2.1.4.1 Fever
3.4.1.2.1.4.2 Cough
3.4.1.2.1.4.3 Shortness of Breath

3.5 The other patients are diverted to the general triage for the next phase of assessment. The Canadian Triage and Acuity Scales for pediatrics involves five levels:

3.5.1 **Level I (Immediate/Resuscitation)** – the color code is BLUE. Level I applies when there are conditions that are threats to life or limb requiring aggressive interventions. Level I patient presents with very obvious signs of distress and unstable vital signs.
3.5.1.1 Examples includes:
3.5.1.1.1 Pediatrics:
3.5.1.1.1.1 Cardiac arrest
3.5.1.1.1.2 Respiratory arrest
3.5.1.1.1.3 Major trauma (in shock)
3.5.1.1.1.4 Shortness of breath (severe respiratory distress)
3.5.1.1.1.5 Altered level of consciousness (GCS 3 – 9)
3.5.1.2 The physician should be notified immediately and patient will require 1:1 nursing care.

3.5.2 **Level II (Emergent)** – the color code is RED. It applies when there are conditions that are potential threat to life, limb or function, requiring rapid medical intervention by physician or medical directive.
3.5.2.1 Examples includes:
3.5.2.1.1 Pediatrics:
3.5.2.1.1.1 Vomiting blood (dizzy on sitting up)
3.5.2.1.1.2 Altered level of consciousness (GCS 10-13)
3.5.2.1.1.3 Chest pain. Cardiac features
3.5.2.1.1.4 Abnormal vital signs
3.5.2.1.1.5 High risk situation:
3.5.2.1.1.5.1 Difficulty of breathing
3.5.2.1.1.5.2 Altered mental status
3.5.2.2 Senior ER physician must see the patient within 15 minutes of arrival.

3.5.3 **Level III (Urgent)** – the color code is YELLOW. It applies when there are conditions that could potentially progress to deterioration.
3.5.3.1 Examples includes:
3.5.3.1.1 Pediatrics:
3.5.3.1.1.1 Shortness of breath (mild respiratory distress)
3.5.3.1.1.2 Vomiting and nausea (mild dehydration)
3.5.3.1.1.3 Headache (moderate pain 4 – 7/10)
3.5.3.1.1.4 Diarrhea (uncontrolled bloody diarrhea)
3.5.3.1.1.5 Abnormal vital signs
3.5.3.2 Patient should be seen within 30 minutes.

3.5.4 **Level IV (Less Urgent)** – color code is GREEN. It applies when there are conditions that relate to patient age, distress or potential for deterioration that would benefit from intervention or reassurance within one hour.
3.5.4.1 Example includes:
3.5.4.1.1 Pediatrics:
3.5.4.1.1.1 Confusion (chronic, no change from usual state)
3.5.4.1.1.2 UTI complaints/symptoms (mild dysuria)

3.5.4.1.1.3 Constipation (mild pain <4/10)

3.5.4.2 Patient should be seen within 30 – 60 minutes.

3.5.4 **Level V (Non Urgent)** – color code is WHITE. It applies when there are conditions that may be acute but non – urgent as well as condition without evidence of deterioration.

3.5.4.1 Examples includes:

3.5.4.1.1 Pediatrics:

3.5.4.1.1.1 Diarrhea (mild, no dehydration)

3.5.4.1.1.2 Minor bites (+/- mild acute peripheral pain)

3.5.4.1.1.3 Dressing change (uncomplicated)

3.5.4.1.1.4 Medication request

3.5.4.2 The patient can be triaged out or send to the OPD or PHC. The waiting time can be up to two hours.

3.6 The patient coming to Obstetrics and Gynecology Emergency Room is assessed according to Obstetrical Triage Acuity Scale involves five levels:

3.6.1 **Level I (Immediate/Resuscitation)** – the color code is BLUE. Level I applies when there are conditions that are threats to life or limb requiring aggressive interventions. Level I patient presents with very obvious signs of distress and unstable vital signs.

