# Triage Assessment Checklist (Emergency Department)

**Based on the South African Triage Scale (SATS)**

**Purpose:** Provide a standardized, rapid triage framework to prioritize emergency patients according to clinical urgency and available resources. Suitable for ED and First Aid Posts.

**Key Principles:** - Rapid identification of life-threats. - Standardized color categories (Red, Orange, Yellow, Green, Blue). - Integrates **TEWS** (Triage Early Warning Score) with clinical discriminators. - Aim: first assessment within **<1 min**; re-triage if patient condition changes.

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## 1) Triage Categories

- **Red (Emergency):** Immediate care required; unstable or life-threatening.
- **Orange (Very Urgent):** Serious, potentially unstable; to be seen within 10 min.
- **Yellow (Urgent):** Stable but requires investigation/treatment; to be seen within 60 min.
- **Green (Routine):** Stable, minor issues; to be seen within 240 min.
- **Blue (Dead):** No signs of life; verify death per local policy.

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## 2) TEWS (Triage Early Warning Score)

**Adult Parameters:** - **Respiratory rate** - **Heart rate** - **Systolic blood pressure** - **Temperature** - **Level of consciousness (AVPU)** - **Mobility** - **Presence of trauma**

**Scoring:** Assign 0–3 points per parameter. Higher TEWS = higher priority.

**Pediatric TEWS:** Age-specific normal ranges. Modify cut-offs for infants/children.

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## 3) Clinical Discriminators

If present, escalate category regardless of TEWS: - Airway compromise (stridor, obstruction) - Severe respiratory distress ($SpO_2$ < 90% on air, cyanosis) - Shock (weak pulses, delayed capillary refill > 3s, SBP < 90 in adults) - GCS < 13 or new seizure - Chest pain, STEMI signs - Severe pain (≥ 8/10) - Active hemorrhage - Severe burns or extensive trauma - Pregnancy complications (eclampsia, heavy bleeding)

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## 4) Step-by-Step Triage Process

1. **Initial look test** — Is the patient obviously dying? If yes → **Red**.
2. **Check vital signs** — RR, HR, SBP, Temp, AVPU, mobility; calculate **TEWS**.
3. **Apply discriminators** — If present, upgrade to higher category.
4. **Assign triage color** (Red, Orange, Yellow, Green, Blue).
5. **Document** triage category, TEWS, discriminator(s), time, and name/signature.
6. **Direct patient** to correct clinical area.
7. **Re-triage** if patient deteriorates or after a set time (e.g., every 60–120 min for Yellow/Green).

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## 5) Triage Checklist (Frontline Use)

- ☐ Patient greeted; obvious airway/breathing/circulation checked
- ☐ TEWS recorded (all vital signs)
- ☐ Clinical discriminators screened
- ☐ Pain score documented
- ☐ Category assigned (color code)
- ☐ Triage tag/label applied
- ☐ Documentation complete with time and signature
- ☐ Patient directed to correct area

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## 6) Re-Triage Triggers

- Vital signs outside normal limits
- Patient reports worsening pain or new symptoms
- Staff concern
- Prolonged waiting beyond target time

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## 7) Pediatric Considerations

- Use age-appropriate TEWS charts.
- Red flags: poor feeding, lethargy, convulsions, apnea, hypoglycemia, shock signs.
- Always weigh and document weight (for dosing).

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## Color Coding Quick Reference

- **Red:** Immediate — life-threatening
- **Orange:** Very urgent — potentially unstable

- **Yellow:** Urgent — stable, needs care
- **Green:** Routine — minor illness/injury
- **Blue:** Dead

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**References:** - South African Triage Scale (SATS) 2012/2014 update. - Western Cape Government: Emergency Medicine Guidelines. - World Health Organization: Emergency Triage Assessment and Treatment (ETAT).