Emergency Triage
Telephone triage and advice
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Manchester Triage Group

EDITED BY
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Mark Newton
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FIRST EDITION
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Preface

It is now 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.

Clinical decisions made by telephone have always been an area of concern for clinicians because not only is the patient not present and it may be difficult to obtain correct information but many of the tools and indicators that we use for decision making are simply not available. It is therefore an inherently more risky process than face-to-face triage.

Quite early on in the implementation of MTS in Manchester, departments began to use a simplified version as a structure for telephone conversations. This was superseded by national algorithm-based telephone helplines and its use in the Emergency Department diminished.

Our colleagues in the Greater Manchester Ambulance Service (GMAS) felt that there was a gap in their resources for undertaking telephone decision making. We have discussed ways of developing tools based on the MTS, with its significant evidence base and good safety record which would embed safety and quality into their telephone decision systems.

A huge amount of work has been done by the now North West Ambulance Service (NWAS) along with MTS to test and audit a robust Telephone Triage tool. It has also been piloted in diverse settings, with ambulance services in the Azores and New Zealand, as well as other services in the United Kingdom using it for the whole or part of their day to day work. It has been tested and refined and has a superb audit trail and safety record associated with it.

The basic principles that drive the MTS (recognition of the presentation and reductive discriminator identification) are unchanging – but changes have been made to reflect the difficulties of assessment by telephone. The outcomes of decisions are condensed into ‘face-to-face now’, ‘face-to-face soon’ and ‘face-to-face later’ with a self-care outcome. Information and advice is suggested alongside
every outcome. The advice ranges from life-saving interventions which can be carried out until health care arrives, to self-care advice.

We recognise the diversity of health care settings and the need for appropriate information and advice; therefore, the information and advice sections of the Telephone Triage tool can be customised by the user to reflect different health economies while retaining the core which is MTS.

Clinical prioritisation (whether called triage or anything else) remains a central plank of clinical risk management in all emergency care settings. This telephone iteration of a triage system which prioritises millions of patients each year provides a robust, safe, evidence-based system for managing the risk inherent in patients who are at a distance from health care providers.

Janet Marsden, Mark Newton, Jill Windle, Kevin Mackway-Jones
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CHAPTER 1

Introduction

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 set up in November 1994 with the aim of establishing consensus amongst senior emergency physicians and emergency nurses about triage standards. It soon became apparent that the Group’s aims could be set out under five headings.
1. Development of common nomenclature
2. Development of common definitions
3. Development of robust triage methodology
4. Development of training package
5. Development of 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.

Despite this enormous variation, it was also apparent that there were a number of common themes running through the different triage systems; these are highlighted in Table 1.2.
Once the common themes of triage had been highlighted, it became possible to quickly agree on a new common nomenclature and definition system. Each of the new categories was given a number, a colour and a name and was defined in terms of ideal maximum time to first contact with the treating clinician. At meetings between representatives of Emergency Nursing and Emergency Medicine nationally, this work informed the derivation of the United Kingdom triage scale as shown in Table 1.3.

As practice has developed over the past 20 years, five-part triage scales have been established around the world. The target times themselves are locally set, being influenced by politics as much as medicine, particularly at lower priorities, but the concept of varying clinical priority remains current.

**Table 1.1**

<table>
<thead>
<tr>
<th>Hospital 1</th>
<th>Hospital 2</th>
<th>Hospital 3</th>
<th>Hospital 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red 0</td>
<td>A 0</td>
<td>Immediate 0</td>
<td>1 0</td>
</tr>
<tr>
<td>Amber &lt;15</td>
<td>B &lt;10</td>
<td>Urgent 5–10</td>
<td>2 &lt;10</td>
</tr>
<tr>
<td></td>
<td>C &lt;60</td>
<td>Semi-urgent30–60</td>
<td></td>
</tr>
<tr>
<td>Green &lt;120</td>
<td>D &lt;120</td>
<td></td>
<td>3 —</td>
</tr>
<tr>
<td>Blue &lt;240</td>
<td>E —</td>
<td>Delay acceptable</td>
<td>— 3 —</td>
</tr>
</tbody>
</table>

**Table 1.2**

<table>
<thead>
<tr>
<th>Priority</th>
<th>Maximum times (minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0 0 0 0 0</td>
</tr>
<tr>
<td>2</td>
<td>&lt;15 &lt;10 5–10 &lt;10</td>
</tr>
<tr>
<td>3</td>
<td>&lt;60 30–60</td>
</tr>
<tr>
<td>4</td>
<td>120 &lt;120</td>
</tr>
<tr>
<td>5</td>
<td>&lt;240 —</td>
</tr>
</tbody>
</table>

**Table 1.3**

<table>
<thead>
<tr>
<th>Number</th>
<th>Name</th>
<th>Colour</th>
<th>Maximum time (minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Immediate</td>
<td>Red</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>Very urgent</td>
<td>Orange</td>
<td>10</td>
</tr>
<tr>
<td>3</td>
<td>Urgent</td>
<td>Yellow</td>
<td>60</td>
</tr>
<tr>
<td>4</td>
<td>Standard</td>
<td>Green</td>
<td>120</td>
</tr>
<tr>
<td>5</td>
<td>Non-urgent</td>
<td>Blue</td>
<td>240</td>
</tr>
</tbody>
</table>
The development of Telephone Triage

After a period where all Emergency Departments in the Manchester area were using ‘Manchester Triage’ and using it on the telephone to triage callers to the ED (prior to NHS Direct), it became apparent that although all Emergency Department staff were using the same language of triage, the interface with paramedic colleagues still faced a language barrier. Key collaborators within the ambulance service recognised that applications of the Manchester Triage method would be extremely useful within the ambulance service and a further group of clinicians across acute care settings and the ambulance service was set up to explore this. Telephone Triage emerged as one of the products of this collaboration and had been used successfully for both secondary triage (since 2006) and latterly primary triage (2012) of those patients accessing care by telephoning ambulance services in a number of ambulance services across the United Kingdom and internationally.

Triage methodology

In general terms, a triage method can try and provide the practitioner with the diagnosis, disposal or clinical priority. ‘Manchester Triage’ is designed to allocate a clinical priority. This decision was based on three major tenets. First, the aim of the triage encounter is to aid clinical management of the individual patient, and this is best achieved by accurate allocation of a clinical priority. Second, the length of the triage encounter is such that any attempts to accurately diagnose a patient are doomed to fail. Third, it is apparent that diagnosis is not accurately linked to clinical priority. The latter reflects a number of aspects of the particular patient’s presentation as well as the diagnosis; for example patients with a final diagnosis of ankle sprain may present with severe or no pain and their clinical priority must reflect this. In Telephone Triage, the allocation of this clinical priority is inherently linked to a place of definitive clinical care, and in the highest priority, a mode of emergency transport to this care.

In outline, the triage method put forward in this book requires practitioners to select from a range of presentations and then to seek a limited number of signs and symptoms at each level of clinical priority. The signs and symptoms that discriminate between the clinical priorities are termed discriminators and they are set out in the form of flow charts for each presentation – the presentational flow charts. Discriminators that indicate higher levels of priority are sought first, and to a large degree, patients who are allocated to the standard clinical priority are selected by default. In this way, it reflects the effective face to face triage methodology taught by the Manchester Triage Group. The clinical priority is inherently linked to a disposal: where does the patient obtain the definitive care which they require and what is the timescale within which this must be obtained for optimum
outcomes. The possible outcomes of Telephone Triage are simplified from the five categories system as there are fewer options available to the Telephone Triage practitioner.

The decisions which must be made are as follows:
- Does the patient need immediate and urgent care? (FtF Now)
- Do they need to be seen face to face by a clinician soon, but not immediately? (FtF Soon)
- Can medical or other care be delayed? (FtF Later)
- Can an ‘advice only’ route be followed, where the problem can be managed by giving self-care advice?

Face to face triage practitioners will note differences between the discriminators seen within face to face triage and those in the Telephone Triage method. For some discriminators used in face to face triage, it is impossible to ascertain without actually having the patient in front of the triage practitioner, whether the discriminator is fulfilled or not. Those discriminators are therefore not used in Telephone Triage. Slight changes are made to other discriminators in order for them to be more appropriate in a Telephone Triage setting.

**Advice**

Advice is presented on the charts at each level and is to highlight issues which can be discussed by the practitioner with the patient or caller. It is important that interim advice is given and that, if the patient is triaged to ‘advice only’, comprehensive advice is given and understanding is checked. The patient must know what to do should the situation change. A key premise of the advice in these charts is that it is general and may be adapted for use in specific settings. The algorithms, as in the case of the face to face algorithms, are evidence based and validated and must not be modified.

The decision making process is discussed in Chapter 2 and the triage method itself is explained in detail in Chapter 3.

**Presentation priority matrix**

Patients who are in the ‘FtF Now’ category are best served by the Emergency Ambulance Service and Emergency Departments, whatever their locations. Those requiring ‘FtF Soon’ or ‘FtFLater’ may have care delivered in a number of locations and by various providers. Thus the time to care in the ‘FtF Soon’ category will vary, depending upon those services available in that health economy. A mapping exercise should be undertaken locally to agree the appropriate dispositions arising from the triage decision (see Chapter 4). It is essential that the practitioner undertaking Telephone Triage is able to use up-to-date details about current local services such as dental emergency arrangements, telephone numbers of primary care facilities and the location of pharmacy provision.
Training for triage

This book and the accompanying course attempt to provide the training necessary to allow introduction of a standard triage method. It is not envisaged that reading the book and attending a course can produce instant expertise in triage. Rather this process will introduce the method and allow practitioners to develop competence at using the material available. This is the first step towards competence in using the system and must be followed up by audit and evaluation of the system in use.

Triage audit

The Triage Group spent considerable time trying to pin down ‘sentinel diagnoses’, that is diagnoses that could be identified retrospectively and which could be used as markers of accurate triage. For the reasons outlined above, it soon became apparent that even retrospective diagnosis could not accurately predict actual clinical priority at presentation.

Successful introduction of a robust audit method is essential to the future of any standard methodology, since reproducibility between individual practitioners and departments must be shown to exist. This is discussed in more detail in chapter 5.

Summary

Triage is a fundamental part of clinical risk management in all areas of urgent and emergency care when clinical load exceeds clinical availability. Emergency Triage promulgates a system that delivers a teachable, auditable method of assigning clinical priority in emergency settings. It is not designed to judge whether patients are appropriately in the emergency setting, but to ensure that those who need care receive it appropriately quickly. It can be used to monitor care and to signpost streams of care – these will be determined by local provision and actual availability.
CHAPTER 2
The decision making process and Telephone Triage

Introduction

Decision making is an essential and integral part of nursing and medical practice. Sound clinical judgement in relation to patient care requires both knowledge and experience. Many practitioners argue that critical decision making is only about ‘common sense’ and ‘problem solving’ and to a certain extent they are correct. It is, however, more than this and requires a high level of skill. Within the decision making process, clinicians are expected to

Interpret
Discriminate
Evaluate

the information they gather about patients and critically appraise their actions following that decision. Without a framework of reference on which to base these decisions, they will be unstructured, haphazard and potentially unsafe. The ability to make sound decisions is essential for safe and effective patient management.

Early triage systems structured the interview but gave no guidance about the action following a decision. Thus the outcome of the triage process was not based on a sound methodology. Triage decisions were unique to each nurse and inherently part of their own decision making process and such decisions are likely to be fundamentally flawed without a framework of reference. To overcome this problem, a framework of reference (methodology) for the process of triage and a method by which practitioners can acquire the necessary skills for its implementation are required.

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The development of expertise

A relationship between experience and skill acquisition has been described in which there are five stages of development as shown below.

<table>
<thead>
<tr>
<th>Novice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advance beginner</td>
</tr>
<tr>
<td>Competent</td>
</tr>
<tr>
<td>Proficient</td>
</tr>
<tr>
<td>Expert</td>
</tr>
</tbody>
</table>

As practitioners develop along this continuum, they acquire skills and learn from their experiences in practice, and it is expected that their decision-making ability alters and improves. The process can be facilitated by providing a system based upon a common framework that is methodologically sound, on which decisions can be based and their effectiveness evaluated.

Decision-making strategies

A number of strategies are used in the decision-making process. They are as follows.

- Reasoning
- Pattern recognition
- Repetitive hypothesising
- Mental representation
- Intuition

Reasoning

There are essentially two types of reasoning involved in critical thinking: inductive and deductive.

Inductive reasoning is the ability to consider all possibilities and is particularly useful for the less experienced. It involves a time-consuming process of considering all patient information collected in order to reach a sound decision about the care they require.

Deductive reasoning is the simultaneous ‘weeding out’ of possible solutions whilst actively collecting patient information. This strategy is often unknown or unrecognised and becomes part of expert practice. It allows the practitioner to rapidly sort relevant from irrelevant information to reach a decision.
Pattern recognition
This is the strategy most commonly used by clinicians and is particularly important when making rapid decisions based on limited information that are necessary during triage. Pattern recognition is a method of piecing information together in an analytical sense. Clinicians interpret the pattern of the patient signs and symptoms by comparison with relationships and conditions from previous cases. This leads them to a decision about the patient’s well-being or a potential diagnosis. The ability to use this decision making skill develops with experience and often appears to be intuition. Novice, proficient or competent practitioners may need to use conscious problem solving to reach a solution, while their more experienced colleagues can employ pattern recognition.

Repetitive hypothesising
Repetitive hypothesising is used by clinicians to test diagnostic reasoning. By gathering data to confirm or eliminate a hypothesis, a decision can be made. Depending on the level of expertise, this method can be either inductive or deductive.

Mental representation
Mental representation is a method of simplifying the situation to provide a general picture and allow focusing on relevant information. This strategy is often used when a problem is highly complex or overwhelming. The use of analogies helps the clinician visualise the situation by simplifying the problem and allowing a different perspective. Triage decisions need to be rapid and this method has limited use at this stage in the patient’s pathway.

Intuition
Intuition is inextricably linked with expertise and is commonly seen as the ability of practitioners to solve problems with relatively little data. Intuition rarely involves conscious analysis and is often expressed as ‘gut feeling’ or ‘strong hunch’. Expert practitioners view situations holistically and draw on past experience. Much of their knowledge is embedded in practice and referred to as tacit, where effective decisions are made by combining knowledge with decision-making theories and intuitive thought. Many expert clinicians are unaware of the mental processes they employ in the assessment and management of patients. Although intuition has remained unmeasurable, the value to clinical practice is acknowledged and well documented.

Decision-making during triage
Despite all the theories, decision making is quite simply a series of steps to reach a conclusion and consists of three main phases: identification of a problem, determination of the alternatives and selection of the most appropriate alternative.
An approach to making critical decisions has been described which uses the following five steps.

1. Identify the problem
2. Gather and analyse information related to the solution
3. Consider all the alternatives and select one for implementation
4. Implement the selected alternative
5. Monitor the implementation and evaluate outcomes

This approach incorporates a number of theories and methods. When applied to triage, the decisions are formed as follows.

**Identify the problem**
This is done by obtaining information from the patients or whoever is calling. Every effort should be made to talk to the patient. This phase allows the relevant presentational flow chart to be identified.

**Gather and analyse information related to the solution**
Once a flow chart has been identified, this phase is facilitated since discriminators can be sought at each level. The charts facilitate rapid assessment by suggesting structured questions. Pattern recognition also plays a part at this stage.

**Consider all alternatives and select one for implementation**
Clinicians collect significant amounts of data about the patients they deal with which is collated into their own mental database and stored in compartments for easy recall. Use of this stored information is most effective when linked to an assessment or organisational framework. The presentational flow charts provide the organisational framework to order the thought process during triage. The flow charts aid decision making by providing a structure and, importantly, support junior staff as they acquire decision-making skills.

**Implement the selected alternative**
There are four levels of priority (as discussed in Chapter 1) and the triage practitioner tests the discriminators against the patient’s presentation and allocates priority at the highest level of positive discriminator. The priority therefore depends upon the urgency of the patient’s condition and once the priority is allocated the appropriate pathway of care begins.

**Monitor the implementation and evaluate outcomes**
The method of triage outlined in this book ensures that the decision is predetermined if the correct process has been followed. The triage practitioner will therefore be able to identify how and why they reached the initial outcome.
(priority), conduct an accurate reassessment and subsequent confirmation or change in priority. Accurate, reproducible decisions ensure that the whole process can be audited.

**Changing current decision-making practice**

For many experienced clinicians, the introduction of a new framework for triage decisions poses some anxieties. It is difficult to unlearn individual methods of decision making which have developed over years of practice. However, this change should be viewed as a further refinement of their present system, providing for the first time a clear rationale for their decisions and an auditable system. This systematic approach will be a major contribution to the body of knowledge when used to teach junior staff, who rely so heavily on experts to inform and guide their own practice. The actual process of triage decision making presented here has been shown to be effective and adaptable to many practice settings and has value to triage practitioners irrespective of their level of experience.
CHAPTER 3
The Telephone Triage method

Introduction

The method outlined in this book is designed to allow the Telephone Triage Practitioner to rapidly assign a clinical priority to each patient. The system selects patients with the highest priority first without making any assumptions about the diagnosis. Telephone Triage prioritisation is driven by presenting signs and symptoms – it is impossible to diagnose by telephone and attempts to do so are fraught with danger.