3.6.1.1 Examples includes:

3.6.1.1.1 Obstetrics:

3.6.1.1.1.1 Imminent birth

3.6.1.1.1.2 Active vaginal bleeding with/without abdominal pain

3.6.1.1.1.3 Seizure activity

3.6.1.1.1.4 Abnormal FHR tracing

3.6.1.1.1.5 No fetal movement

3.6.1.1.1.6 Acute onset severe abdominal pain

3.6.1.1.1.7 Altered level of consciousness

3.6.1.1.1.8 Cord prolapse

3.6.1.1.1.9 Severe respiratory distress

3.6.1.1.1.10 Suspected sepsis

3.6.1.2 The physician should be notified immediately and patient will require 1:1 nursing care.

3.6.2 **Level II (Emergent)** – the color code is RED. It applies when there are conditions that are potential threat to life, limb or function, requiring rapid medical intervention by physician or medical directive.

3.6.2.1 Examples includes:

3.6.2.1.1 Obstetrics:

3.6.2.1.1.1 Suspected preterm labor/ PPROM<37 weeks

3.6.2.1.1.2 Bleeding associated with cramping (>spotting) <37 weeks

3.6.2.1.1.3 Hypertension >160/110mmHg and/or headache, visual disturbance, RUQ pain

3.6.2.1.1.4 Atypical FHR tracing, abnormal BPP, abnormal Doppler's

3.6.2.1.1.5 Decrease fetal movement

3.6.2.1.1.6 Major trauma

3.6.2.1.1.7 Shortness of breath

3.6.2.1.1.8 Unplanned and unattended birth

3.6.2.2 Senior ER physician must see the patient within 15 minutes of arrival.

3.6.3 **Level III (Urgent)** – the color code is YELLOW. It applies when there are conditions that could potentially progress to deterioration.

3.6.3.1 Examples includes:

3.6.3.1.1 Obstetrics:

3.6.3.1.1.1 Sign of active labor >37 weeks

3.6.3.1.1.2 Bleeding associated with cramping (>spotting) >37 weeks

3.6.3.1.1.3 Mild hypertension >140/90mmHg with/ without associated signs and symptoms

3.6.3.1.1.4 Abnormal pain/back pain greater than expected in pregnancy
3.6.3.1.1.5 Flank pain/hematuria
3.6.3.1.1.6 Nausea/vomiting and/or diarrhea with suspected dehydration

3.6.3.2 Patient should be seen within 30 minutes.

3.6.4 **Level IV (Less Urgent)** – color code is GREEN. It applies when there are conditions that relate to patient age, distress or potential for deterioration that would benefit from intervention or reassurance within one hour.

3.6.4.1 Example includes:

3.6.4.1.1 Obstetrics:

3.6.4.1.1.1 Sign of early labor/SROM >37 weeks
3.6.4.1.1.2 Spotting
3.6.4.1.1.3 Ongoing assessment from outpatient clinic (for hypertension, blood work)
3.6.4.1.1.4 Minor trauma (minor MVC/fall)
3.6.4.1.1.5 Nausea/vomiting and/or diarrhea
3.6.4.1.1.6 Signs of infection (ie: dysuria, cough, fever, chills)

3.6.4.2 Patient should be seen within 30 – 60 minutes.

3.6.5 **Level V (Non Urgent)** – color code is WHITE. It applies when there are conditions that may be acute but non – urgent as well as condition without evidence of deterioration.

3.6.5.1 Examples includes:

3.6.5.1.1 Obstetrics:

3.6.5.1.1.1 Discomforts of pregnancy.
3.6.5.1.1.2 Anything that does not seem to pose threat to mother or fetus
3.6.5.1.1.3 Cervical ripening
3.6.5.1.1.4 Outpatient placenta previa protocol
3.6.5.1.1.5 Pre – booked visits (e.i. Rh and progesterone injections, NST)
3.6.5.1.1.6 Assessment for version
3.6.5.1.1.7 Rashes

3.6.5.2 The patient can be triaged out or send to the OPD or PHC. The waiting time can be up to two hours.

3.7 In the event of sudden influx of patients, and it exceeds the required nurse – patient ratio, the following must be implemented:

3.7.1 The head nurse/shift in – charge should call the 1st nurse on call.
3.7.2 Rotating Supervisor must be informed.
3.7.2.1 Refer to cross training list.

