Emergency Triage
Manchester Triage Group
Contents

Editors, vi
Members of the original Manchester Triage Group, vii
International Reference Group, viii
Preface to the third edition, ix
Preface to the first edition, xi
1 Introduction, 1
2 The decision-making process and triage, 6
3 The triage method, 11
4 Pain assessment as part of the triage process, 25
5 Patient management, triage and the triage practitioner, 35
6 Auditing the triage process, 42
7 Telephone triage, 47
8 Beyond prioritisation, 54
Presentational flow chart index, 62
Presentational flow charts, 64
Discriminator dictionary, 174
Index, 185
General discriminators, 190
Editors

Kevin Mackway-Jones, Consultant Emergency Physician, Manchester Royal Infirmary and Royal Manchester Children’s Hospital; Medical Director, North West Ambulance Service; Honorary Civilian Consultant Advisor in Emergency Medicine to the British Army; Professor of Emergency Medicine, Centre for Effective Emergency Care, Manchester Metropolitan University.

Janet Marsden, Professor of Ophthalmology and Emergency Care and Director, Centre for Effective Emergency Care, Manchester Metropolitan University.

Jill Windle, Lecturer Practitioner in Emergency Nursing, Salford Royal Hospitals NHS Foundation Trust and University of Salford.
Members of the original Manchester Triage Group

Kassim Ali, Consultant in Emergency Medicine
Simon Brown, Senior Emergency Nurse
Helen Fiveash, Senior Emergency Nurse
Julie Flaherty, Senior Paediatric Emergency Nurse
Stephanie Gibson, Senior Emergency Nurse
Chris Lloyd, Senior Emergency Nurse
Kevin Mackway-Jones, Consultant in Emergency Medicine
Sue McLaughlin, Senior Paediatric Emergency Nurse
Janet Marsden, Senior Ophthalmic Emergency Nurse
Rosemary Morton, Consultant in Emergency Medicine
Karen Orry, Senior Emergency Nurse
Barbara Phillips, Consultant in Paediatric Emergency Medicine
Phil Randall, Consultant in Emergency Medicine
Joanne Royle, Senior Emergency Nurse
Brendan Ryan, Consultant in Emergency Medicine
Ian Sammy, Consultant in Emergency Medicine
Steve Southworth, Consultant in Emergency Medicine
Debbie Stevenson, Senior Emergency Nurse
Claire Summers, Consultant in Emergency Medicine
Jill Windle, Lecturer Practitioner in Emergency Nursing
International Reference Group

Austria
Stefan Kovacevic
Andreas Lueger
Willibald Pateter

Brazil
Welfane Cordeiro
Maria do Carmos Rausch
Bárbara Torres

Germany
Joerg Krey
Heinzpeter Moecke
Peter Niebuhr

Mexico
Alfredo Tanaka Chavez
Elizabeth Hernandez Delgadillo
Noe Arellano Hernandez

Norway
Grethe Doelbakken
Endre Sandvik
Germar Schneider

Portugal
Paulo Freitas
Antonio Marques
Angela Valenca

Spain
Conxa Oliver Martinez
Gema Garcia Riestra
Gabriel Redondo Torres

viii
Preface to the third edition

Time continues to move on and it is now nearly 20 years since a group of senior emergency physicians and emergency nurses first met to consider solutions to the muddle that was triage in Manchester, UK. We had no expectation that the solution to our local problems would be robust enough (and timely enough) to become the triage solution for the whole United Kingdom. Never in our wildest dreams did we imagine that the Manchester Triage System (MTS) would be generic enough to be adopted around the world. Much to our surprise, however, both of these fantastic ideas came about, and the MTS continues to be used in many languages to triage tens of millions of Emergency Department attenders each year.