Five-step process to triage decision making
1. Identify the problem
2. Gather and analyse information related to the solution
3. Evaluate all the alternatives and select one for implementation
4. Implement the selected alternative
5. Monitor the implementation and evaluate outcomes

Identifying the problem

Clinical practice is geared around the concept of a presenting complaint – that is the chief sign or symptom identified by the patient or carer. A list of presentations pertinent to Telephone triage is shown below.
<table>
<thead>
<tr>
<th>Abdominal pain in adults</th>
<th>Irritable child</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal pain in children</td>
<td>Limb problems</td>
</tr>
<tr>
<td>Abscesses and local infections</td>
<td>Limping child</td>
</tr>
<tr>
<td>Allergy</td>
<td>Major trauma</td>
</tr>
<tr>
<td>Apparently drunk</td>
<td>Medication request</td>
</tr>
<tr>
<td>Assault</td>
<td>Mental illness</td>
</tr>
<tr>
<td>Asthma</td>
<td>Neck pain</td>
</tr>
<tr>
<td>Back pain</td>
<td>Overdose and poisoning</td>
</tr>
<tr>
<td>Behaving strangely</td>
<td>Palpitations</td>
</tr>
<tr>
<td>Bites and stings</td>
<td>Pregnancy</td>
</tr>
<tr>
<td>Burns and scalds</td>
<td>PV bleeding</td>
</tr>
<tr>
<td>Chemical exposure</td>
<td>Rashes</td>
</tr>
<tr>
<td>Chest pain</td>
<td>Self-harm</td>
</tr>
<tr>
<td>Collapsed adult</td>
<td>Sexually acquired infection</td>
</tr>
<tr>
<td>Crying baby</td>
<td>Shortness of breath in adults</td>
</tr>
<tr>
<td>Dental problems</td>
<td>Shortness of breath in children</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Sore throat</td>
</tr>
<tr>
<td>Diarrhoea and vomiting</td>
<td>Testicular pain</td>
</tr>
<tr>
<td>Ear problems</td>
<td>Torso injury</td>
</tr>
<tr>
<td>Eye problems</td>
<td>Unwell adult</td>
</tr>
<tr>
<td>Facial problems</td>
<td>Unwell baby</td>
</tr>
<tr>
<td>Falls</td>
<td>Unwell child</td>
</tr>
<tr>
<td>Fits</td>
<td>Unwell newborn</td>
</tr>
<tr>
<td>Foreign body</td>
<td>Urinary problems</td>
</tr>
<tr>
<td>GI bleed</td>
<td>Worried parent</td>
</tr>
<tr>
<td>Headache</td>
<td>Wounds</td>
</tr>
<tr>
<td>Head injury</td>
<td></td>
</tr>
</tbody>
</table>

This list of presentational flow charts covers almost all presentations to Emergency Departments and therefore to a Telephone Triage service prior to attendance at an emergency care setting. The list, charts and contents were finalised after considerable discussion and have been refined in both this and previous editions following changes in practice, research and international consultation. The presentations fall broadly into the categories of illness, injury, children, abnormal and unusual behaviour.

The first part of the triage method requires the practitioner to select the most appropriate presentational flow chart from the list. The chart identifies discriminators which allow the clinical priority to be determined.

A key feature of the method is that the charts are consistent in their approach, as it is recognised that a number of patients’ chief complaints may lead to more than one presentational flow chart. For example, a patient who feels generally unwell with a stiff neck and a headache will be given the same priority whether the practitioner uses the *Unwell Adult*, *Neck Pain* or *Headache* flow charts.
Gathering and analysing information

To a great extent, the patient’s presentation elicited by the first few moments of the telephone conversation with patient or carer will dictate which presentational flow chart is selected. The Telephone Triage practitioner should ALWAYS try to speak to the patient rather than someone calling on their behalf. If the patient is unable to speak to the Telephone Triage practitioner, the practitioner should ensure that the person providing information is in visual and verbal contact with the patient. Following this selection, information must be gathered and analysed to allow the actual priority to be determined. The flow chart structures this process by showing key discriminators at each level of priority – the assessment is carried out by finding the highest level at which the answer posed by the discriminator question is positive. Discriminators are deliberately posed as questions by the triage practitioner to facilitate the process and suggestions for appropriate questions are integrated into the discriminator dictionary which begins on page 34.

Discriminators

Discriminators, as their name implies, are factors that discriminate between patients such that they allow them to be allocated to one of the five clinical priorities. They can be General or Specific and are arranged in A, B, C, D, E format. General discriminators apply to all patients irrespective of their presentation and therefore appear time and time again throughout the charts; on each occasion, the general discriminators will lead the Triage Practitioner to allocate the same clinical priority. Specific discriminators are applicable to individual presentations or to small groups of presentations and tend to relate to key features of particular conditions. Thus while Severe pain is a general discriminator, Cardiac pain and Pleuritic pain are specific discriminators. General discriminators appear in many more charts than specific ones. All the discriminators used are defined in the discriminator dictionary at the end of the book, and the definitions of the specific ones in use on individual charts are repeated on the accompanying chart notes for ease of reference. All discriminators are reviewed for each edition. Any changes are published on the triage web site at www.triagenet.net.

Face to face triage practitioners will note differences between the discriminators seen within face to face triage and those in the Telephone Triage method. For some discriminators used in face to face triage, it is impossible to ascertain without actually having the patient in front of the triage practitioner, whether the discriminator is fulfilled or not. Those discriminators are therefore not used in Telephone Triage. Slight changes are made to other discriminators in order for them to be more appropriate in a Telephone Triage setting.

General discriminators are a recurring feature of the charts, and a proper understanding of them is essential to an understanding of the triage method. Six general discriminators are discussed further here – these are shown in the box.
Life threat

*Life threat* is perhaps the most obvious general discriminator of all. Broadly speaking this recognises that any cessation or threat to the vital (ABC) functions places the patient in priority 1 (Red – FtF Now).

Patients who are unable to maintain their own airway for any length of time have an insecure airway. Additionally, patients with stridor have significant airway threat – this may be an inspiratory or expiratory noise, or both. Stridor is heard best on breathing with the mouth open. Inadequacy of breathing includes absence (defined as no respiration or respiratory effort as assessed by looking, listening and feeling for 10 seconds) and includes patients who are failing to breathe well enough to maintain adequate oxygenation. There may be an increased work of breathing, signs of inadequate breathing or exhaustion.

Haemorrhage

Haemorrhage is a feature of many presentations – particularly, but not exclusively, those involving trauma. The haemorrhage discriminators in Telephone Triage are uncontrolled major and uncontrolled minor. The use of the success of attempts to control haemorrhage is deliberate as, in general, continuing bleeding has a higher clinical priority. While of course in practice it can be difficult to decide which category a particular haemorrhage falls into, the definitions of the discriminators are designed to help the practitioner to do this. A haemorrhage that is not rapidly controlled by the application of sustained direct pressure, and in which blood continues to flow heavily or soak through large dressings quickly, is described as an uncontrollable major haemorrhage. A haemorrhage in which blood continues to flow slightly or ooze is described as uncontrollable minor haemorrhage.
**Conscious level**

Conscious level is considered differently for adults and children. In adults only currently fitting patients and those with an altered conscious level are always categorised as priority 1 (Red – FtF Now), while all unresponsive children are placed in this clinical priority. All patients with a history of unconsciousness should be allocated to priority 2 (Yellow – FtF Soon).

The fact that all patients with alterations in conscious level are allocated to the ‘FtF Now’ priority may be at odds with current practice; this is especially so with regard to the clinical priority given to patients who are intoxicated or under the influence of drugs.

Two points need to be made about this. First, the aetiology of alterations in level of consciousness is largely irrelevant in determining the risk to the patient – an altered conscious level due to drugs or alcohol is clinically as important as altered conscious level due to other causes. Second, most drunk patients do not have an altered level of consciousness. Specific points about the allocation of clinical priority to patients who are apparently drunk are dealt with in the presentational flow chart of that name.
Temperature

Temperature is used as a general discriminator. Although accurate measurement of temperature may be difficult to achieve in practice, many parents employ various types of temperature measuring device to assess temperature in children.

Clinical impression of skin temperature is important and is crucial where immediate assessment of core temperature is not possible. This cannot be ascertained by telephone but only by very careful questioning and should be used with caution where an actual temperature is not available. Other signs of pyrexia such as rigors and feeling very cold should be taken into account when assessing temperature by telephone.

If the skin is very hot, then the patient is clinically said to be very hot – this corresponds to a temperature of greater than 41°C; similarly if the skin is hot, then the patient is clinically said to be hot and this corresponds to a temperature of greater than 38.5°C. A patient with warm skin fulfils the discriminator of warmth and this goes with a temperature of less than 38.5°C.

Patients with cold skin can be said to be clinically cold – a core temperature of less than 35°C matches this. One would expect exposed skin in a cold environment to be cold. The practitioner must discriminate by careful questioning whether unexposed skin in a cold environment is cold, or exposed skin in a warmer environment is cold, that is, whether skin is colder than would be expected in the particular circumstances.

A very hot patient (1 year and above) will always be categorised as priority 1 (Red – FtF Now), whilst a hot patient will be categorised as priority 2 (Yellow – FtF Soon). Patients who are cold will be allocated to priority 1 (Red – FtF Now). The hot baby (from birth to 12 months) will always be categorised as priority 1 (Red – FtF Now) and the warm newborn (a baby of 28 days old or less) as priority 2 (Yellow – FtF Soon).
Pain
From the patients’ perspective, pain is a major factor in determining priority. The use of pain as a general discriminator throughout the presentational flow charts recognises this fact and implies that every Telephone Triage assessment should include an assessment of pain. Because accurate assessment of pain is almost impossible in Telephone Triage, there are only two categories of pain recordable in this system. In general terms, the discriminator severe pain is intended to imply pain that is unbearable, often described as the worst ever. Any patient with a lesser degree of pain is recorded as ‘unresolved pain’ which is defined as pain which has not resolved despite waiting an appropriate time or being given appropriate analgesia. This patient should, if no other discriminators suggest a higher categorisation, be allocated priority 3 (Green – FtF Later) and not be allocated to an ‘advice only’ category.

The general pain discriminator describes the intensity or severity of pain only. Other characteristics of pain, such as site, radiation and periodicity, may feature as specific discriminators in particular presentational flow charts.
Acuteness
Within the triage method, certain conventions have been used to help with consistency. The term ‘abrupt’ is used to indicate onset within seconds or minutes and ‘acute’ indicates a time period within 24 hours. Recent symptoms and signs are those that have appeared within the past 7 days.

Evaluating alternatives and selecting one
Selection of the most appropriate flow chart presents a number of general and specific discriminators which can then be tested against the patient. The skill in implementing the triage method lies in the application of this testing. Practitioners must decide whether the criteria for the presence of each discriminator is fulfilled and must decide which discriminator is the most applicable at the highest clinical priority. For example, for the adult who presents with abdominal pain and complains of persistent vomiting and is hot (both priority 2 – FtF Soon), the most appropriate discriminator is persistent vomiting as this provides more significant information about this patient.
Implementing the selected alternative

This step is essentially a procedural one. The inevitable outcome of the information gathering, analysis and evaluation leads to allocation of one of the clinical priorities shown in the box.

<table>
<thead>
<tr>
<th>Number</th>
<th>Name</th>
<th>Colour</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>FtF Now</td>
<td>Red</td>
</tr>
<tr>
<td>2</td>
<td>FtF Soon</td>
<td>Yellow</td>
</tr>
<tr>
<td>3</td>
<td>FtF Later</td>
<td>Green</td>
</tr>
<tr>
<td>4</td>
<td>Advice only</td>
<td>Blue</td>
</tr>
</tbody>
</table>

Documentation

Implementation involves recording the allocated priority and showing the decision making that led to it. The triage method outlined here allows documentation to be simple and precise. The minimum required is a record of which presentational flow chart is being used, which discriminator defines the category and which category has been selected. Thus, for instance, the triage record of a patient with chest pain might be as shown in the box.

- Chest pain
- Pleuritic pain
- FtF Soon (yellow)

This simple approach to documentation allows for simple audit but it is recognised that computer decision support software is widely used and will dictate the way the triage event is recorded.

Patient assessment

The purist view of the triage event is a rapid and focussed encounter in which information is gathered and applied to assign a priority. This type of assessment is a skill in itself and carries a higher degree of risk when undertaken without the ability to actually see the patient and when, on many occasions, the person making the telephone call is not actually the patient.

The following framework can be used to teach the process to Telephone Triage practitioners, ensuring decisions are based on relevant and appropriate patient data.

It is important that the assessment of a patient is systematic and all elements of that assessment are pieced together to give a complete picture of the patient’s problem. For this reason, the Telephone Triage practitioner should have sufficient
experience of urgent/emergency care and the interpersonal skills to communicate
effectively with patients and their families and carers.

The approach to this assessment should take the following format (Table 3.1):

By following this systematic process, facilitated by the triage methodology,
patient assessment can be performed rapidly and confidently to reach an
appropriate clinical priority in order to guide decision making.

**Table 3.1**

<table>
<thead>
<tr>
<th>Assessment component</th>
<th>Triage activity</th>
</tr>
</thead>
</table>
| Greeting the patient/caller | Listen to voice  
Ascertaining whether patient or other and if possible, ask to speak to the patient |
| Patient history | Ask the patient what the problem is  
This is a short, concise, subjective history and tells you about the patient's injury/illness/health-related problem |
| Presenting complaint | Patients’ presenting complaint can be established from the subjective history they provide  
*This leads the triage practitioner to choose the most appropriate presentation flow chart* |
| Focused questions (interview) | This is where the triage practitioners’ knowledge and skills are most evident. Application of anatomical knowledge, pattern recognition of presenting complaints and the ability to react effectively to life-threatening situations are all the domain of the triage practitioner  
Focused questions can be used to obtain more detail if required, for example mechanism of injury, duration of the problem and current medications. *The format of these questions will be directed by the discriminators in the chosen presentation flow chart* |
| Physical examination and assessment of physical parameters | Physical examination and assessment of physical parameters is possible during face to face triage but less so on the end of a telephone, but some questions such as the following could be asked:  
- What things sound like – *do they make a gurgling sound when they breathe?*  
- What things look like – *does the limb look a different colour when you compare it to the other side?*  
- What things feel like – *do they feel hot or cold to the touch?*  
- What effect the problem is having – *is your vision blurred or strange?* |
| Pain assessment | Pain assessment in Telephone Triage is difficult so pain has been revised to:  
- Severe pain (FtF now)  
- Unresolved pain (pain which has not resolved despite the use of appropriate analgesia) in the absence of any other discriminator (FtF later) |
Checking for understanding

It is absolutely crucial that the patient, or the person calling on behalf of the patient, understands the information and advice being given by the Telephone Triage practitioner, and checking for understanding should be a continual part of the process.

Interim advice

As the patient is remote from the triage practitioner, interim advice maybe necessary in order to promote recovery or prevent deterioration in the condition of the patient before face to face assessment. For example, if the triage practitioner obtains information that the patient is not breathing effectively or has airway compromise, then life-saving basic life support advice must be given to the caller so that resuscitation can be attempted until help arrives. Similarly, if a child is unwell and is triaged to ‘medicine later’ it may be appropriate to give the carer advice on simple measures to alleviate symptoms such as fever and diarrhoea. Each chart shows interim advice which can be added to depending on the local requirement.

Advice only

In the advice only category, tailored advice should be given to the patient and checked for understanding.

The advice which should be provided to the patient by the Telephone Triage practitioner (as appropriate) for the chart ‘Abdominal Pain in Adults’ is summarized below.
A key premise of the advice in these charts is that it is general and may be adapted for use in specific settings. The algorithms, as in the case of the face to face algorithms, are evidence based and validated and must not be altered.

**Monitoring and evaluating**

Understanding should be checked by questioning and the patient asked if they have any questions for the practitioner, before the Telephone Triage episode is complete.

It is important that callers are given information about what to do if things change and the evaluation, particularly of ‘advice only’ decisions, may be undertaken by patient call back and continuous audit.
CHAPTER 4

The presentation priority matrix

The Manchester Triage System was designed to be a robust, auditable clinical risk management tool that identified the clinical priority of individual patients. As has been alluded to earlier in this book, the process itself and the outcome of the process can be useful beyond prioritisation.

Presentation-priority matrix mapping

As the idea of the inappropriate patient becomes replaced by the concepts of inappropriate care delivery and patient choice, multiple entry gates to emergency care and the ‘emergency care village’ become realities. Clinicians must be equipped with tools that enable them to decide safely and effectively where patients might be best managed.

In Telephone Triage, it is crucial that the outcome of the prioritisation process informs decisions about the most appropriate disposition of the patient. In particular, the combination of the presentational chart used and the priority allocated (the presentation-priority matrix) should be matched to particular types of provision of emergency care so that every patient with a particular outcome is dealt with in an appropriate, effective and consistent way. This outcome will be different depending on the locality, time of day and services available at that time. Thus a patient presenting, by telephone, with a limb problem and allocated to the ‘Face-to-Face (FtF) Soon’ priority could be seen in a minor injury unit, in the Emergency Department (ED) or in primary care, while a patient with chest pain allocated to the ‘FtF Now’ will always have an emergency ambulance dispatched and be taken to an Emergency Department. The MTS consists of 53 presentations and up to 3 priorities – making a total of 155 presentation-priority combinations.
A mapping exercise should be undertaken with all providers of care to consider appropriate disposition of all of these and a consensus reached with clinicians in all areas so that all patients reach appropriate face to face assessment and care.

**Explanation of the process**
When making decisions as to the most appropriate disposition for patients, it is important to identify a range of stakeholders who will work to develop the matrix finally reaching a consensus decision. Where patients will be directed across a range of services, it is useful to engage different providers and different professionals, job roles to give a balanced view of how patients will be directed.

**Completing the PPM**
- Establish the list of dispositions to which patients can be directed (see examples below).
- Provide each stakeholder with a blank matrix and a copy of Emergency Triage: Telephone Triage and Advice; this is strictly an open book exercise to ensure each stakeholder bases their decisions on the same methodology the Telephone Triage practitioners will be using.
- The stakeholders will individually use a reductionist approach (start at priority 1 – FtF Now – and work along the priorities to priority 4 – Advice Only) to consider for each of the presentation charts which disposition is appropriate for the patient in a particular priority, for example
  - Unwell Adult – Priority 1 – FtF Now – inadequate breathing = Despatch of Emergency Ambulance
  - Dental problems – Priority 3 – FtF Later – unresolved pain = Primary Care or Dental Service
- All completed matrices collated, where consensus not reached further iteration required until a clear map of agreed dispositions is produced.
- This process can and should be repeated at intervals to ensure any change in services is represented in the matrix.