4. PROCEDURE:

N/A

5. MATERIAL AND EQUIPMENT:

N/A

6. RESPONSIBILITIES:

6.1 Physician
6.2 Nurse

7. APPENDICES:

7.1 Obstetrical Triage Acuity Scale
7.2 Canadian Triage and Acuity Scale

8. REFERENCES:

8.1 MOH, Guidelines for Emergency Department, Clinical Policies and Procedures, 2013.

9. APPROVALS:

	Name	Title	Signature	Date
Prepared by:	Ms. Alreem Mofareh Al Rashidi	Head Nurse of PER		January 05, 2025
Prepared by:	Ms. Reem Kammadh Al Dhafeeri	Head Nurse of OBSER		January 05, 2025
Reviewed by:	Mr. Sabah Turayhib Al Harbi	Director of Nursing		January 07, 2025
Reviewed by:	Dr. Amal Abdullah Al Harbi	Pediatric Emergency Room Consultant		January 08, 2025
Reviewed by:	Dr. Mohannad Yaghmour	Obstetrics and Gynecology Emergency Room Head of the Department		January 08, 2025
Reviewed by:	Mr. Abdulelah Ayed Al Mutairi	QM&PS Director		January 09, 202
Reviewed by:	Dr. Tamer Mohamed Naguib	Medical Director		January 12, 2025
Approved by:	Mr. Fahad Hazam Al Shammary	Hospital Director		January 19, 2025

Obstetrical Triage Acuity Scale
Level 1 Triage Color (Blue)

OTAS	Level 1 (Resuscitative)
TIME TO SECONDARY HEALTHCARE PROVIDER	• Immediate
RE – ASSESSMENT	• Continuous nursing care
LABOR / FLUID	• Imminent birth
BLEEDING	• Active vaginal bleeding with/without abdominal pain
HYPERTENSION	• Seizure activity
FETAL ASSESSMENT	• Abnormal FHR tracing • No fetal movement
OTHER	• Acute onset severe abdominal pain • Altered level of consciousness • Cord prolapse • Severe respiratory distress • Suspected sepsis

Obstetrical Triage Acuity Scale
Level 2 Triage Color (RED)

OTAS	Level 2 (Emergent)
TIME TO SECONDARY HEALTHCARE PROVIDER	• Equal or <15 minutes
RE – ASSESSMENT	• Every 15 minutes
LABOR / FLUID	• Suspected preterm labor / PPROM <37 weeks
BLEEDING	• Bleeding associated with cramping (>spotting) <37 weeks
HYPERTENSION	• Hypertension >160/110mmHg and/or headache, visual disturbance, RUQ pain
FETAL ASSESSMENT	• Atypical FHR tracing, abnormal BPP, abnormal Doppler's • Decrease fetal movement
OTHER	• Major trauma • Shortness of breath • Unplanned and unattended birth

Obstetrical Triage Acuity Scale
Level 3 Triage Color (YELLOW)

OTAS	Level 3 (Urgent)
TIME TO SECONDARY HEALTHCARE PROVIDER	• Equal or <30 minutes
RE – ASSESSMENT	• Every 15 minutes
LABOR / FLUID	• Sign of active labor >37 weeks
BLEEDING	• Bleeding associated with cramping (>spotting) >37 weeks
HYPERTENSION	• Mild hypertension >140/90mmHg with/without associated signs and symptoms
FETAL ASSESSMENT	
OTHER	• Abdominal pain/back pain greater than expected in pregnancy • Flank pain/hematuria • Nausea/vomiting and/or diarrhea with suspected dehydration

Obstetrical Triage Acuity Scale
Level 4 Triage Color (GREEN)

OTAS	Level 4 (Less Urgent)
TIME TO SECONDARY HEALTHCARE PROVIDER	• ≤60 minutes
RE – ASSESSMENT	• Every 30 minutes
LABOR / FLUID	• Sign of early labor/ SROM >37 weeks
BLEEDING	• Spotting
HYPERTENSION	
FETAL ASSESSMENT	
OTHER	• Ongoing assessment from outpatient clinic (for hypertension, blood work) • Minor trauma (minor MVC/ Fall) • Nausea/vomiting and/or diarrhea • Signs of infection (i.e. dysuria, cough, fever, chills)