The basic principles that drive the MTS (recognition of the presentation and reductive discriminator identification) are unchanging – but from time to time it has become necessary to make some adjustments to the detail. The third edition builds on the changes we made in the second; it takes into account the comments passed to us by users over the years (for which we are very grateful) and also the contributions of the International Reference Group, who bring a broad perspective from other clinical situations and cultures. It also seeks to include modifications that reflect new research and alterations in the practice of emergency care. Significant changes include new charts for unwell neonates and babies and a major, evidence-based change in the way in which fever in childhood is prioritised. We have clarified discriminator terminology and definitions where this was proving difficult (for instance ‘abnormal pulse’ is now clarified as ‘new abnormal pulse’ and ‘known immunosupression’ has been restated as ‘known or likely immunospression’). We have also taken the opportunity to standardise the order in which discriminators appear on the charts. Overall though, as in the second edition, the changes are small in number.

This new edition also continues our attempt to put triage in the context of changes that are happening in many emergency care systems around the world. Emergency care continues to be the focus of political and management attention. The care of increasing numbers of patients with
Preface to the third edition

less urgent conditions (who make up the majority in most settings) continue to be a source of concern, since under-resourced systems that focused (rightly) on patients with the highest clinical priority inevitably resulted in delayed care for those at the other end of the priority scale. In the consumer age, this delay (which delivers a poor patient experience) is unacceptable. It is often easier to blame the clinical prioritisation system (triage) for this delay than to deal with an under-resourced system. Another current vogue is to try to replace a dedicated emergency care triage system with a hospital-wide track and trigger score. The evidence is clear that, unsurprisingly, this cannot be done without a considerable additional risk to physiologically normal patients early in the evolution of their illness.

Our standpoint has always been that proper emergency triage is vital in all systems or circumstances where the demand for emergency care outstrips the ability to deliver it. We continue to believe that these circumstances occur occasionally in even the best managed and resourced systems, and frequently in those with the usual demands and staffing. Thus clinical prioritisation (whether called triage, initial assessment or anything else) remains a cornerstone of clinical risk management in emergency care, and abandoning it completely is not an option.

Kevin Mackway-Jones, Janet Marsden, Jill Windle
Manchester, 2013
Preface to the first edition

Every day, emergency departments are faced with a large number of patients suffering from a wide range of problems. The workload varies from day to day and from hour to hour and depends on the number of patients attending and what is wrong with them. It is absolutely essential that there is a system in place to ensure that these patients are seen in order of clinical need, rather than in order of attendance.

In the past year great steps have been made towards establishing a National Triage Scale in the United Kingdom; this follows on from similar work in Australia and Canada. This book is intended to allow practitioners of triage to work to a set standard when applying national scales to the patients presenting to their departments. The members of the multi-professional consensus group that designed this methodology hope that individual practitioners will use it to inform the triage process and ensure that their decisions are both valid and reproducible.

This manual contains the basic knowledge necessary for triage practitioners to begin to build their competence in performing triage. It is hoped that practitioners will find a useful source reference and aide-memoire.

Kevin Mackway-Jones, 1996
CHAPTER 1

Introduction

Background

Triage is a system of clinical risk management employed in Emergency Departments worldwide to manage patient flow safely when clinical need exceeds capacity. Systems are intended to ensure care is defined according to patient need and in a timely manner. Early Emergency Department triage was intuitive, rather than methodological, and was therefore neither reproducible between practitioners nor auditable.

The Manchester Triage Group was first set up in November 1994 with the aim of establishing consensus among senior emergency nurses and emergency physicians about triage standards. It soon became apparent that the Group’s aims could be set out under five headings.

- Development of the common nomenclature
- Development of common definitions
- Development of a robust triage methodology
- Development of a training package
- Development of an audit guide for triage

Nomenclature and definitions

A review of the triage nomenclature and definitions that were in use at the time revealed considerable differences. A representative sample of these is summarised in Table 1.1, where the priority categories are shown on the left and the maximum respective times (in minutes) to first contact by a treating clinician are listed in the right-hand columns.