**The dispositions**
A large ambulance service disposition matrix using presentation and priority is shown here. The dispositions available will be subject to local emergency care provision. For example, the lack of an emergency eye unit, or the fact that one exists but is not open 24 hours a day, will change where patients with eye problems are managed. It may, however, also stimulate debate with the local ophthalmic service in order to provide a more appropriate service for these patients. The dispositions shown below, assume a complete range of emergency care provision. The Telephone Triage practitioner will need to exercise judgement as to which is the most appropriate. This decision will be influenced by the availability of the services, the current pressures on them, the triage discriminator and perhaps the patient’s choice or their ability to travel to a service.
Experience has shown that triage must be accurate (as assessed by audit) if it is to be used to drive disposition.

**Times to ‘face to face’**

The times associated with each of these outcomes will be driven by a number of factors including local emergency provision as well as locally and nationally driven priorities and targets. What is clear is that ‘FtF Now’ will always require urgent care as quickly as is possible in the prevailing circumstances and it may be agreed locally that the Telephone Triage professional remains in contact with the patient or the caller until appropriate help arrives.

*Key definitions for this PPM:*

- ED – Emergency Department or Urgent Care Centre (condition dependent)
- EDC – Emergency Dental Centre and/or Own Transport
- EEC – Emergency Eye Centre and/or Own Transport
- MAT – Maternity Services (e.g. labour ward, early pregnancy unit)
- MIU – Minor Injuries Unit or Walk-In Centre and/or Own Transport
- PA – Psychiatric Assessment
- PC – Primary Care Emergency Centre (e.g. GP-led walk-in facility, GP Surgery) and/or Own Transport
- SC – Self Care Advice and/or PC referral greater than 4 hours
- SHC – Sexual Health Clinic or G.U.M Service and/or Own Transport

<table>
<thead>
<tr>
<th>Presentation</th>
<th>‘FtF Now’ outcome</th>
<th>‘FtF Soon’ outcome</th>
<th>‘FtF Later’ outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal pain (adult)</td>
<td>ED</td>
<td>Consider PC</td>
<td>PC</td>
</tr>
<tr>
<td>Abdominal pain (child)</td>
<td>ED</td>
<td>ED</td>
<td>PC</td>
</tr>
<tr>
<td>Abscesses and local infections</td>
<td>ED</td>
<td>Consider PC</td>
<td>PC</td>
</tr>
<tr>
<td>Allergy</td>
<td>ED</td>
<td>PC</td>
<td>SC</td>
</tr>
<tr>
<td>Apparently drunk</td>
<td>ED</td>
<td>Consider MIU</td>
<td>PC or MIU</td>
</tr>
<tr>
<td>Assault</td>
<td>ED</td>
<td>Consider PC</td>
<td>PC or MIU</td>
</tr>
<tr>
<td>Asthma</td>
<td>ED</td>
<td>ED</td>
<td>PC or MIU</td>
</tr>
<tr>
<td>Back pain</td>
<td>ED</td>
<td>ED</td>
<td>PC or SC</td>
</tr>
<tr>
<td>Behaving strangely</td>
<td>ED</td>
<td>Consider PC</td>
<td>PC or SC</td>
</tr>
<tr>
<td>Bites and stings</td>
<td>ED</td>
<td>ED</td>
<td>PC or SC</td>
</tr>
<tr>
<td>Burns and scalds</td>
<td>ED</td>
<td>Consider PC</td>
<td>PC or SC</td>
</tr>
<tr>
<td>Chemical exposure</td>
<td>ED</td>
<td>Consider PC</td>
<td>PC</td>
</tr>
<tr>
<td>Chest pain</td>
<td>ED</td>
<td>ED</td>
<td>PC</td>
</tr>
<tr>
<td>Collapsed adult</td>
<td>ED</td>
<td>ED</td>
<td>PC</td>
</tr>
<tr>
<td>Crying baby</td>
<td>ED</td>
<td>ED</td>
<td>PC</td>
</tr>
<tr>
<td>Dental problems</td>
<td>ED</td>
<td>EDC</td>
<td>EDC</td>
</tr>
<tr>
<td>Diabetes</td>
<td>ED</td>
<td>ED</td>
<td>PC</td>
</tr>
<tr>
<td>Diarrhoea and vomiting</td>
<td>ED</td>
<td>Consider PC</td>
<td>SC</td>
</tr>
<tr>
<td>Presentation</td>
<td>‘FtF Now’ outcome</td>
<td>‘FtF Soon’ outcome</td>
<td>‘FtF Later’ outcome</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------------</td>
<td>--------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Ear problems</td>
<td>ED</td>
<td>ED</td>
<td>PC</td>
</tr>
<tr>
<td>Eye problems</td>
<td>ED</td>
<td>EEC</td>
<td>PC</td>
</tr>
<tr>
<td>Facial problems</td>
<td>ED</td>
<td>ED</td>
<td>PC or MIU</td>
</tr>
<tr>
<td>Falls</td>
<td>ED</td>
<td>ED</td>
<td>PC or MIU</td>
</tr>
<tr>
<td>Fits</td>
<td>ED</td>
<td>ED</td>
<td>Consider SC</td>
</tr>
<tr>
<td>Foreign body</td>
<td>ED</td>
<td>Consider PC or MIU</td>
<td>PC or MIU</td>
</tr>
<tr>
<td>GI bleed</td>
<td>ED</td>
<td>Consider PC</td>
<td>PC</td>
</tr>
<tr>
<td>Headache</td>
<td>ED</td>
<td>ED</td>
<td>PC</td>
</tr>
<tr>
<td>Head injury</td>
<td>ED</td>
<td>ED</td>
<td>Consider PC</td>
</tr>
<tr>
<td>Irritable child</td>
<td>ED</td>
<td>ED</td>
<td>PC</td>
</tr>
<tr>
<td>Limb problems</td>
<td>ED</td>
<td>ED</td>
<td>PC or MIU</td>
</tr>
<tr>
<td>Limping child</td>
<td>ED</td>
<td>ED</td>
<td>PC</td>
</tr>
<tr>
<td>Major Trauma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication request</td>
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<td>PC</td>
<td>PC</td>
</tr>
<tr>
<td>Mental illness</td>
<td>ED</td>
<td>ED or consider PA</td>
<td>ED or consider PA</td>
</tr>
<tr>
<td>Neck pain</td>
<td>ED</td>
<td>ED</td>
<td>PC or MIU</td>
</tr>
<tr>
<td>Overdose and poisoning</td>
<td>ED</td>
<td>ED</td>
<td>Consider PC</td>
</tr>
<tr>
<td>Palpitations</td>
<td>ED</td>
<td>ED</td>
<td>Consider PC</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>ED or MAT</td>
<td>ED or MAT</td>
<td>PC or MAT</td>
</tr>
<tr>
<td>PV bleeding</td>
<td>ED or MAT</td>
<td>ED or MAT</td>
<td>PC</td>
</tr>
<tr>
<td>Rashes</td>
<td>ED</td>
<td>ED</td>
<td>PC or SC</td>
</tr>
<tr>
<td>Self-harm</td>
<td>ED</td>
<td>ED or PA</td>
<td>N/A</td>
</tr>
<tr>
<td>Sexually acquired infection</td>
<td>ED</td>
<td>Consider PC</td>
<td>PC or SHC</td>
</tr>
<tr>
<td>Shortness of breath (adult)</td>
<td>ED</td>
<td>Consider PC</td>
<td>PC</td>
</tr>
<tr>
<td>Shortness of breath (child)</td>
<td>ED</td>
<td>ED</td>
<td>PC</td>
</tr>
<tr>
<td>Sore throat</td>
<td>ED</td>
<td>PC</td>
<td>SC</td>
</tr>
<tr>
<td>Testicular pain</td>
<td>ED</td>
<td>ED</td>
<td>PC or SHC</td>
</tr>
<tr>
<td>Torso injury</td>
<td>ED</td>
<td>Consider PC</td>
<td>PC or MIU</td>
</tr>
<tr>
<td>Unwell adult</td>
<td>ED</td>
<td>Consider PC</td>
<td>PC</td>
</tr>
<tr>
<td>Unwell baby</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unwell child</td>
<td>ED</td>
<td>ED</td>
<td>PC</td>
</tr>
<tr>
<td>Unwell newborn</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urinary problems</td>
<td>ED</td>
<td>Consider PC</td>
<td>PC</td>
</tr>
<tr>
<td>Worried Parent</td>
<td>ED</td>
<td>ED</td>
<td>PC</td>
</tr>
<tr>
<td>Wounds</td>
<td>ED</td>
<td>ED or MIU</td>
<td>PC or MIU</td>
</tr>
</tbody>
</table>

Example of a priority matrix used by an ambulance service taking into account local services and transport options.
CHAPTER 5
Ensuring safety in Telephone Triage

Introduction

Telephone Triage carries more risk than face to face triage because the practitioner has no clues other than what they are able to ascertain by conversation with the person at the other end of the telephone, who may not be the patient. It is absolutely crucial then that all staff undertaking Telephone Triage are appropriately trained, assessed to ensure competence and that continuous audit is undertaken to ensure that both individual practitioners and the service as a whole remain safe and effective. Standard Operating Procedures should be formulated within the organisation in which Telephone Triage takes place to ensure that all processes are in place and approved before Telephone Triage begins to be used. When the Manchester Triage Group set out its aims at its very first meeting in November 1994, it clearly identified the need for a robust audit methodology. The reasons for this were very simple that the MTS was designed to reduce unwarranted variations in the triage process and this reduction could only be ensured by audit. Audit, in this context at least, is a quality management procedure; since triage is a fundamental cornerstone of clinical risk management, failure to ensure the quality of triage may have serious consequences.

Fortunately, the Manchester Triage methodology in its telephone as well as its face to face iteration is eminently auditable. The presentation – discriminator – priority progression (the process) by which individual triage practitioners arrive at their conclusions is very easy for an auditor to note and easily assessable for accuracy by a trained assessor. The nature of Telephone Triage is often driven by the need to effectively prioritise resources. Clinicians may be disproportionately focused on avoiding the use of emergency (scarce) resources rather than clinical quality.
Audit should therefore be weighted towards quality measures to ensure patient safety and observe principles of good clinical governance.

### Appropriate training

Practitioners undertaking Telephone Triage must be experienced in the face to face aspects of their profession. Like face to face triage described within the Manchester Triage System, Telephone Triage is an expert system, designed for use by experienced practitioners rather than a simple algorithm designed for non-professional personnel. It requires very specific clinical information and the practitioners must be very skilled in telephone questioning techniques in order to ascertain the information required to make appropriate decisions and to ensure that the caller understands any instructions given.

Supervision by an experienced practitioner should be available at all times during the training process and appropriate supervision should be available even after the practitioner has been deemed competent to ensure that practitioners have clinical advice should they have difficulty with a particular call.

### Competence assessment

All practitioners must be assessed for theoretical competence as well as for practical competence and should have a period of mentoring by an experienced practitioner before they are able to take calls alone.

### Audit method

At a basic level, the accuracy of individual triage practitioners underpins the whole quality agenda. Thus, the most robust triage audit continuously assesses the practitioners for accuracy (and is linked by reflective practice and, if necessary, additional training to improve performance). The method outlined below is an audit of individual practitioner triage activity and is designed to audit the quality of decision making against the MTS standard, along with standards of record keeping and documentation.

| All triage practitioners are identified |
| All episodes of triage are identified |
| Episodes are all assigned to individual practitioners |
| Two percent of episodes per practitioner (minimum of 10 episodes) are randomly selected |
| Episodes are assessed by a senior trained triage practitioner |
| The completeness of episodes is expressed as a simple proportion |
| The accuracy of episodes is expressed as a simple proportion |
| The number of incomplete episodes is fed back to the practitioner |
| The overall accuracy is fed back to the practitioner |
| Any causes of inaccurate triage are fed back to the practitioner |
To ensure consistency of audit, 10% of episodes assessed are performed independently by a second senior practitioner. Any differences are moderated by discussion. Continuous audit can be time‐consuming but is an excellent means of assessing standards of triage activity and decision making (Table 5.1).

As can be seen from this, two measures of the triage process are obtained: completeness and accuracy. These are defined in the following.

### Completeness

An episode is complete if all the steps necessary to reach the conclusion have been undertaken. As the method is reductive (that is it assumes everybody is priority 1 and works down from there), this requires that the practitioner excludes all the discriminators in any higher priority. Thus, if pain appears as a discriminator in the chart selected, then the episode would be incomplete if no result was recorded. Advice must be given to the patient about what disposition has been chosen and how it will be operationalised (an ambulance has been despatched, make your way to your local walk‐in centre, make an appointment to see your doctor in the morning, etc.) and the record is not complete unless this has been communicated to the patient or caller and advice given in the meantime.

### Accuracy

An episode is recorded as accurate if both presentation and discriminator selected are appropriate and if correct advice has been given to the patient. It is important to realise that there may be appropriate alternatives (indeed the system is designed to ensure that this can occur); thus audit should be carried out by a practitioner with sufficient experience to make this judgement.

### Targets

- 0% episodes incomplete
- 95% accuracy
- 95% agreement between assessors
Chapter 5

Triage in practice

The triage audit will have a number of additional effects on the triage process. It is not possible to carry out the audit without accurate triage notes, call recordings, or indeed, both; any deficiencies in record making will be highlighted. Feedback on a regular basis will improve these assessments. Experience has shown that this is an early ‘win’ from audit.

Peer review

Audit is a more powerful tool if it is undertaken by peers as well as by managers. A peer audit allows open discussion and reflective learning to take place and must be an integral part of triage audit.

System review

In Telephone Triage, it is also important to find out what happened to the patient after the practitioner has finished the Telephone Triage episode so follow-up of patients must take place.

We suggest the following in the initial phases of adoption of a Telephone Triage system:

- 10% of patients who were triaged to ‘FtF Now’ should be followed up, the face to face priority matched with the Telephone Triage priority
- 10% of ‘FtF Soon’ and ‘FtF Later’ followed up, matching the telephone priority against face to face triage, or a simulation of a face to face priority based on the presenting complaint
- 100% of ‘Advice Only’ patient should be followed up with a telephone call in a few days to ensure that the decision made was correct.

This should be part of the implementation process. Once Telephone Triage is established successfully, the degree of audit can be determined locally. The suggested percentages for individual audit may also prove onerous if Telephone Triage is undertaken for the whole of a health economy and a decision may be made locally to change these. It must be remembered though that this follow-up of Telephone Triage is vitally important to ensure that the decision, in particular, to categorise patients as ‘Advice only’ is safe.
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</table>
Abdominal Pain in Adults

**Airway compromise, inadequate breathing or shock:**
- If unconscious, place in the recovery position, if conscious, try to reassure.
- Provide Life Support Advice if required.
- Take available analgesia for pain control.
- Keep sample of vomit/stool if possible.

**Take available analgesia for pain control**
- Call back if symptoms worsen or concerned.
- Keep sample of stool if possible.

**Maintain hydration with clear fluids or oral rehydration therapy**
- Take available analgesia for pain control.
- Call back if symptoms worsen or concerned.

**Unresolved vomiting**
- Unresolved pain.
- Recent problem.

**Maintain fluid intake – plenty of clear fluids/consider oral rehydration therapy**
- Paracetamol qds for pain and temperature control.
- Rest.
- Refer to GP if symptoms persist.
- Call back if symptoms worsen or concerned.

**FtF Now**
- Airway compromise
- Inadequate breathing
- Vomiting blood
- Passing fresh or altered blood PR
- PV blood loss, 20 week pregnant or more
- Known abdominal or aortic aneurysm
- Very hot
- Pain radiating to the back
- Severe pain

**FtF Soon**
- Black or red currant stools
- Persistent vomiting
- Possibly pregnant
- Hot
- Shoulder tip pain

**FtF Later**
- Unresolved vomiting
- Unresolved pain
- Recent problem

**Advice only**
Abdominal pain in adults

See also

<table>
<thead>
<tr>
<th>Discriminator</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diarrhoea and vomiting</td>
<td>This is a presentation-defined flow diagram. Abdominal pain is a common cause of presentation. A number of general discriminators are used including Life Threat and Pain. Specific discriminators are included in the ‘face to face Now’ and ‘face to face Soon’ categories to ensure that the more severe pathologies are appropriately triaged. In particular, discriminators are included to ensure that patients with moderate and severe GI bleeding and those with signs of retroperitoneal or diaphragmatic irritation are given sufficiently high categorisation</td>
</tr>
<tr>
<td>GI bleeding</td>
<td></td>
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<td>Pregnancy</td>
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</tbody>
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Specific discriminators

<table>
<thead>
<tr>
<th>Discriminator</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vomiting blood</td>
<td>Vomited blood may be fresh (bright or dark red) or coffee ground in appearance</td>
</tr>
<tr>
<td>Passing fresh or altered blood PR</td>
<td>In active massive GI bleeding, dark red blood will be passed PR. As GI transit time increases, this becomes darker, eventually becoming melaena</td>
</tr>
<tr>
<td>PV blood loss and 20 weeks pregnant or more</td>
<td>Any loss of blood per vaginum in a woman is known to be beyond the 20th week of pregnancy</td>
</tr>
<tr>
<td>Known abdominal or aortic aneurysm</td>
<td>Self (or caller) reported to have abdominal or aortic aneurysm</td>
</tr>
<tr>
<td>Pain radiating to the back</td>
<td>Pain that is also felt in the back either intermittently or constantly</td>
</tr>
<tr>
<td>Black or redcurrant stools</td>
<td>Any blackness fulfils the criteria of black stool while a dark red stool, classically seen in intussusceptions, is redcurrant stool</td>
</tr>
<tr>
<td>Persistent vomiting</td>
<td>Vomiting that is continuous or that occurs without any respite between episodes</td>
</tr>
<tr>
<td>Possibly pregnant</td>
<td>Any woman whose normal menstruation has failed to occur is possibly pregnant. Furthermore, any woman of childbearing age who has unprotected sex should be considered to be potentially pregnant</td>
</tr>
<tr>
<td>Shoulder tip pain</td>
<td>Pain felt in the tip of the shoulder. This often indicates diaphragmatic irritation</td>
</tr>
<tr>
<td>Unresolved vomiting</td>
<td>Vomiting which has not resolved, despite any appropriate actions</td>
</tr>
</tbody>
</table>
Airway compromise, inadequate breathing or shock:
if unconscious place in the recovery position, if conscious try to reassure
Provide Life Support Advice if required
Take available analgesia for pain control
Keep sample of vomit/stool if possible

Airway compromise
Inadequate breathing
Vomiting blood
Passing fresh or altered blood PR
Very hot
Signs of severe pain
Hot baby
Non-blanching rash

Black or redcurrant stools
Persistent vomiting
Visible abdominal mass
Inconsolable by parents
Hot

Unresolved vomiting
Pain
Recent problem

Oral rehydration therapy – monitor urine output
Paracetamol qds for pain and temperature control
Continue to feed babies
Refer to GP if symptoms persist
Call back if symptoms worsen or new symptoms develop

Maintain hydration with clear fluids or oral rehydration therapy
Take paracetamol for pain control
Call back if symptoms worsen or new symptoms develop

Take available analgesia for pain control
Call back if symptoms worsen or concerned
Keep sample of stool if possible

Abdominal Pain in Children
**Abdominal pain in children**

### See also

Diarrhoea and vomiting  
This is a presentation-defined flow diagram. Children who present with abdominal pain may have a range of pathologies and this chart has been designed to allow them to be accurately prioritised. A number of general discriminators are used including *Life Threat* and *Pain*. Specific discriminators are included to ensure the children who are actively bleeding, and those who have the signs or symptoms of more severe pathologies such as intussusception are given immediate care.