Obstetrical Triage Acuity Scale
Level 5 Triage Color (WHITE)

OTAS	Level 5 (Non – Urgent)
TIME TO SECONDARY HEALTHCARE PROVIDER	• Equal or <120 minutes
RE – ASSESSMENT	• Every 60 minutes
LABOR / FLUID	• Discomforts of pregnancy
BLEEDING	
HYPERTENSION	
FETAL ASSESSMENT	
OTHER	• Anything that does not seem to pose threat to mother or fetus • Cervical Ripening • Outpatient placenta previa protocol • Pre – booked visits (i.e. Rh and progesterone injections, NST) • Assessment for version • Rashes

Level 1 (RESUSCITATIVE)
Triage Color (BLUE)
TIME TO PHYSICIAN IMMEDIATE

CODE / ARREST
MAJOR TRAUMA
SHOCK STATES
UNCONSCIOUS
SEVERE RESPIRATORY DISTRESS
VITAL SIGNS ABSENT / UNSTABLE
SEVERE DEHYDRATION
NEAR DEATH ASTHMA

Level 2 (EMERGENT)
Triage Color (RED)
TIME TO PHYSICIAN ≤15 MINUTES
REASSESSMENT EVERY 15 MINUTES

Altered mental state
Vomiting and/or diarrhea with suspicion of dehydration
Severe chest pain
Head injury
Severe Headache (pain scale 8 – 10 / 10)
Moderate To Severe Dyspnea / Difficulty Breathing
Neonate
Sign of Serious Infection (Purpuric Rash / Toxic)
Severe Trauma
Overdose
Abdominal Pain all severe abdominal pain (8 – 10 / 10)
GI bleeding with abnormal vital signs (vomiting gross blood, coffee ground emesis and melena)
Severe asthma
Anaphylaxis (respiratory symptoms or complaints of tightness in the throat and skin: urticarial, itchiness with any type of non – purpuric rash)
Children under 3 months With fever (temperatures equal or more than 38.0°C rectal)
Fever with signs of lethargy (any age)
Vomiting and Diarrhea: with suspicion of signs of dehydration
Acute psychosis / extreme agitation
Diabetes with (hypoglycemia / hyperglycemia)
Chemotherapy or immunocompromised **(HIV, known immune deficiency, malignancy) with or without fever**

Level 3 (URGENT)
Triage Color (YELLOW)
TIME TO PHYSICIAN ≤30 MINUTES
REASSESSMENT EVERY 60 MINUTES

Moderate trauma Patient with fractures or discolorations or sprains with severe pain (8 – 10/10)
Asthma, mild / moderate Moderate O_2 saturation 92 – 94% / mild asthma O_2 saturation >95%
Seizure **Alert on arrival with normal vital signs**
Moderate pain (4 – 7/10), headache, back pain
Pain scale 8 – 10 with minor injuries
Vomiting and diarrhea Age ≤ than 2 years
Dialysis (or transplant patients)
No active GI bleeding
Chest pain Sharp localized pains, worse with deep breathing, cough, movement or palpation not associated with shortness of breath or other signs that might suggest significant heart or lung disease
Eye pain: pain scale 8 – 10 / 10