### Chart notes

### Specific discriminators

<table>
<thead>
<tr>
<th>Discriminator</th>
<th>Explanation</th>
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<tbody>
<tr>
<td>Vomiting blood</td>
<td>Vomited blood may be fresh (bright or dark red) or coffee ground in appearance</td>
</tr>
<tr>
<td>Passing fresh or altered blood PR</td>
<td>In active massive GI bleeding, dark red blood will be passed PR. As GI transit time increases, this becomes darker, eventually becoming melaena.</td>
</tr>
<tr>
<td>Non-blanching rash</td>
<td>A rash that does not blanch (go white) when pressure is applied to it. Often tested using a glass tumbler to apply pressure as any colour change can be observed through the bottom of the tumbler.</td>
</tr>
<tr>
<td>Black or redcurrant stools</td>
<td>Any blackness fulfils the criteria of black stool while a dark red stool, classically seen in intussusceptions, is redcurrant stool.</td>
</tr>
<tr>
<td>Persistent vomiting</td>
<td>Vomiting that is continuous or that occurs without any respite between episodes.</td>
</tr>
<tr>
<td>Visible abdominal mass</td>
<td>A mass in the abdomen that is visible to the naked eye.</td>
</tr>
<tr>
<td>Inconsolable by parents</td>
<td>Children whose crying or distress does not respond to attempts by their parents to comfort them fulfil this criterion.</td>
</tr>
<tr>
<td>Unresolved vomiting</td>
<td>Vomiting which has not resolved, despite any appropriate actions.</td>
</tr>
</tbody>
</table>
Abscesses and Local Infection

Airway compromise, inadequate breathing or shock:
- If unconscious, place in the recovery position, if conscious, try to reassure
- Provide Life Support Advice if required
- Take available analgesia for pain control

FtF Now

Airway compromise
Inadequate breathing
Vascular compromise
Severe pain

FtF Soon

Hot joint
Pain on joint movement
Hot

FtF Later

Unresolved pain
Recent problem
Swelling

Advice

Advice only

Take paracetamol qds for pain and temperature control
Take ibuprofen tds if required
Observe for spreading infection/tracking
Woundcare advice – primary care for dressings change if required
Refer to GP if symptoms persist or worsen

Take available analgesia for pain control
Call back if symptoms worsen or concerned

Take available analgesia for pain control
Draw around infected area with pen – observe for increased redness
Seek urgent attention if significant spread, red streaking, local lymphadenopathy or rigors
Call back if symptoms worsen or new symptoms develop
Abscesses and local infections

See also

<table>
<thead>
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<th>See also</th>
<th>Chart notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bites and stings</td>
<td>This is a presentation-defined flow diagram designed to allow prioritisation of patients who present with a variety of local infections and abscesses. Underlying conditions may vary from life-threatening orbital cellulitis to acneiform spots. A number of general discriminators are used including Life Threat, Pain and Temperature. Specific discriminators have been included to allow identification of more urgent conditions such as gas gangrene and septic arthritis</td>
</tr>
</tbody>
</table>
Airway compromise, inadequate breathing or shock:
- If unconscious, place in the recovery position; if conscious, try to reassure.

Acutely short of breath, unable to talk in sentences:
- If possible, sit down and lean slightly forward.
- Take available antihistamines if appropriate.

Airway compromise
- Oedema of the tongue
- Stridor
- Inadequate breathing
- Facial oedema
- Unable to talk in sentences
- Altered conscious level

Wheeze
- Widespread rash or blistering
- Significant history of allergy

Local inflammation
- Unresolved pain or itch
- Unresolved rash

Pharmacist advice
- Contact GP or out-of-hours if symptoms persist.
- Take available antihistamines.
- Avoid contact with allergen.
- Avoid scratching.

Advice only
- Pharmacist advice
- Contact GP or out-of-hours if symptoms persist.
- Take available antihistamines.
- Avoid contact with allergen.
- Avoid scratching.
### Allergy

**See also**

- Asthma
- Bites and stings
- Collapsed adult
- Unwell adult

**Chart notes**

This is a presentation-defined flow diagram designed to allow prioritisation of patients with symptoms and signs that may indicate allergy. Patients with allergic reactions range from those with life-threatening anaphylaxis to those with an itchy insect bite. A number of general discriminators are used including *Life Threat*, *Conscious Level* and *Pain*. Specific discriminators have been included to allow prioritization of the most urgent conditions.

### Specific discriminators

<table>
<thead>
<tr>
<th>Discriminator</th>
<th>Explanation</th>
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</thead>
<tbody>
<tr>
<td>Oedema of the tongue</td>
<td>Swelling of the tongue of any degree</td>
</tr>
<tr>
<td>Facial oedema</td>
<td>Diffuse swelling around the face usually involving the lips</td>
</tr>
<tr>
<td>Unable to talk in sentences</td>
<td>Patients who are so breathless that they cannot complete relatively short sentences in one breath</td>
</tr>
<tr>
<td>Widespread rash or blistering</td>
<td>Any discharging or blistering eruption covering more than 10% body surface area</td>
</tr>
<tr>
<td>Significant history of allergy</td>
<td>A known sensitivity with severe reaction (e.g. to nuts or bee sting) is significant</td>
</tr>
<tr>
<td>Local inflammation</td>
<td>Local inflammation will involve pain, swelling and redness confined to a particular site or area</td>
</tr>
</tbody>
</table>
Airway compromise, inadequate breathing or shock:
- If unconscious place in the recovery position, if conscious try to reassure

Acutely short of breath, unable to talk in sentences:
- If possible sit down and lean slightly forward
- Provide Life Support Advice if required

Patient should not be left alone
- Maintain safety of patient
- Keep warm
- Call back if symptoms worsen or concerned

Apply dressing to minor wounds
- Take paracetamol for pain control
- Call back if symptoms worsen or new symptoms develop

Oral rehydration therapy/clear fluids
- Avoid using machinery or driving
- Paracetamol qds for pain control
- Avoid NSAIDs – GI irritant
- Call back if symptoms worsen or new symptoms develop

Advice

Advice only

Apparent Drunk

FtF Now

FtF Soon

FtF Later
 Apparently drunk

See also  |  Chart notes
---|---
Behaving strangely  |  This is a presentation-defined flow diagram. A large number of patients access emergency care in an apparently drunken state. This chart implicitly recognises that not all these patients are drunk and is designed to ensure accurate identification and prioritisation of patients who are suffering from conditions which make them appear drunk, or from such severe drunkenness that their life is threatened. A number of general discriminators have been used including *Life Threat* and *Conscious Level*
Collapsed adult  |
Head injury  |

Specific discriminators  |  Explanation
---|---
History of unconsciousness  |  There may be a reliable witness who can state whether the patient was unconscious (and for how long). If not a patient who is unable to remember the incident should be assumed to have been unconscious
History of head injury  |  A history of a recent physically traumatic event involving the head. Usually this will be reported by the patient, but if the patient has been unconscious, this history should be sought from a reliable witness
Persistent vomiting  |  Vomiting that is continuous or that occurs without any respite between episodes
Airway compromise, inadequate breathing or shock:
if unconscious place in the recovery position, if conscious try to reassure
Acutely short of breath, unable to talk in sentences:
if possible sit down and lean slightly forward
Provide Life Support Advice if required
If significant mechanism of injury, keep the patient still
Apply pressure appropriate to injury to control major haemorrhage

Take available analgesia for pain control
Wound care advice if required
Call back if symptoms worsen or concerned

If new deformity, immobilise affected body parts
Take available analgesia for pain control
Wound care advice if required
Call back if symptoms worsen or concerned

Dependent on Injury – refer to appropriate TTA Card
Take paracetamol qds for pain control
Take ibuprofen tds if required
Wound care advice
Call back if symptoms worsen or concerned
Assault

See also

Head injury
Torso injury
Wounds

Chart notes

This is a presentation-defined flow diagram.

Assault is a common presentation, and patients with non-specific conditions following assault may be triaged using this chart. Patients who have specific injuries are better triaged using the charts which pertain to those injuries. A number of general discriminators are used including Life Threat, Haemorrhage and Pain. Specific discriminators are included to identify patients who have a significant history of injury which may indicate a more urgent requirement for treatment.

Specific discriminators

<table>
<thead>
<tr>
<th>Specific discriminators</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acutely short of breath</td>
<td>Shortness of breath that comes on suddenly or a sudden exacerbation of chronic shortness of breath</td>
</tr>
<tr>
<td>New neurological deficit less than 24 hours</td>
<td>Any loss of neurological function that has come on within the previous 24 hours. This might include altered or lost sensation, weakness of the limbs (either transiently or permanently) and alterations in bladder or bowel function</td>
</tr>
<tr>
<td>Significant mechanism of injury</td>
<td>Penetrating injuries (stab or gunshot) and injuries with high energy transfer</td>
</tr>
<tr>
<td>New neurological deficit more than 24 hours</td>
<td>Any loss of neurological function including altered or lost sensation, weakness of the limbs (either transiently or permanently) and alterations in bladder or bowel function</td>
</tr>
<tr>
<td>History of unconsciousness</td>
<td>There may be a reliable witness who can state whether the patient was unconscious (and for how long). If not, a patient who is unable to remember the incident should be assumed to have been unconscious</td>
</tr>
<tr>
<td>Deformity</td>
<td>This will always be subjective. Abnormal angulation or rotation is implied</td>
</tr>
<tr>
<td>Swelling</td>
<td>An abnormal increase in size</td>
</tr>
</tbody>
</table>
Airway compromise, inadequate breathing or shock:
- If unconscious place in the recovery position, if conscious try to reassure
- Acutely short of breath, unable to talk in sentences, very low PEFR:
  - If possible sit down and lean slightly forward.
  - Provide Life Support Advice if required
  - Take nebuliser if available
  - Patient should not be left alone

Asthma

Airway compromise
Inadequate breathing
Unable to talk in sentences
Altered conscious level
Significant respiratory history

FtF Now

Wheeze
No improvement with own asthma medications
Hot

FtF Soon

Productive cough
Recent problem

FtF Later

Advice only

Avoid triggers/allergen if known
Promote compliance with prescribed medication
Refer to asthma/practice nurse
Call back if symptoms worsen or concerned

Advice

Take prescribed medication if available
Take available analgesia for pain control
Call back if symptoms worsen or concerned

Advice

Take nebuliser if available
Take available analgesia for pain control
Call back if symptoms worsen or concerned

Advice
Asthma

**See also**

<table>
<thead>
<tr>
<th>Allergy</th>
<th>Chart notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shortness of breath in adults</td>
<td>This is a presentation-defined flow diagram which is intended for use in patients who present with the symptoms and signs of known asthma. The severity of asthmatic patients at presentation varies from those whose lives are threatened to those requiring a repeat prescription of inhalers. A number of general discriminators are used including Life Threat and Conscious Level. Specific discriminators are included to indicate those signs and symptoms which indicate severe and life-threatening asthma</td>
</tr>
<tr>
<td>Shortness of breath in children</td>
<td></td>
</tr>
</tbody>
</table>

**Specific discriminators**

<table>
<thead>
<tr>
<th>Specific discriminators</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unable to talk in sentences</td>
<td>Patients who are so breathless that they cannot complete relatively short sentences in one breath</td>
</tr>
<tr>
<td>Significant respiratory history</td>
<td>A history of previous life threatening episodes of a respiratory condition (e.g. COPD) is significant as is brittle asthma</td>
</tr>
<tr>
<td>Wheeze</td>
<td>This can be audible wheeze or a feeling of wheeze. Very severe airway obstruction is silent (no air can move)</td>
</tr>
<tr>
<td>No improvement with own asthma medications</td>
<td>This history should be available from the patient. A failure to improve with bronchodilator therapy given by the GP or paramedic is equally significant</td>
</tr>
<tr>
<td>Productive cough</td>
<td>A cough which is productive of phlegm, whatever the colour</td>
</tr>
</tbody>
</table>
Airway compromise, inadequate breathing or shock:
- If unconscious place in the recovery position, if conscious try to reassure
- Provide Life Support Advice if required
- Take available analgesia for pain control

Back Pain

Airway compromise
Inadequate breathing
New neurological deficit less than 24 hours
Abdominal pain
Significant mechanism of injury
Severe pain
Known abdominal aortic aneurysm

PtF Now

If direct trauma, keep patient still
- Take available analgesia for pain/temperature control
- Call back if symptoms worsen, concerned or new symptoms develop

PtF Soon

New neurological deficit more than 24 hours
Direct trauma to the back
Unable to walk
Hot

PtF Later

Unresolved pain
Recent problem
- Take available analgesia for pain control
- Keep mobile within limits of pain control
- Call back if symptoms worsen or new symptoms develop

Advice only

Keep mobile
- Take paracetamol qds for pain control
- Take ibuprofen tds if required
- See GP if stronger analgesia required
- Lifestyle advice – weight, posture, kinetics, mattress, sit comfortably
- Hot and cold compress
- Call back if symptoms worsen or concerned

Advice
Back pain

See also | Chart notes
---|---
Abdominal pain | This is a presentation-defined flow diagram. Patients with back pain may present either as an acute event or as an acute exacerbation of a chronic problem. A number of general discriminators are used including Life Threat, Pain and Temperature. Specific discriminators have been selected in order to allow for appropriate categorisation of more urgent problems. In particular, discriminators are included to allow appropriate classification of abdominal aneurysm and patients with neurological signs and symptoms.
Neck pain | 

### Specific discriminators

<table>
<thead>
<tr>
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<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>New neurological deficit less than 24 hours</td>
<td>Any loss of neurological function that has come on within the previous 24 hours. This might include altered or lost sensation, weakness of the limbs (either transiently or permanently) and alterations in bladder or bowel function.</td>
</tr>
<tr>
<td>Abdominal pain</td>
<td>Any pain felt in the abdomen. Abdominal pain associated with back pain may indicate abdominal aortic aneurysm, whilst association with PV bleeding may indicate ectopic pregnancy or miscarriage.</td>
</tr>
<tr>
<td>Significant mechanism of injury</td>
<td>Penetrating injuries (stab or gunshot) and injuries with high energy transfer.</td>
</tr>
<tr>
<td>New neurological deficit more than 24 hours</td>
<td>Any loss of neurological function including altered or lost sensation, weakness of the limbs (either transiently or permanently) and alterations in bladder or bowel function.</td>
</tr>
<tr>
<td>Direct trauma to the back</td>
<td>This may be top to bottom (loading) for instance when people fall and land on their feet, bending (forwards, backwards or to the side) or twisting.</td>
</tr>
<tr>
<td>Unable to walk</td>
<td>It is important to try and distinguish between patients who have pain and difficulty walking and those who cannot walk. Only the latter can be said to be unable to walk.</td>
</tr>
</tbody>
</table>
Airway compromise, inadequate breathing or shock:
- If unconscious place in the recovery position, if conscious try to reassure
- Provide Life Support Advice if required
- Maintain own safety – it may be necessary to withdraw from the patient if risk of harm
- If possible remove anything the patient may use to cause self-harm

Maintain own safety – it may be necessary to withdraw from the patient if risk of harm
- If possible remove anything the patient may use to cause self-harm
- If patient has taken overdose, please collect all packaging for the crew/ED
- Call back if symptoms worsen, concerned or new symptoms develop

Enquire about social/family support networks
- If appropriate refer to GP or give information for agencies such as MIND

Advice

**Behaving Strangely**

Airway compromise
Inadequate breathing
Altered conscious level
New neurological deficit less than 24 hours
Risk of self-harm
Risk of harm to others

FtF Now

History of head injury
History of unconsciousness
Significant psychiatric history
History of overdose or poisoning
New neurological deficit more than 24 hours

FtF Soon

Recent problem

FtF Later

Advice only

Consider GP referral
Behaving strangely

<table>
<thead>
<tr>
<th>Specific discriminators</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>New neurological deficit less than 24 hours</td>
<td>Any loss of neurological function that has come on within the previous 24 hours. This might include altered or lost sensation, weakness of the limbs (either transitently or permanently) and alterations in bladder or bowel function.</td>
</tr>
<tr>
<td>Risk of self-harm</td>
<td>The potential of the patient to actively attempt further self-harm. If in doubt, assume a high risk.</td>
</tr>
<tr>
<td>Risk of harm to others</td>
<td>The potential of the patient to actively attempt to harm others. This may be assessed by considering the state of mind, body posture and behaviour. If in doubt, assume a high risk.</td>
</tr>
<tr>
<td>History of head injury</td>
<td>A history of a recent physically traumatic event involving the head. Usually this will be reported by the patient, but if the patient has been unconscious, this history should be sought from a reliable witness.</td>
</tr>
<tr>
<td>History of unconsciousness</td>
<td>There may be a reliable witness who can state whether the patient was unconscious (and for how long). If not, a patient who is unable to remember the incident should be assumed to have been unconscious.</td>
</tr>
<tr>
<td>Significant psychiatric history</td>
<td>A history of a major psychiatric illness or event.</td>
</tr>
<tr>
<td>History of overdose or poisoning</td>
<td>This information may come from others or may be deduced if medication is missing.</td>
</tr>
<tr>
<td>New neurological deficit more than 24 hours</td>
<td>Any loss of neurological function including altered or lost sensation, weakness of the limbs (either transitently or permanently) and alterations in bladder or bowel function.</td>
</tr>
</tbody>
</table>
Bites and Stings

**Airway compromise, inadequate breathing or shock:**
if unconscious place in the recovery position, if conscious try to reassure

**Acutely short of breath, new wheeze:**
if possible sit down and lean slightly forward

**Uncontrollable major haemorrhage:**
continue to press over the bleeding part. Do not release the pressure

---

**Uncontrollable minor haemorrhage:**
continue to press over the bleeding part. Do not release the pressure
Widespread rash or blistering:
Try not to scratch the affected area. If you have an antihistamine tablet, take one now (not to drive if sedated)
Call back if symptoms worsen, concerned or new symptoms develop

---

**Local inflammation**
**Swelling**
**Unresolved pain or itch**

**If locally red and hot, apply a cool cloth or ice wrapped in a cloth for 5 minutes at a time**
Keep the affected part raised
If you have an antihistamine tablet, take one now (not to drive if sedated)

---

**Advice only**

If locally red and hot, apply a cool cloth or ice wrapped in a cloth for 5 minutes at a time
Keep the affected part raised
See your local chemist about taking antihistamines
Your symptoms should settle down within 48 hours If things are getting worse or the area appears infected (red lines tracking up from the bite) then make an appointment to see your GP
Check you are covered for tetanus

---

**Advice**

**If you have antihistamine tablet, take one now (not to drive if sedated)**

---

**Advice only**

**If you have antihistamine tablet, take one now (not to drive if sedated)**

---

**FtF Now**
Airway compromise
Oedema of the tongue
Inadequate breathing
Unable to talk in sentences
Uncontrollable major haemorrhage
Facial oedema
High lethality envenomation

---

**FtF Soon**
Uncontrollable minor haemorrhage
Moderate lethality envenomation
Widespread rash or blistering
Significant history of allergy
Hot

---

**FtF Later**
Widespread rash or blistering:
Try not to scratch the affected area. If you have an antihistamine tablet, take one now (not to drive if sedated)

---

**Advice**

**Airway compromise**
**Oedema of the tongue**
**Inadequate breathing**
**Unable to talk in sentences**
**Uncontrollable major haemorrhage**
**Facial oedema**
**High lethality envenomation**
**Bites and stings**

See also | Chart notes
---|---
Abscesses and local infections | This is a presentation-defined flow diagram designed to allow accurate prioritisation of patients who present following bites and stings. Bites may, of course, range from those delivered by insects to those delivered by large animals; therefore there is a complete range of priority covered by this presentation. A number of general discriminators are used including *Life Threat*, *Haemorrhage* and *Pain*. Specific discriminators have been added to the chart to allow accurate identification of patients who need immediate treatment because of more severe injury or the development of allergic reactions.

Allergy

**Specific discriminators** | **Explanation**
---|---
Oedema of the tongue | Swelling of the tongue of any degree
Unable to talk in sentences | Patients who are so breathless that they cannot complete relatively short sentences in one breath
Facial oedema | Diffuse swelling around the face usually involving the lips
High lethality envenomation | Lethality is the potential of the envenomation to cause harm. Local knowledge may allow identification of the venomous creature, but advice may be required. If in doubt, assume a high risk
Moderate lethality envenomation | Lethality is the potential of the envenomation to cause harm. Local knowledge may allow identification of the venomous creature, but advice may be required
Widespread rash or blistering | Any discharging or blistering eruption covering more than 10% body surface area
Significant history of allergy | A known sensitivity with severe reaction (e.g. to nuts or bee sting) is significant
Local inflammation | Local inflammation will involve pain, swelling and redness confined to a particular site or area
Airway compromise, inadequate breathing or shock:
- if unconscious place in the recovery position, if conscious try to reassure

Acutely short of breath, unable to talk in sentences:
- if possible sit down and lean slightly forward
- Irrigate injured area with water (preferably running water) for 20 minutes

Provide Life Support Advice if required
- Take available analgesia for pain control
- Irrigate injured area with water (preferably running water) for 20 minutes
- Do not apply creams

Remove jewellery if in direct contact with burn
- Irrigate injured area with water (preferably running water) for 20 minutes if necessary
- Apply clean dry non-adherent dressing – primary care for change
- Do not burst blisters
- Take available analgesia for pain control
- Seek advice from pharmacist for otc creams
- See GP if symptoms worsen or concerned

Airway compromise
- Inadequate breathing
- Inhalational injury
- Acutely short of breath
- Altered conscious level
- High lethality chemical
- Significant mechanism of injury
- Severe pain

Smoke exposure
- Electrical injury
- Moderate lethality chemical

Local inflammation
- Unresolved pain

Remove jewellery if in direct contact with burn
- Take paracetamol qds control
- Take ibuprofen tds if required
- Pharmacy advice for localised treatment
- Call back if symptoms worsen
Burns and scalds

Chart notes

This is a presentation-defined flow diagram. There is a complete range of severity with this presentation and the chart has been designed to allow accurate identification of patients within each category. A number of general discriminators are used including Life Threat, Conscious Level and Pain. Specific discriminators have been added to allow identification of patients who have suffered inhalational injury and those in whom the mechanism suggests that further investigation and treatment may be appropriate.

<table>
<thead>
<tr>
<th>Specific discriminators</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inhalational injury</td>
<td>A history of being confined in a smoke-filled space is the most reliable indicator of smoke inhalation. Carbon deposits around the mouth and nose and hoarse voice may present. History is also the most reliable way of diagnosing inhalation of chemicals – there will not necessarily be any signs.</td>
</tr>
<tr>
<td>Acutely short of breath</td>
<td>Shortness of breath that comes on suddenly or a sudden exacerbation of chronic shortness of breath.</td>
</tr>
<tr>
<td>High lethality chemical</td>
<td>Lethality is the potential of the chemical to cause harm. Advice may be required to establish the level of risk. If in doubt, assume a high risk.</td>
</tr>
<tr>
<td>Significant mechanism of injury</td>
<td>Penetrating injuries (stab or gunshot) and injuries with high energy transfer.</td>
</tr>
<tr>
<td>Smoke exposure</td>
<td>Smoke inhalation should be assumed if the patient has been confined in a smoke-filled space. Physical signs such as oral or nasal soot are less reliable but significant if present.</td>
</tr>
<tr>
<td>Electrical injury</td>
<td>Any injury caused or possibly caused by electric current. This includes AC and DC and both artificial and natural sources.</td>
</tr>
<tr>
<td>Moderate lethality chemical</td>
<td>Lethality is the potential of the chemical to cause harm. Advice may be required to establish the level of risk. If in doubt, assume a high risk.</td>
</tr>
<tr>
<td>Local inflammation</td>
<td>Local inflammation will involve pain, swelling and redness confined to a particular site or area.</td>
</tr>
</tbody>
</table>
Chemical Exposure

- **Advice**
  - Provide Life Support Advice if required
  - Take available analgesics for pain control
  - Maintain own safety. It may be necessary to withdraw from the patient if risk of harm
  - Irrigate injured area with water until help arrives
  - Remove patient from contamination if possible

- **FtF Now**
  - Airway compromise
  - Oedema of the tongue
  - Stridor
  - Inadequate breathing
  - Altered conscious level
  - Currently fitting
  - Acute chemical eye injury
  - Facial oedema
  - High lethality chemical
  - Risk of continued contamination
  - Severe pain

- **FtF Soon**
  - Widespread discharge or blistering
  - Moderate lethality chemical

- **FtF Later**
  - Unresolved pain
  - Recent problem

- **Advice only**
  - Call back if symptoms worsen, change or persist

- **FtF Later**
  - Call back if symptoms worsen or new symptoms develop
Chemical exposure

See also

Overdose and poisoning
Shortness of breath in adults
Shortness of breath in children

Chart notes

This is a presentation-defined flow diagram. While this presentation is not common, it is important because it is often the chief complaint of the patient. The signs and symptoms do not necessarily fit easily into any other presentational group. A number of general discriminators are used including Life Threat, Conscious Level and Pain. Specific discriminators which include those for the shortness of breath have been added to appropriate categories. Acute Chemical Eye Injury and Risk of Continued Contamination appear in the ‘face to face Now’ category.

Specific discriminators

<table>
<thead>
<tr>
<th>Discriminator</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oedema of the tongue</td>
<td>Swelling of the tongue of any degree</td>
</tr>
<tr>
<td>Stridor</td>
<td>This may be an inspiratory or expiratory noise or both. Stridor is heard best on breathing with the mouth open</td>
</tr>
<tr>
<td>Acute chemical eye injury</td>
<td>Any substance splashed into or placed into the eye within the past 24 hours that caused stinging, burning or reduced vision should be assumed to have caused chemical injury</td>
</tr>
<tr>
<td>Facial oedema</td>
<td>Diffuse swelling around the face usually involving the lips</td>
</tr>
<tr>
<td>High lethality chemical</td>
<td>Lethality is the potential of the chemical to cause harm. Advice may be required to establish the level of risk. If in doubt, assume high risk</td>
</tr>
<tr>
<td>Risk of continued contamination</td>
<td>If chemical exposure is likely to continue (usually due to lack of adequate decontamination), then this discriminator applies. Risks to health care workers must not be forgotten if this situation occurs</td>
</tr>
<tr>
<td>Widespread discharge or blistering</td>
<td>Any discharging or blistering eruption covering more than 10% body surface area</td>
</tr>
<tr>
<td>Moderate lethality chemical</td>
<td>Lethality is the potential of the chemical to cause harm. Advice may be required to establish the level of risk. If in doubt, assume high risk</td>
</tr>
</tbody>
</table>
Airway compromise, inadequate breathing or shock:
if unconscious place in the recovery position, if conscious try to reassure

Acutely short of breath, unable to talk in sentences:
if possible sit down and lean slightly forward
Provide Life Support Advice if required
If suspicion of cardiac origin, take aspirin and GTN if available
Take available analgesia for pain control

Take available analgesia for pain control
Maintain hydration with clear fluids or oral rehydration therapy
Call back if symptoms worsen or concerned

Take available analgesia for pain control
See pharmacist for advice re pain relief (if muscular) cough linctus, etc.
Call back if symptoms worsen, concerned or new symptoms develop

Call back if symptoms worsen, change or persist
Pharmacist pain relief (if muscular) cough linctus, etc
Lifestyle advice – smoking cessation
Maintain fluid intake
GP if symptomatic of LRTI
Chest pain

Chart notes

This is a presentation-defined flow diagram. Chest pain is a common presentation. Causes of chest pain may vary from acute myocardial infarction to muscular irritation, and appropriate categorisation is paramount. A number of general discriminators are used including Life Threat and Pain. Specific discriminators include the nature and severity of pain (cardiac or pleuritic).

<table>
<thead>
<tr>
<th>Specific discriminators</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Acutely short of breath</td>
<td>Shortness of breath that comes on suddenly or a sudden exacerbation of chronic shortness of breath</td>
</tr>
<tr>
<td>Cardiac pain</td>
<td>Classically a severe dull ‘gripping’ or ‘heavy’ pain in the centre of the chest, radiating to the left arm or to the neck. May be associated with sweating and nausea</td>
</tr>
<tr>
<td>Persistent vomiting</td>
<td>Vomiting that is continuous or that occurs without any respite between episodes</td>
</tr>
<tr>
<td>Pleuritic pain</td>
<td>A sharp, localised pain in the chest that worsens on breathing, coughing or sneezing</td>
</tr>
<tr>
<td>Significant cardiac history</td>
<td>A known recurrent dysrhythmia which has life-threatening effects is significant, as is a known cardiac condition that may deteriorate rapidly</td>
</tr>
</tbody>
</table>
Airway compromise, inadequate breathing or shock:
- If unconscious place in the recovery position, if conscious try to reassure
- Provide Life Support Advice if required
- Take available analgesia for pain control

Take available analgesia for pain control/temperature
- If new deformity, immobilise the affected body parts
- Call back if symptoms worsen or concerned
- Keep warm

Recent problem
- Unresolved swelling
- Unresolved pain

Advice

Airway compromise
- Inadequate breathing
- Altered conscious level
- New neurological deficit less than 24 hours
- Currently fitting
- Non-blanching rash
- Very hot
- Cardiac pain
- Severe pain

Collapse Adult

History of unconsciousness
- New neurological deficit more than 24 hours
- Significant history of allergy
- Hot
- Cold
- Deformity

Advice only

Call back if symptoms worsen
- Consider causes/triggers
- See GP if symptoms persist

Advice
Collapsed adult

**See also**  
Apparently drunk
Falls
Fits
Unwell adult

**Chart notes**  
This is a presentation-defined flow diagram. Presentation with collapse is not uncommon and this chart is designed to allow rapid triage of patients who present in this way. A number of general discriminators are used including Life Threat, Conscious Level, Pain and Temperature. Specific discriminators have been added to the chart to try and rule out more serious pathology. As with all charts, those pathologies (such as myocardial infarction) which can potentially benefit from early intervention are deliberately categorised highly.

<table>
<thead>
<tr>
<th>Specific discriminators</th>
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</tr>
</thead>
<tbody>
<tr>
<td>New neurological deficit less than 24 hours</td>
<td>Any loss of neurological function that has come on within the previous 24 hours. This might include altered or lost sensation, weakness of the limbs (either transiently or permanently) and alterations in bladder or bowel function.</td>
</tr>
<tr>
<td>Non-blanching rash</td>
<td>A rash that does not blanch (go white) when pressure is applied to it. Often tested using a glass tumbler to apply pressure as any colour change can be observed through the bottom of the tumbler.</td>
</tr>
<tr>
<td>Cardiac pain</td>
<td>Classically a severe dull ‘gripping’ or ‘heavy’ pain in the centre of the chest, radiating to the left arm or to the neck. May be associated with sweating and nausea.</td>
</tr>
<tr>
<td>New neurological deficit more than 24 hours</td>
<td>Any loss of neurological function including altered or lost sensation, weakness of the limbs (either transiently or permanently) and alterations in bladder or bowel function.</td>
</tr>
<tr>
<td>Significant history of allergy</td>
<td>A known sensitivity with severe reaction (e.g. to nuts or bee sting) is significant.</td>
</tr>
<tr>
<td>Deformity</td>
<td>This will always be subjective. Abnormal angulation or rotation is implied.</td>
</tr>
</tbody>
</table>
Airway compromise, inadequate breathing or shock:
if unconscious place in the recovery position, if conscious try to reassure

Acutely short of breath, unable to talk in sentences, very low PEFR:
if possible sit down and lean slightly forward. Take a nebuliser if available
Provide Life Support Advice if required
Give available analgesia for pain control

Give available analgesia for pain control/paracetamol for temperature
Reassure caller
Call back if symptoms worsen or concerned

Alert caller to red flags – symptoms of meningitis
Discuss causes of crying such as hunger, tiredness, colic, wind, soiled nappy, hot or cold
Check causes above – work through
Discuss approach to management of baby
Contact health visitor (over 10 days old) or midwife (up to 10 days old)
Call back if symptoms worsen, concerned or new symptoms develop

Alert caller to red flags – symptoms of meningitis
Discuss causes of crying such as hunger, tiredness, colic, wind, soiled nappy, hot or cold
Check causes above – work through
Discuss approach to management of baby
Contact health visitor (over 10 days old) or midwife (up to 10 days old)
Crying baby

<table>
<thead>
<tr>
<th>See also</th>
<th>Chart notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unwell child</td>
<td>This is a presentation-defined flow diagram. This chart has been designed to allow accurate prioritisation of children who are presented by their parents with a chief complaint of crying. A number of general discriminators have been used including Life Threat, Conscious Level and Pain. Specific discriminators include those which allow recognition of more specific pathologies such as septicaemia or which indicate that a more serious pathology might exist. For any child aged 28 days or under, the unwell newborn chart should be used.</td>
</tr>
<tr>
<td>Worried parent</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specific discriminators</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Floppy</td>
<td>Parents may describe their children as floppy. Tone is generally reduced – the most noticeable sign is often lolling of the head.</td>
</tr>
<tr>
<td>Non-blanching rash</td>
<td>A rash that does not blanch (go white) when pressure is applied to it. Often tested using a glass tumbler to apply pressure as any colour change can be observed through the bottom of the tumbler.</td>
</tr>
<tr>
<td>Signs of severe pain</td>
<td>Young children and babies in severe pain cannot complain. They will usually cry out continuously and inconsolably and be tachycardic. They may well exhibit signs such as pallor and sweating.</td>
</tr>
<tr>
<td>Unable to feed</td>
<td>This is usually reported by the parents. Children who will not take any solid or liquid (as appropriate) by mouth.</td>
</tr>
<tr>
<td>Inconsolable by parents</td>
<td>Children whose crying or distress does not respond to attempts by their parents to comfort them fulfil this criterion.</td>
</tr>
<tr>
<td>Prolonged or uninterrupted crying</td>
<td>A child who has cried continuously for 2 hours or more fulfils this criteria.</td>
</tr>
<tr>
<td>Atypical behaviour</td>
<td>A child who behaves in a way that is not usual in the given situation. The carers will often volunteer this information. Such children are often referred to as fractious or ‘out of sorts’</td>
</tr>
</tbody>
</table>
**Dental Problems**