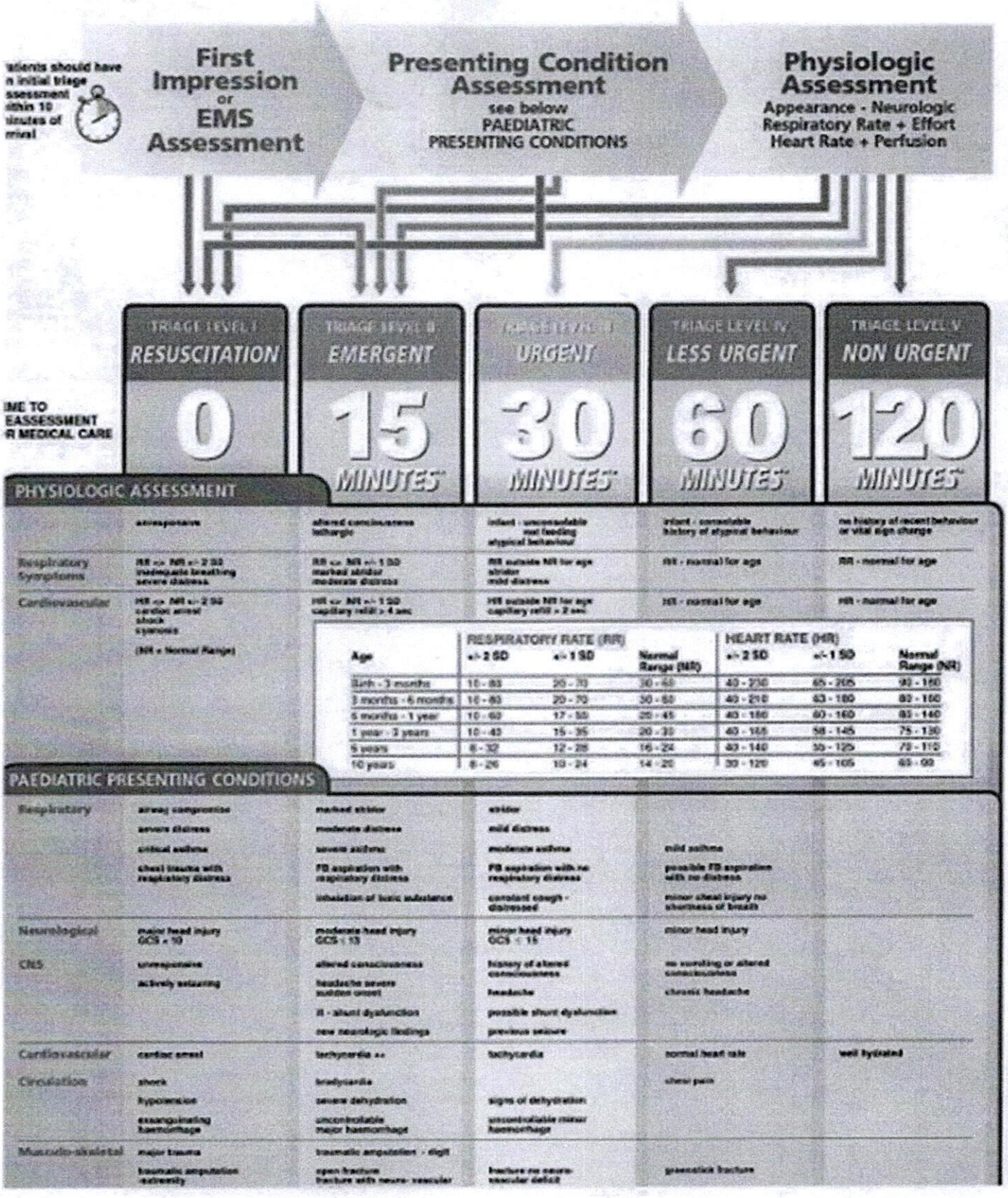
Level 4 LESS URGENT (SEMI URGENT)
Triage Color (GREEN)
TIME TO PHYSICIAN 1 HOUR
REASSESSMENT EVERY 60 MINUTES

MINOR TRAUMA Minor fractures, sprains, contusions, abrasions, lacerations, requiring investigation or intervention. Normal vital signs, moderate pain (4 – 7/10)
Abdominal pain Pain moderate intensity (4 – 7/10) or in a child in "no distress"
Headache Not sudden, not severe, not migraine, no association with high – risk features
Ear Pain (with ear discharge or mild fever)
Chest pain These patients should have no acute distress, pain (4 – 7/10), no shortness of breath, no visceral features, no previous heart problems, normal vital signs
Corneal Foreign Body If pain is mild or moderate (4 – 7/10), no change in visual acuity
Chronic Back Pain
URI symptoms Patient with upper airway congestion, cough, aches, mild fever, sore throat
Vomiting and diarrhea No signs of dehydration and age >2
Moderate pain scale 4 – 7/10
Minor allergic reaction