**FtF Now**
- Airway compromise, inadequate breathing or shock:
  - if unconscious place in the recovery position, if conscious try to reassure
  - Provide Life Support Advice if required
  - Take available analgesia for pain control
  - Apply pressure to stem bleeding

**FtF Soon**
- Acutely avulsed tooth
  - Uncontrollable minor haemorrhage
  - Apply pressure to stem bleeding
  - For avulsed teeth – rinse with water and place in cup of milk/water/contact lens fluid and refer emergency dentist
  - Refer emergency dentist if antibiotics required
  - Call back if symptoms worsen or concerned

**FtF Later**
- Unresolved pain
  - Recent problem

**Advice only**
- Take paracetamol qds for pain control
  - Take ibuprofen tds if required
  - Refer to dentist or emergency dental service if symptoms worsen or persist
### Dental problems

<table>
<thead>
<tr>
<th>See also</th>
<th>Chart notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facial problems</td>
<td>This is a presentation-defined flow diagram designed to allow accurate prioritisation of patients presenting problems affecting teeth or gums. A number of general discriminators have been used including <em>Life Threat</em>, <em>Pain</em>, <em>Haemorrhage</em> and <em>Temperature</em>. Acute avulsion of a tooth has been included in the very urgent ‘face to face Soon’ category since speed of reimplantation affects outcome</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specific discriminators</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acutely avulsed tooth</td>
<td>A tooth that has been avulsed intact within the previous 24 hours</td>
</tr>
</tbody>
</table>
Airway compromise, inadequate breathing or shock:
- If unconscious place in the recovery position, if conscious try to reassure
- Provide Life Support Advice if required
- Take available analgesia for pain control
- Check blood glucose
  - If hypoglycaemic and managing airway, give oral carbohydrates

Hyperglycaemia Persistent vomiting Hot

Loss of glucose control

Contact GP/practice/diabetic nurse for review
- Monitor/control blood sugar levels
- Lifestyle advice – diet, active, smoking, weight, eye check ups
- Diabetes.org.uk
- Call back if symptoms worsen, concerned or new symptoms develop

Diabetes.org.uk
Call back if symptoms worsen or persist
Diabetes

Chart notes

This is a presentation-defined flow diagram designed to allow categorisation of known diabetic patients. A number of general discriminators are used including Life Threat, Conscious Level, Blood Glucose Level and Temperature

<table>
<thead>
<tr>
<th>Specific discriminators</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hyperglycaemia</td>
<td>Glucose greater than 17 mmol/l</td>
</tr>
</tbody>
</table>
**Diarrhoea and Vomiting**

**FtF Now**
- Airway compromise
- Inadequate breathing
- Floppy or unresponsive child
- Altered conscious level
- Fails to react to parents
- Vomiting blood
- Passing fresh or altered blood PR
- Hot baby
- Very hot
- Severe pain

**FtF Soon**
- History of acutely vomiting blood
- Black or red currant stools
- Persistent vomiting
- Hot
- Signs of dehydration

**FtF Later**
- Unresolved vomiting
- Unresolved pain
- Recent problem

**Advice only**

**Maintain clear fluid intake** — monitor urine output especially in elderly and young
- Paracetamol for stomach cramps
- Continue feeding babies
- Encourage carbohydrate-rich diet as symptoms resolve
- See pharmacist — re oral rehydration therapy medications
- Lifestyle advice — hygiene
- Call back if symptoms worsen, concerned or if symptoms develop

**Advice**

**Diagnosis**
- Airway compromise
- Inadequate breathing
- Floppy or unresponsive child
- Altered conscious level
- Fails to react to parents
- Vomiting blood
- Passing fresh or altered blood PR
- Hot baby
- Very hot
- Severe pain

**Steps**
- If unconscious place in the recovery position, if conscious try to reassure
- Provide Life Support Advice if required
- Take available analgesia for pain control
- Keep sample of vomit if possible

**Diagnosis**
- History of acutely vomiting blood
- Black or red currant stools
- Persistent vomiting
- Hot
- Signs of dehydration

**Steps**
- Keep sample of vomit/stool if history of fresh/altered blood
- Maintain hydration with clear fluids or oral rehydration therapy
- Call back if symptoms worsen or concerned

**Diagnosis**
- Unresolved vomiting
- Unresolved pain
- Recent problem

**Steps**
- Maintain hydration with clear fluids or oral rehydration therapy
- Take available analgesia for pain control
- Encourage carbohydrate rich diet as symptoms resolve
- See pharmacist — re oral rehydration therapy medications
- Lifestyle advice — hygiene
- Call back or see GP if symptoms worsen, concerned or if symptoms develop

**Diagnosis**
- Maintain clear fluid intake — monitor urine output especially in elderly and young
- Paracetamol for stomach cramps
- Continue feeding babies
- Encourage carbohydrate-rich diet as symptoms resolve
- See pharmacist — re oral rehydration therapy medications
- Lifestyle advice — hygiene
- Call back if symptoms worsen or persist
Diarrhoea and vomiting

**See also**
- Abdominal pain in adults
- Abdominal pain in children
- GI bleeding

**Chart notes**
This is a presentation-defined flow diagram. Most patients who present with diarrhoea or vomiting do not have high priority. However, a number may have serious underlying pathology. A number of general discriminators are used including Life Threat and Pain. Specific discriminators have been included to ensure that patients suffering from GI bleeding and those with dehydration and other severe effects of diarrhoea and vomiting are included in the appropriate categories.

<table>
<thead>
<tr>
<th>Specific discriminators</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Floppy</td>
<td>Parents may describe their children as floppy. Tone is generally reduced – the most noticeable sign is often lolling of the head</td>
</tr>
<tr>
<td>Fails to react to parents</td>
<td>Failure to react in any way to a parents’ face or voice. Abnormal reactions and apparent lack of recognition of a parent are also worrying signs</td>
</tr>
<tr>
<td>Vomiting blood</td>
<td>Vomited blood may be fresh (bright or dark red) or coffee ground in appearance</td>
</tr>
<tr>
<td>Passing fresh or altered blood PR</td>
<td>In active massive GI bleeding, dark red blood will be passed PR. As GI transit time increases, this becomes darker, eventually becoming melaena</td>
</tr>
<tr>
<td>History of acutely vomiting blood</td>
<td>Frank haematemesis, vomiting of altered blood (coffee ground) or of blood mixed in the vomit within the past 24 hours</td>
</tr>
<tr>
<td>Black or redcurrant stools</td>
<td>Any blackness fulfills the criteria of black stool while a dark red stool, classically seen in intussusceptions, is redcurrant stool</td>
</tr>
<tr>
<td>Persistent vomiting</td>
<td>Vomiting that is continuous or that occurs without any respite between episodes</td>
</tr>
<tr>
<td>Signs of dehydration</td>
<td>These include dry tongue, sunken eyes, increased skin turgor and, in small babies, a sunken anterior fontanelle. Usually associated with a low urine output</td>
</tr>
</tbody>
</table>
Ear Problems

Airway compromise, inadequate breathing or shock:
- If unconscious place in the recovery position, if conscious try to reassure
- Provide Life Support Advice if required
- Take available analgesia for pain control

Apply direct pressure for uncontrolled and minor haemorrhage
- Minor head injury advice
- Take available analgesia for pain control
- Apply dressing or pressure required to stem bleeding
- Call back if symptoms worsen or concerned

Do not pack or plug the ear
- Suitable analgesia
- Do not insert anything into ear canal
- Take available analgesia for pain/temperature control
- Call back or see GP if symptoms worsen, concerned or new symptoms develop

Airway compromise
Inadequate breathing
Altered conscious level
Uncontrollable major haemorrhage
Hot baby
Severe pain

Uncontrollable minor haemorrhage
History of head injury
Persistent vomiting
Auricular haematoma

Vertigo
Recent hearing loss
Warmth
Untreated pain
Recent problem

Advice only

Do not insert anything into ear canal
- Take paracetamol qds for pain control
- Take ibuprofen tds if required
- See GP if symptoms persist
- Ear infection usually self resolve within 7–10 days
- Call back if symptoms worsen or persist
Ear problems

See also  Chart notes
Facial problems  This is a presentation-defined flow diagram designed to allow
Head injury  accurate prioritisation of patients presenting with conditions
  affecting the ear. A number of general discriminators are used
  including Life Threat, Pain, Haemorrhage and Temperature

<table>
<thead>
<tr>
<th>Specific discriminators</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of head injury</td>
<td>A history of a recent physically traumatic event involving the head. Usually this will be reported by the patient, but if the patient has been unconscious, this history should be sought from a reliable witness</td>
</tr>
<tr>
<td>Persistent vomiting</td>
<td>Vomiting that is continuous or that occurs without any respite between episodes</td>
</tr>
<tr>
<td>Auricular haematoma</td>
<td>A tense haematoma (usually post traumatic) in the outer ear</td>
</tr>
<tr>
<td>Vertigo</td>
<td>An acute feeling of spinning or dizziness, possibly accompanied by nausea and vomiting</td>
</tr>
<tr>
<td>Recent hearing loss</td>
<td>Loss of hearing in one or both ears within the previous week</td>
</tr>
</tbody>
</table>
For chemical injury, irrigate with copious amounts of water. Don’t get stuff from the bad eye into the good eye. Provide Life Support Advice if required. Take available analgesia for pain control.

For chemical injuries, immediately irrigate the eye with clean water (this can be easier using a shower if available) until assistance arrives. For alkali or hydrofluoric acid burns, continue to irrigate eye until crew arrive or you reach the ED.

If altered vision, do not use machinery or drive. Avoid touching or rubbing the eye. Take available analgesia for pain control. Call back if symptoms worsen or concerned.

Take available analgesia for pain control. See GP or optometrist if symptoms persist. Call back if symptoms worsen or new symptoms develop.

Your local pharmacist may be able to offer some medication or advice. Hygiene advice. Contact lenses should not be worn until symptoms subside. For allergic reactions, try antihistamines and avoid the irritant if known. See a doctor if the eye becomes more inflamed in the next couple of days. See GP or optometrist if symptoms persist.
### Eye problems

<table>
<thead>
<tr>
<th>See also</th>
<th>Chart notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facial problems</td>
<td>This is a presentation-defined flow diagram designed to allow accurate prioritisation of patients attending with conditions affecting the eye. A number of specific discriminators have been used including Acute Chemical injury, which indicates that immediate action is required, Penetrating eye injury and Acute complete loss of vision</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specific discriminators</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute chemical eye injury</td>
<td>Any substance splashed into or placed into the eye within the past 12 hours that caused stinging, burning or reduced vision should be assumed to have caused chemical injury</td>
</tr>
<tr>
<td>Penetrating eye injury</td>
<td>A recent physically traumatic event involving penetration of the globe</td>
</tr>
<tr>
<td>Acute complete loss of vision</td>
<td>Loss of vision in one or both eyes within the preceding 24 hours which has not returned to normal</td>
</tr>
<tr>
<td>Recent reduced visual acuity</td>
<td>Any reduction in corrected visual acuity within the past 7 days</td>
</tr>
<tr>
<td>Foreign body sensation</td>
<td>A sensation of something in the eye, often expressed as scraping or grittiness</td>
</tr>
<tr>
<td>Diplopia</td>
<td>Double vision which resolves when one eye is closed</td>
</tr>
<tr>
<td>Red eye</td>
<td>Any redness to the eye. A red eye may be painful or painless and may be complete or partial</td>
</tr>
</tbody>
</table>
Airway compromise, inadequate breathing or shock:
- If unconscious, place in the recovery position, if conscious try to reassure.
- Provide Life Support Advice if required.
- Take available analgesia for pain control.
- Apply pressure appropriate to injury to control major haemorrhage.

Facial Problems

Airway compromise
Inadequate breathing
Uncontrollable major haemorrhage
Altered conscious level
New neurological deficit less than 24 hours
Very hot
Severe pain

FtF Now

Uncontrollable minor haemorrhage
New neurological deficit more than 24 hours
Gross deformity
Recently reduced visual acuity
Acutely avulsed tooth
History of unconsciousness
Auricular haematoma
Diplopia

FtF Soon

Altered facial sensation
Red eye
Unresolved pain
Recent problem

FtF Later

Suitable analgesia
- Apply direct pressure for uncontrolled and minor haemorrhage.
- If tooth avulsed then rinse mouth with water. Place tooth the right way up back in socket. If tooth won’t go in bring tooth to hospital in saline, contact lens solution or milk.
- Call back if symptoms worsen or new symptoms develop.

Take available analgesia for pain control
- Red eye – see GP or pharmacy for advice.
- Seek dental or GP advice if cause of swelling maybe an abscess.
- Call back if symptoms worsen or new symptoms develop.

Suitable analgesia
- If things are getting worse or didn’t get better call back or contact your doctor.
- Ice pack to reduce swelling.
- Take paracetamol qds for pain control.
- Take ibuprofen tds if required.
- Call GP if symptoms persist.
**Facial problems**

<table>
<thead>
<tr>
<th>See also</th>
<th>Chart notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental problems</td>
<td>This presentation-defined flow diagram has been designed to allow accurate prioritisation of patients presenting with problems affecting the face. A number of general discriminators have been used including Life Threat, Haemorrhage and Pain</td>
</tr>
<tr>
<td>Ear problems</td>
<td></td>
</tr>
<tr>
<td>Eye problems</td>
<td></td>
</tr>
<tr>
<td>Head injury</td>
<td></td>
</tr>
</tbody>
</table>

**Specific discriminators**

<table>
<thead>
<tr>
<th>Specific discriminators</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>New neurological deficit less than 24 hours</td>
<td>Any loss of neurological function that has come on within the previous 24 hours. This might include altered or lost sensation, weakness of the limbs (either transiently or permanently) and alterations in bladder or bowel function</td>
</tr>
<tr>
<td>New neurological deficit more than 24 hours</td>
<td>Any loss of neurological function including altered or lost sensation, weakness of the limbs (either transiently or permanently) and alterations in bladder or bowel function</td>
</tr>
<tr>
<td>Gross deformity</td>
<td>This will always be subjective. Gross and abnormal angulation or rotation is implied</td>
</tr>
<tr>
<td>Recent reduced visual acuity</td>
<td>Any reduction in corrected visual acuity within the past 7 days</td>
</tr>
<tr>
<td>Acutely avulsed tooth</td>
<td>A tooth that has been avulsed intact within the previous 24 hours</td>
</tr>
<tr>
<td>Auricular haematoma</td>
<td>A tense haematoma (usually post traumatic) in the outer ear</td>
</tr>
<tr>
<td>Diplopia</td>
<td>Double vision which resolves when one eye is closed</td>
</tr>
<tr>
<td>Altered facial sensation</td>
<td>Any alteration of sensation on the face</td>
</tr>
<tr>
<td>Red eye</td>
<td>Any redness to the eye. A red eye may be painful or painless and may be complete or partial</td>
</tr>
</tbody>
</table>
Airway compromise, inadequate breathing or shock:
- if unconscious place in the recovery position, if conscious try to reassure
- Provide Life Support Advice if required
- If significant MOI, keep the patient still
- Apply pressure appropriate to injury to control major haemorrhage
- For open fracture advise clean dressing to cover exposed area
- Do not apply direct pressure to open fracture
- Take available analgesia for pain control

Uncontrollable minor haemorrhage
- New neurological deficit more than 24 hours
- History of unconsciousness
- Deformity

Unresolved pain
- Swelling
- Recent problem

Take available analgesia for pain control
- Rest, ice, compression, elevation
- Refer to appropriate agency
- Call back if symptoms worsen, concerned or new symptoms develop

Take paracetamol qds for pain control
- Take ibuprofen tds if required
- Refer to falls teams, age concern, RoSPA
- Environmental – lighting, flooring, carpets, footwear, obstacles on stairs
- Call back if new symptoms develop

Advice
- Falls

PtF Now
- Airway compromise
- Inadequate breathing
- Currently fitting
- Altered conscious level
- Uncontrollable major haemorrhage
- New neurological deficit less than 24 hours
- Significant mechanism of injury
- Open fracture
- Severe pain

PtF Soon
- Uncontrollable minor haemorrhage
- New neurological deficit more than 24 hours
- History of unconsciousness
- Deformity

PtF Later
- Unresolved pain
- Swelling
- Recent problem

Advice only
### Falls

**See also**

<table>
<thead>
<tr>
<th>Collapsed adult</th>
<th>Chart notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>This is a presentation-defined flow diagram. Many patients who present with a history of falls have suffered trauma as a result, and their priority will reflect the injuries suffered. Some, however, may have had a serious underlying pathology which has caused them to fall or may have developed complications after falling. This chart is designed to allow accurate prioritisation whether the injury or underlying cause is more pressing. A number of general discriminators have been included to ensure that patients suffering from serious underlying conditions or limb-threatening injuries are given a high priority</td>
</tr>
</tbody>
</table>

**Specific discriminators**

<table>
<thead>
<tr>
<th>Discriminator</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>New acute neurological deficit less than 24 hours</td>
<td>Any loss of neurological function that has come on within the previous 24 hours. This might include altered or lost sensation, weakness of the limbs (either transiently or permanently) and alterations in bladder or bowel function</td>
</tr>
<tr>
<td>Significant mechanism of injury</td>
<td>Penetrating injuries (stab or gunshot) and injuries with high energy transfer</td>
</tr>
<tr>
<td>Open fracture</td>
<td>All wounds in the vicinity of a fracture should be regarded with suspicion. If there is any possibility of communication between the wound and the fracture, then the fracture should be assumed to be open</td>
</tr>
<tr>
<td>New neurological deficit more than 24 hours</td>
<td>Any loss of neurological function including altered or lost sensation, weakness of the limbs (either transiently or permanently) and alterations in bladder or bowel function</td>
</tr>
<tr>
<td>Deformity</td>
<td>This will always be subjective. Abnormal angulation or rotation is implied</td>
</tr>
<tr>
<td>Swelling</td>
<td>An abnormal increase in size</td>
</tr>
</tbody>
</table>
Airway compromise, inadequate breathing or shock:
if unconscious place in the recovery position, if conscious try to reassure

Acutely short of breath, unable to talk in sentences, very low PEFR:
if possible sit down and lean slightly forward. Take a nebuliser if available
Provide Life Support Advice if required
Do not leave alone until fully recovered
Take available analgesia for pain control

If patient has taken overdose please collect all packaging for the crew/ED
Do not leave alone until fully recovered
Call back if symptoms worsen or new symptoms develop.

Take available analgesia for pain control
Rest in quiet area
Avoid alcohol
Call back if symptoms worsen or new symptoms develop

Advice only
Rest in quiet area
Avoid alcohol
Analgesia for headache
Inform GP
Call back immediately if fitting recurs
Fits

See also

Head injury
Headache
Overdose and poisoning

Chart notes
This is a presentation-defined flow diagram. The chart is designed to allow rapid categorisation of patients who are currently fitting or who have fitted. A number of general discriminators are used including Life Threat, Conscious Level and Temperature. Specific discriminators include Signs of meningism and a focal or progressive loss of function.

Specific discriminators

Currently fitting
New neurological deficit less than 24 hours
Signs of meningism
Non-blanching rash
New neurological deficit more than 24 hours
History of head injury
History of overdose or poisoning

Explanation
Patients who are in the tonic or clonic stages of a grand mal convulsion and patients currently experiencing partial fits fulfil this criterion.
Any loss of neurological function that has come on within the previous 24 hours. This might include altered or lost sensation, weakness of the limbs (either transiently or permanently) and alterations in bladder or bowel function.
Classically a stiff neck together with headache and photophobia.
A rash that does not blanch (go white) when pressure is applied to it. Often tested using a glass tumbler to apply pressure as any colour change can be observed through the bottom of the tumbler.
Any loss of neurological function including altered or lost sensation, weakness of the limbs (either transiently or permanently) and alterations in bladder or bowel function.
A history of a recent physically traumatic event involving the head. Usually this will be reported by the patient, but if the patient has been unconscious, this history should be sought from a reliable witness.
This information may come from others or may be deduced if medication is missing.
Airway compromise, inadequate breathing or shock:
if unconscious place in the recovery position, if conscious try to reassure

Acutely short of breath, unable to talk in sentences:
if possible sit down and lean slightly forward
Provide Life Support Advice if required
if significant mechanism of injury, keep the patient still
Apply pressure appropriate to injury to control major haemorrhage
Take available analgesia for pain control

Take available analgesia for pain control
Apply dressing or pressure if required to stem bleeding
Call back if symptoms worsen

Refer to Emergency Department/Urgent Care Centre if suspicion of swallowed/inhaled foreign body

Foreign Body

Airway compromise
Stridor
Inadequate breathing
Uncontrollable major haemorrhage
Altered conscious level
Penetrating eye injury
Significant mechanism of injury
Severe pain

FtF Now

Uncontrollable minor haemorrhage

FtF Soon

Local inflammation
Red eye
Swelling
Unresolved pain

FtF Later

Advice

Advice

Advice

Advice Only
### Foreign body

**See also**

<table>
<thead>
<tr>
<th>Wounds</th>
<th>Chart notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Torso injury</td>
<td>This is a presentation-defined flow diagram designed to allow accurate prioritisation of patients who present with foreign bodies in any part of their anatomy. The severity of such cases can range from the inconvenient to the life-threatening and this chart is designed to differentiate between these. A number of general discriminators have been used including <em>Life Threat, Haemorrhage</em> and <em>Pain</em>. The only specific discriminator that relates to anatomical site is that of <em>Penetrating Eye Injury</em>.</td>
</tr>
</tbody>
</table>

### Specific discriminators

<table>
<thead>
<tr>
<th>Specific discriminator</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stridor</td>
<td>This may be an inspiratory or expiratory noise or both. <em>Stridor</em> is heard best on breathing with the mouth open</td>
</tr>
<tr>
<td>Penetrating eye injury</td>
<td>A recent physically traumatic event involving penetration of the globe</td>
</tr>
<tr>
<td>Significant mechanism of injury</td>
<td>Penetrating injuries (stab or gunshot) and injuries with high energy transfer</td>
</tr>
<tr>
<td>Local inflammation</td>
<td>Local inflammation will involve pain, swelling and redness confined to a particular site or area</td>
</tr>
<tr>
<td>Red eye</td>
<td>Any redness to the eye. A red eye may be painful or painless and may be complete or partial</td>
</tr>
</tbody>
</table>
Airway compromise, inadequate breathing or shock:
- If unconscious place in the recovery position, if conscious try to reassure
- Provide life support advice if required
- Keep sample of vomit if possible
- Take available analgesia for pain control

Take available analgesia for pain control
- Keep sample of vomit/stools if possible
- Call back if symptoms worsen

Take available analgesia for pain control
- Call back if symptoms worsen or new symptoms develop

Advice only
- Avoid NSAIDs
- See GP if symptoms persist
# GI bleeding

A number of general discriminators are used including *Life Threat* and *Pain*. Specific discriminators have been selected to indicate the current severity of the GI bleeding. Thus patients vomiting blood or those passing fresh or altered blood PR have a higher category than those with a history of vomiting.

<table>
<thead>
<tr>
<th>See also</th>
<th>Chart notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal pain in adults</td>
<td>This is a presentation-defined flow diagram. Patients may present with GI bleeding either as vomiting fresh or altered blood or by passing blood PR. A number of general discriminators are used including <em>Life Threat</em> and <em>Pain</em>. Specific discriminators have been selected to indicate the current severity of the GI bleeding. Thus patients vomiting blood or those passing fresh or altered blood PR have a higher category than those with a history of vomiting</td>
</tr>
<tr>
<td>Abdominal pain in children</td>
<td></td>
</tr>
<tr>
<td>Diarrhoea and vomiting</td>
<td></td>
</tr>
</tbody>
</table>

## Specific discriminators

<table>
<thead>
<tr>
<th>Specific discriminators</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vomiting blood</td>
<td>Vomited blood may be fresh (bright or dark red) or coffee ground in appearance</td>
</tr>
<tr>
<td>Passing fresh or altered blood PR</td>
<td>In active massive GI bleeding, dark red blood will be passed PR. As GI transit time increases, this becomes darker, eventually becoming melaena</td>
</tr>
<tr>
<td>History of acutely vomiting blood</td>
<td>Frank haematemesis, vomiting of altered blood (coffee ground) or of blood mixed in the vomit within the past 24 hours</td>
</tr>
<tr>
<td>Black or redcurrant stools</td>
<td>Any blackness fulfils the criteria of black stool while a dark red stool, classically seen in intussusceptions, is redcurrant stool</td>
</tr>
<tr>
<td>Significant history of GI bleed</td>
<td>Any history of massive GI bleeding or of any GI bleed associated with oesophageal varices</td>
</tr>
<tr>
<td>Bleeding disorder</td>
<td>Congenital or acquired bleeding disorder</td>
</tr>
</tbody>
</table>
Headache

**Airway compromise, inadequate breathing or shock:**
- If unconscious place in the recovery position, if conscious try to reassure
- Provide Life Support Advice if required
- Take available analgesia for pain/temperature control

**New neurological deficit less than 24 hours**
- Altered conscious level
- Signs of meningism
- Non-blanching rash
- Abrupt onset
- Acute complete loss of vision
- Very hot
- Severe pain

**Airway compromise, Inadequate breathing**
- Currently fitting

**Take available analgesia for pain/temperature control**

**New neurological deficit more than 24 hours**
- Persistent vomiting
- History of unconsciousness
- Recent reduced visual acuity
- Temporal scalp tenderness
- Hot

**Unresolved vomiting**
- Pain
- Recent problem

**Take available analgesia for pain control**
- Consider causes – stress, computer, over use of painkillers
- Keep a headache diary
- Consider relaxation techniques
- Clear fluids – avoid dehydration
- Avoid caffeine/alcohol
- Call back if symptoms worsen or new symptoms develop

**Advice only**
- Take paracetamol qds for pain control
- Take ibuprofen tds if required
- Consider causes – stress, computer, over use of painkillers
- Keep a headache diary
- Consider relaxation techniques
- Clear fluids – avoid dehydration
- Avoid caffeine/alcohol
- See GP if symptoms persist
Headache

See also

Head injury
Neck pain

Chart notes

This is a presentation defined-flow diagram. A large number of conditions can present with headache and a number of these require urgent intervention. A number of general discriminators are used including Life Threat, Conscious Level, Pain and Temperature. Specific discriminators have been used to identify severe causes such as subarachnoid haemorrhage and meningococcaemia. New neurological signs or symptoms together with reduction in visual acuity and tenderness of the scalp are used to indicate the need for immediate clinical review.

Specific discriminators

<table>
<thead>
<tr>
<th>Specific discriminator</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>New neurological deficit less than 24 hours</td>
<td>Any loss of neurological function that has come on within the previous 24 hours. This might include altered or lost sensation, weakness of the limbs (either transiently or permanently) and alterations in bladder or bowel function</td>
</tr>
<tr>
<td>Signs of meningism</td>
<td>Classically a stiff neck together with headache and photophobia</td>
</tr>
<tr>
<td>Non-blanching rash</td>
<td>A rash that does not blanch (go white) when pressure is applied to it. Often tested using a glass tumbler to apply pressure as any colour change can be observed through the bottom of the tumbler</td>
</tr>
<tr>
<td>Abrupt onset</td>
<td>Onset within seconds or minutes. May cause waking in sleep</td>
</tr>
<tr>
<td>Acute complete loss of vision</td>
<td>Loss of vision in one or both eyes within the preceding 24 hours which has not returned to normal</td>
</tr>
<tr>
<td>New neurological deficit more than 24 hours</td>
<td>Any loss of neurological function including altered or lost sensation, weakness of the limbs (either transiently or permanently) and alterations in bladder or bowel function</td>
</tr>
<tr>
<td>Recent reduced visual acuity</td>
<td>Any reduction in corrected visual acuity within the past 7 days</td>
</tr>
<tr>
<td>Temporal scalp tenderness</td>
<td>Tenderness on palpation over the temporal area (especially over the artery)</td>
</tr>
<tr>
<td>History of unconsciousness</td>
<td>There may be a reliable witness who can state whether the patient was unconscious (and for how long). If not, a patient who is unable to remember the incident should be assumed to have been unconscious</td>
</tr>
<tr>
<td>Persistent vomiting</td>
<td>Vomiting that is continuous or that occurs without any respite between episodes</td>
</tr>
</tbody>
</table>
Head Injury

Airway compromise, inadequate breathing or shock:
- If unconscious: place in the recovery position, if conscious try to reassure
- Provide Life Support Advice if required
- If significant MOI, keep the patient still
- Apply pressure appropriate to injury to control major haemorrhage
- Take available analgesia for pain control

Airway compromise
Inadequate breathing
Currently fitting
Altered conscious level
Uncontrollable major haemorrhage
New neurological deficit less than 24 hours
Significant mechanism of injury
Severe pain

Advice

Uncontrollable minor haemorrhage
New neurological deficit more than 24 hours
History of unconsciousness
Persistent vomiting
Bleeding disorder

Take available analgesia for pain control
Apply dressing or pressure if required to stem any bleeding
Maintain hydration with clear fluids or oral rehydration therapy
Call back if symptoms worsen

Unresolved vomiting
Unresolved pain

Take available analgesia for pain control
Maintain hydration with clear fluids or oral rehydration therapy
Call back if symptoms worsen or new symptoms develop

Avoid strenuous activity for 48 hours
Avoid alcohol
Call back in event of new symptoms
See GP if symptoms persist
Head injury

See also | Chart notes
---|---
Fits | This is a presentation-defined flow diagram. Head injury is an extremely common presentation and its effects may vary from life-threatening extradural haemorrhage to minimal scalp injury. A number of general discriminators have been used including Life Threat, Conscious Level (both in adults and children), Haemorrhage and Pain. Specific discriminators are included to select those patients with significant mechanism and the development of neurological signs and symptoms, to a higher priority
Headache | 
Neck pain | 

### Specific Discriminators

<table>
<thead>
<tr>
<th>Specific Discriminators</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently fitting</td>
<td>Patients who are in the tonic or clonic stages of a grand mal convolution and patients currently experiencing partial fits fulfil this criterion</td>
</tr>
<tr>
<td>New neurological deficit less than 24 hours</td>
<td>Any loss of neurological function that has come on within the previous 24 hours. This might include altered or lost sensation, weakness of the limbs (either transiently or permanently) and alterations in bladder or bowel function</td>
</tr>
<tr>
<td>Significant mechanism of injury</td>
<td>Penetrating injuries (stab or gunshot) and injuries with high energy transfer</td>
</tr>
<tr>
<td>New neurological deficit more than 24 hours</td>
<td>Any loss of neurological function including altered or lost sensation, weakness of the limbs (either transiently or permanently) and alterations in bladder or bowel function</td>
</tr>
<tr>
<td>History of unconsciousness</td>
<td>There may be a reliable witness who can state whether the patient was unconscious (and for how long). If not, a patient who is unable to remember the incident should be assumed to have been unconscious</td>
</tr>
<tr>
<td>Persistent vomiting</td>
<td>Vomiting that is continuous or that occurs without any respite between episodes</td>
</tr>
<tr>
<td>Bleeding disorder</td>
<td>Congenital or acquired bleeding disorder</td>
</tr>
</tbody>
</table>
Irritable Child

**Airway compromise, inadequate breathing or shock:**
- if unconscious place in the recovery position, if conscious try to reassure
- Provide Life Support Advice if required
- Take available analgesia for pain control

**Take available analgesia for pain control**
- Try to calm and reassure caller as this will help calm the child
- Call back if symptoms worsen

**Take available analgesia for pain control**
- Alert caller to red flags – symptoms of meningitis
- Discuss causes of crying such as hunger, tiredness, colic, wind, soiled nappy, hot or cold
- Check causes above – work through
- Try to calm and reassure caller as this will help calm the child
- Call back if symptoms worsen or new symptoms develop

**Alert caller to red flags – symptoms of meningitis**
- Discuss causes of crying such as hunger, tiredness, colic, wind, soiled nappy, hot or cold
- Discuss approach to management of baby
- Contact health visitor (over 10 days old) or midwife (up to 10 days old)
- See GP if symptoms persist

**Airway compromise**
- Inadequate breathing
- Altered conscious level
- Signs of meningism
- Non-blanching rash
- History of overdose or poisoning
- Hot baby
- Very hot
- Signs of severe pain

**Prolonged or uninterrupted crying**
- Not feeding
- Not distractable
- Hot

**Atypical behaviour**
- Unresolved pain

**Advice only**

**FtF now**

**FtF Soon**

**FtF Later**
## Irritable child

### See also
- Crying baby
- Unwell child
- Worried parent

### Chart notes
This is a presentation-defined flow diagram. It is designed to be used in **children over the age of 12 months**. A number of general discriminators have been used including **Life Threat**, **Conscious Level** and **Pain**. Specific discriminators include those which allow recognition of more specific pathologies such as septicaemia or which indicate that a more serious pathology might exist.

### Specific discriminators

<table>
<thead>
<tr>
<th>Specific discriminator</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signs of meningism</td>
<td>Classically a stiff neck together with headache and photophobia</td>
</tr>
<tr>
<td>Non-blanching rash</td>
<td>A rash that does not blanch (go white) when pressure is applied to it. Often tested using a glass tumbler to apply pressure as any colour change can be observed through the bottom of the tumbler</td>
</tr>
<tr>
<td>History of overdose or poisoning</td>
<td>This information may come from others or may be deduced if medication is missing</td>
</tr>
<tr>
<td>Signs of severe pain</td>
<td>Young children and babies in severe pain cannot complain. They will usually cry out continuously and inconsolably and be tachycardic. They may well exhibit signs such as pallor and sweating</td>
</tr>
<tr>
<td>Prolonged or uninterrupted crying</td>
<td>A child who has cried continuously for 2 hours or more fulfils this criterion</td>
</tr>
<tr>
<td>Not feeding</td>
<td>Children who do not take any solid or liquid (as appropriate) by mouth. Children who take the food but always vomit afterwards may also fulfil this criterion</td>
</tr>
<tr>
<td>Not distractible</td>
<td>Children who are distressed by pain or other things who cannot be distracted by conversation or play fulfil this criterion</td>
</tr>
<tr>
<td>Atypical behaviour</td>
<td>Children who behave in a way that is not usual in the given situation. The carers will often volunteer this information. Such children are often referred to as fractious or ‘out of sorts’</td>
</tr>
</tbody>
</table>
Airway compromise, inadequate breathing or shock:
- if unconscious place in the recovery position, if conscious try to reassure
- Provide Life Support Advice if required

Acutely short of breath, unable to talk in sentences:
- if possible sit down and lean slightly forward
- Apply pressure appropriate to injury to control major haemorrhage
- Open fracture: advise clean dressing to cover exposed area
- Do not apply direct pressure to open fracture
- Take available analgesia for pain control

Take available analgesia for pain control
- If new deformity, immobilise the affected body parts
- Rest, compression, elevation
- Remove jewellery if on affected hand/wrist
- Call back if symptoms worsen

Take available analgesia for pain control
- Remove jewellery if on affected hand/wrist
- Call back or see GP if symptoms worsen or new symptoms develop

Swelling
- Unresolved pain
- Recent problem

Advice only

Take paracetamol qds for pain control
- Take ibuprofen tds if required
- Exercise within pain free range of movement
- See GP if symptoms persist

Advice

Limb Problems

FtF Now

Airway compromise
Inadequate breathing
Uncontrollable major haemorrhage
Vascular compromise
New neurological deficit less than 24 hours
Open fracture
Very hot
Severe pain
Altered conscious level
Hot baby

Take available analgesia for pain control

Advice

FtF Soon

Uncontrollable minor haemorrhage
New neurological deficit more than 24 hours
Bleeding disorder
Deformity
Hot
Pleuritic pain

Advice

FtF Later

Hot baby

Advice

Unresolved pain
Recent problem

Advice

90 Presentational flow charts
## Limb problems

### See also

**Limping child**

This is a presentation-defined flow diagram. Injuries to the limbs, while rarely life-threatening, may cause considerable morbidity. A number of general discriminators are used including *Life Threat, Haemorrhage* and *Pain*. Specific discriminators are included to ensure that limb-threatening injuries are seen and treated urgently. Discriminators are also included to remind the triage practitioner to consider the signs and symptoms of thromboembolic disease and its complications.