Level 5 (NON URGENT)
Triage Color (WHITE)
TIME TO PHYSICIAN ≤2 HOURS
REASSESSMENT EVERY 120 MINUTES

Minor Trauma Contusion, abrasions, minor lacerations (not requiring closures by any means)
Sore Throat, URI Patient with minor complaints, not severe and no respiratory symptoms / compromise.
Abdominal Pain mild pain (<4) which is chronic or recurring, with normal vital signs
Diarrhea Alone no signs dehydration and age >2
Vomiting Alone no signs dehydration and age >2
Pain Scale Less Than 4
Minor Symptoms

The Canadian Paediatric E.D. Triage and Acuity Scale



Musculo-skeletal	major trauma traumatic amputation -extremity hypothermia	traumatic amputation - digit open fracture fracture with neuro- vascular deficit back pain with neurologic symptom avulsed 2° tooth	fracture no neuro-vascular deficit light cast joint pain with fever dental trauma	greenstick fracture extremity swelling sprain/strain	
Skin	burn, > 25 % BSA or airway involved	burn > 10 % BSA burn- face, hand, foot chemical/electrical purpuric rash	burn < 10 % BSA frostbite cellulitis - ill / fever complex lacerations	minor burn minor cold injury local cellulitis simple laceration	superficial burn abrasion, contusion, local rash minor insect bite
Gastrointestinal	penetrating or blunt trauma with shock difficulty swallowing with airway compromise	acute bleeding - vomitus or rectal abdominal pain with vomiting / diarrhea / abnormal vital signs	persistent or bilious vomiting acute vomiting/ diarrhea age < 2 ? appendicitis	constipation / pain acute vomiting / diarrhea age > 2	 vomiting or diarrhea no pain, no dehydration
Genitourinary Gynecologic	vaginal bleed - unstable	severe testicular pain ? ectopic pregnancy urine retention >24 hr severe vaginal bleed paraphimosis	moderate testicular pain / swelling inguinal mass / pain urine retention > 8 hrs vaginal bleeding	scrotal trauma possible UTI	
Ear/Nose/Throat	airway compromise	amputation ear uncontrolled epistaxis sore throat with drooling, stridor difficulty swallowing hoarseness after trauma	foreign body nose epistaxis controlled puncture palate tonsillar pustules with difficulty swallowing hearing problem Post T & A bleed	ear drainage earache	sore throat mouth sores nasal congestion laryngitis
Eye		chemical exposure penetrating injury orbital infection	vision change periorbital infection	tearing, discharge affecting function corneal FB	conjunctivitis
Hematologic Immunologic	anaphylaxis	bleeding disorder fever- neutropenic / sickle cell	sickle cell crisis moderate allergic reaction	local allergic reaction	
Endocrine	diabetic- altered consciousness	diabetic- ketoacidosis hypoglycemia	hyperglycemia		
Psychiatry		toxic overdose high risk of harm to self / others violent behaviour	ingestion requiring observation moderate risk of harm to self / others disruptive/distressed	low risk of harm to self/ others depression	chronic symptoms with no change
Behaviour Change	unresponsive	lethargic child infant < 7 days old	unconsolable infant infant not feeding	irritable- consolable atypical behaviour	
Infection	septic shock	infant < 3 mon 36< temperature ≥ 38 toxic appearance - any age	infant 3-36 mon with temperature > 38.5	infant > 36 mon with temperature > 38.5 non toxic appearance	
Child Abuse	unstable situation or conflict	ongoing risk	physical assault sexual abuse <48 hr	signs / history of family violence	
Pain		Severe 8 - 10 / 10	Moderate 4 - 7 / 10	Mild 1 - 3 / 10	

TIMES TO ASSESSMENT are operating objectives, not established standards of care. Facilities without onsite physician coverage may meet assessment objectives using negated protocols and remote communication.

Health Canada Santé Canada

MedicAlert