### Specific discriminators

<table>
<thead>
<tr>
<th>Specific discriminator</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acutely short of breath</td>
<td>Shortness of breath that comes on suddenly or a sudden exacerbation of chronic shortness of breath</td>
</tr>
<tr>
<td>Vascular compromise</td>
<td>There will be a combination of pallor, coldness, altered sensation and pain with or without absent pulses distal to the injury</td>
</tr>
<tr>
<td>New neurological deficit less than 24 hours</td>
<td>Any loss of neurological function that has come on within the previous 24 hours. This might include altered or lost sensation, weakness of the limbs (either transiently or permanently) and alterations in bladder or bowel function</td>
</tr>
<tr>
<td>Open fracture</td>
<td>All wounds in the vicinity of a fracture should be regarded with suspicion. If there is any possibility of communication between the wound and the fracture, then the fracture should be assumed to be open</td>
</tr>
<tr>
<td>New neurological deficit more than 24 hours</td>
<td>Any loss of neurological function including altered or lost sensation, weakness of the limbs (either transiently or permanently) and alterations in bladder or bowel function</td>
</tr>
<tr>
<td>Bleeding disorder</td>
<td>Congenital or acquired bleeding disorder</td>
</tr>
<tr>
<td>Deformity</td>
<td>This will always be subjective. Abnormal angulation or rotation is implied</td>
</tr>
<tr>
<td>Pleuritic pain</td>
<td>A sharp, localised pain in the chest that worsens on breathing, coughing or sneezing</td>
</tr>
<tr>
<td>Swelling</td>
<td>An abnormal increase in size</td>
</tr>
</tbody>
</table>
Airway compromise, inadequate breathing or shock:
- if unconscious place in the recovery position, if conscious try to reassure
- Provide Life Support Advice if required
- Take available analgesia for pain control

Take available analgesia for pain/temperature control
- Call back if symptoms worsen

Bleeding disorder
- Deformity
- Hot joint
- Hot
- Pain on joint movement

Unresolved pain
- Recent problem

Take paracetamol qds for pain control
- Take ibuprofen tds if required
- Call back if symptoms persist or worsen
- See GP if symptoms persist
## Limping child

### Chart notes

**Limb injuries**

This is a presentation-defined flow diagram. Children who present with limp range from those who have suffered a minor soft tissue injury to the foot or ankle to those who have developed septic arthritis of the hip. This chart is designed to allow accurate prioritisation of such children. A number of general discriminators are used including *Life Threat*, *Pain* and *Temperature*. Specific discriminators have been included to allow children with more urgent pathologies which threaten distal function from being accurately identified and those in whom the limp is a sinister sign of systemic disease from being spotted quickly.

### Specific discriminators

<table>
<thead>
<tr>
<th>Specific discriminators</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-blanching rash</td>
<td>A rash that does not blanch (go white) when pressure is applied to it. Often tested using a glass tumbler to apply pressure as any colour change can be observed through the bottom of the tumbler.</td>
</tr>
<tr>
<td>Bleeding disorder</td>
<td>Congenital or acquired bleeding disorder</td>
</tr>
<tr>
<td>Deformity</td>
<td>This will always be subjective. Abnormal angulation or rotation is implied</td>
</tr>
<tr>
<td>Hot joint</td>
<td>Any warmth around a joint fulfils this criterion. Often accompanied by redness</td>
</tr>
<tr>
<td>Pain on joint movement</td>
<td>This can be pain on either active (patient) movement or passive (examiner) movement</td>
</tr>
</tbody>
</table>
Presentational flow charts

Major Trauma

- Provide Life Support Advice if required (appropriate to major trauma)
- If unconscious place in the recovery position, if conscious try to reassure
- Apply pressure appropriate to injury to control major haemorrhage

Airway compromise
- Inadequate breathing
- Altered conscious level
- Unresponsive child
- Uncontrollable major haemorrhage
- New neurological deficit less than 24 hours
- Significant mechanism of injury
- Severe pain

FtF Now

Uncontrollable minor haemorrhage
- History of unconsciousness

FtF Soon

Use another chart

Advice

Apply dressing or pressure if required to stem bleeding
- Call back if symptoms worsen or concerned

Advice
Major trauma

<table>
<thead>
<tr>
<th>See also</th>
<th>Chart notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Most health care providers know what is implied by major trauma, but it is a strange presentation in that it is defined not by the patients or their injury but on some judgement of that injury by carers at the scene or triage practitioner. For this reason, it is impossible to categorise a patient with this presentation as less than ‘face to face Soon’. If it is necessary to do this, then a deliberate decision needs to be made that the original description of the patient as having suffered major trauma was incorrect, and the patient should be categorised using a different presentational flow diagram. A number of general discriminators have been used including Life Threat, Haemorrhage, Conscious Level and Pain. Specific discriminators are designed to ensure that patients with a significant mechanism of injury are given immediate care.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specific discriminators</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>New neurological deficit less than 24 hours</td>
<td>Any loss of neurological function that has come on within the previous 24 hours. This might include altered or lost sensation, weakness of the limbs (either transiently or permanently) and alterations in bladder or bowel function.</td>
</tr>
<tr>
<td>Significant mechanism of injury</td>
<td>Penetrating injuries (stab or gunshot) and injuries with high energy transfer.</td>
</tr>
<tr>
<td>History of unconsciousness</td>
<td>There may be a reliable witness who can state whether the patient was unconscious (and for how long). If not, a patient who is unable to remember the incident should be assumed to have been unconscious.</td>
</tr>
</tbody>
</table>
Advice to attend local pharmacy for emergency resupply

Lack of medication causing exacerbation or relapse of condition
Requesting post coital contraception and unprotected sex 66–72 hours ago

If normally available on prescription see your GP
If normally available from drug services see your normal worker

Withdrawal possible
Requesting post coital contraception and unprotected sex 0–65 hours ago

Contact normal medical provider

Medication Request

FtF Soon

FtF Later

Advice only
**Medication request**

**Chart notes**

This is presentation-defined flow diagram designed to prioritise those who request medications. It is impossible to categorise a patient with this presentation as ‘face to face Now’. If the patient has general discriminators which suggest a ‘face to face Now’ categorisation or a ‘face to face Soon’ categorisation, then another chart should be used. For that reason there are no general discriminators in this chart.

<table>
<thead>
<tr>
<th>Specific discriminators</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of medication causing exacerbation or relapse of condition</td>
<td>Lack of regular medications such as insulin which may cause exacerbation or relapse of condition if not obtained soon</td>
</tr>
<tr>
<td>Requesting post-coital contraception and unprotected sex 66–72 hours ago</td>
<td>There is a window of opportunity for post-coital contraception which best evidence suggests ends at 72 hours</td>
</tr>
<tr>
<td>Withdrawal possible</td>
<td>Where the lack of medication will lead to symptoms of drug/substance withdrawal or other unwanted effects</td>
</tr>
<tr>
<td>Requesting post-coital contraception and unprotected sex 0–65 hours ago</td>
<td>Medication is required but there is a larger window of opportunity for obtaining it</td>
</tr>
</tbody>
</table>
Airway compromise, inadequate breathing or shock:
- If unconscious place in the recovery position, if conscious try to reassure
- Provide Life Support Advice if required
- Maintain own safety – it may be necessary to withdraw from the patient if risk of harm
- If possible remove anything the patient may use to cause self-harm

Airway compromise
Inadequate breathing
Altered conscious level
Risk of self-harm
Risk of harm to others

Marked distress
Significant psychiatric history

See GP or refer to other agencies such as CPN/MIND/support worker
Call back or see GP if symptoms worsen or new symptoms develop

Maintain own safety – it may be necessary to withdraw from the patient if risk of harm
If possible remove anything the patient may use to cause self-harm
If patient has taken overdose, please collect all packaging for the crew/ED
Call back if symptoms worsen

Call back if symptoms worsen
See GP or refer to other agencies such as CPN/MIND/support worker
Call back or see GP if symptoms worsen or new symptoms develop
Mental illness

See also

<table>
<thead>
<tr>
<th>Presentational flow charts</th>
</tr>
</thead>
<tbody>
<tr>
<td>99</td>
</tr>
</tbody>
</table>

Mental illness

See also

<table>
<thead>
<tr>
<th>Apparently drunk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behaving strangely</td>
</tr>
</tbody>
</table>

Chart notes

This is a presentation-defined flow diagram which has been designed to allow clinical prioritisation of patients who present with known or newly declared mental illness. A number of general discriminators have been used including Life Threat and Conscious Level. This chart is designed to allow assessment of both physical and psychiatric aspects of the presentation.

Specific discriminators are included to allow accurate prioritisation of patients with a known significant psychiatric history and those who have a degree of risk of causing harm to others or to themselves. Patients who suffer from marked distress are placed in ‘face to face Soon’ category.

Specific discriminators

<table>
<thead>
<tr>
<th>Risk of self-harm</th>
<th>The potential of the patient to actively attempt further self-harm. If in doubt, assume a high risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk of harm to others</td>
<td>The potential of the patient to actively attempt to harm others. This may be assessed by considering the state of mind, body posture and behaviour. If in doubt, assume a high risk</td>
</tr>
<tr>
<td>Marked distress</td>
<td>Patients who are markedly physically or emotionally upset fulfil this criterion</td>
</tr>
<tr>
<td>Significant psychiatric history</td>
<td>A history of a major psychiatric illness or event</td>
</tr>
</tbody>
</table>
Neck Pain

Airway compromise, inadequate breathing or shock:
- if unconscious place in recovery position, if conscious try to reassure
- Provide Life Support Advice if required
- Take available analgesia for pain control
- If direct trauma or significant MOI, keep patient still

Airway compromise
- Inadequate breathing
- Altered conscious level
- New neurological deficit less than 24 hours
- Signs of meningism
- Non-blanching rash
- Very hot
- Severe pain

FtF Now

New neurological deficit more than 24 hours
- Direct trauma to the neck
- Hot

FtF Soon

Unresolved pain
- Take paracetamol qds for pain control
- Take ibuprofen tds if required
- Consider physiotherapy referral if symptoms recur
- Exercise within pain free range of movement
- Firm supporting pillow
- Maintain good posture
- Avoid driving if neck movement is restricted
- See GP if symptoms persist

Advice only

Take available analgesia for pain control
- Call back if symptoms worsen

FtF Later
## Neck pain

### See also

<table>
<thead>
<tr>
<th>Chart notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Back pain</td>
</tr>
<tr>
<td>Headache</td>
</tr>
</tbody>
</table>

### Chart notes

This is a presentation-defined flow diagram. Pain in the neck may arise because of local pathology or meningeal irritation. This chart is designed to allow rapid identification of patients presented with symptoms or signs which indicate more urgent pathologies. A number of general discriminators are used including **Life Threat**, **Pain** and **Temperature**. The specific discriminators which indicate meningitis are included under ‘face to face Now’ category.

### Specific discriminators

<table>
<thead>
<tr>
<th>Specific discriminator</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>New neurological deficit less than 24hrs</td>
<td>Any loss of neurological function that has come on within the previous 24 hours. This might include altered or lost sensation, weakness of the limbs (either transiently or permanently) and alterations in bladder or bowel function.</td>
</tr>
<tr>
<td>Signs of meningism</td>
<td>Classically a stiff neck together with headache and photophobia</td>
</tr>
<tr>
<td>Non-blanching rash</td>
<td>A rash that does not blanch (go white) when pressure is applied to it. Often tested using a glass tumbler to apply pressure as any colour change can be observed through the bottom of the tumbler.</td>
</tr>
<tr>
<td>New neurological deficit more than 24 hours</td>
<td>Any loss of neurological function including altered or lost sensation, weakness of the limbs (either transiently or permanently) and alterations in bladder or bowel function.</td>
</tr>
<tr>
<td>Direct trauma to the neck</td>
<td>This may be top to bottom (loading) for instance when something falls on the head, bending (forwards, backwards or to the side), twisting or distracting such as in hanging.</td>
</tr>
</tbody>
</table>
Airway compromise, inadequate breathing or shock:
- if unconscious place in the recovery position, if conscious try to reassure
- Provide Life Support Advice if required
- Maintain own safety – it may be necessary to withdraw from the patient if risk of harm
- If possible remove anything the patient may use to cause self-harm

Maintain own safety – it may be necessary to withdraw from the patient if risk of harm
- If possible remove anything the patient may use to cause self-harm
- If patient has taken overdose, please collect all packaging for the crew/ED
- Call back if symptoms worsen

Take available analgesia for pain control
- Remove/keep medicines out of reach from children or vulnerable people, store in a high cupboard
- Refer to the psychiatric service if available
- Call back if symptoms worsen or new symptoms develop

Remove/keep medicines out of reach from children or vulnerable people, store in a high cupboard
Call back in event of new symptoms
Overdose and poisoning

This is a presentation-defined flow diagram. The flow chart has been designed to allow both the physical and psychiatric aspects of overdose to be considered and to ensure accurate prioritisation of patients from both perspectives. It also allows prioritisation of patients who have been accidentally (or deliberately) poisoned.

A number of general discriminators have been used including Life Threat and Unconscious Level. Specific discriminators include the assessed lethality of the overdose (which can be decided following discussion with a Poisons Centre) and an assessment of the risk of further attempts at self-harm.

### Specific discriminators

<table>
<thead>
<tr>
<th>Specific discriminator</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>High lethality</td>
<td>Lethality is the potential of the substance taken to cause harm. Advice from a Poisons Centre may be required to establish the level of risk of serious illness or death. If in doubt, assume a high risk.</td>
</tr>
<tr>
<td>Risk of further self-harm</td>
<td>The potential of the patient to actively attempt further self-harm. If in doubt, assume a high risk.</td>
</tr>
<tr>
<td>History of unconsciousness</td>
<td>There may be a reliable witness who can state whether the patient was unconscious (and for how long). If not, a patient who is unable to remember the incident should be assumed to have been unconscious.</td>
</tr>
<tr>
<td>Marked distress</td>
<td>Patients who are markedly physically or emotionally upset fulfil this criterion.</td>
</tr>
<tr>
<td>Moderate lethality</td>
<td>Lethality is the potential of the substance taken to cause serious illness or death. Advice from a Poisons Centre may be required to establish the level of risk to the patient.</td>
</tr>
<tr>
<td>Significant psychiatric history</td>
<td>A history of a major psychiatric illness or event.</td>
</tr>
</tbody>
</table>
Airway compromise, inadequate breathing or shock:
- If unconscious place in the recovery position, if conscious try to reassure

Acutely short of breath, unable to talk in sentences:
- If possible sit down and lean slightly forward
- Provide Life Support Advice if required
- If suspicious of cardiac origin, take aspirin and GTN if available
- Take available analgesia for pain control
- If patient has taken overdose, please collect all packaging for the crew/ED

Call back if symptoms worsen

Palpitation diary
- Trigger factors – lifestyle, caffeine, chocolate, drugs, reflux, heavy meals, nicotine, anxiety, stress
- Call back if symptoms worsen or new symptoms develop

History of unconsciousness
- Current palpitation
- Significant cardiac history
- Hot

Recent problem

Advice only

Palpitation diary
- Trigger factors – lifestyle, caffeine, chocolate, drugs, reflux, heavy meals, nicotine, anxiety, stress
- Call back or see GP if symptoms persist or worsen
## Palpitations

**See also**

- Chest pain
- Collapsed adult
- Unwell adult

**Chart notes**

This is a presentation-defined flow diagram designed to allow the accurate prioritisation of those patients that present with a chief complaint of palpitations. Palpitations can have many causes ranging from the effects of ischaemic heart disease and other cardiac abnormalities to anxiety. Whatever the cause, it is their effect on circulation and their propensity to develop into life-threatening dysrhythmias that determine the clinical priority of the patient. Thus this chart is written to ensure that the signs and symptoms of cardiac insufficiency are included in the ‘face to face Now’ category, together with historical pointers to potential early problems.

<table>
<thead>
<tr>
<th>Specific discriminators</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acutely short of breath</td>
<td>Shortness of breath that comes on suddenly or a sudden exacerbation of chronic shortness of breath</td>
</tr>
<tr>
<td>History of overdose or poisoning</td>
<td>This information may come from others or may be deduced if medication is missing</td>
</tr>
<tr>
<td>Cardiac pain</td>
<td>Classically a severe dull ‘gripping’ or ‘heavy’ pain in the centre of the chest, radiating to the left arm or to the neck. May be associated with sweating and nausea</td>
</tr>
<tr>
<td>History of unconsciousness</td>
<td>There may be a reliable witness who can state whether the patient was unconscious (and for how long). If not, a patient who is unable to remember the incident should be assumed to have been unconscious</td>
</tr>
<tr>
<td>Current palpitation</td>
<td>A feeling of the heart racing (often described as a fluttering) that is still present</td>
</tr>
<tr>
<td>Significant cardiac history</td>
<td>A known recurrent dysrhythmia which has life-threatening effects is significant, as is a known cardiac condition that may deteriorate rapidly</td>
</tr>
</tbody>
</table>
Airway compromise, inadequate breathing or shock:
if unconscious place in the recovery position, if conscious try to reassure
Provide Life Support Advice if required
Provide delivery advice?

Maintain hydration with clear fluids or oral rehydration therapy
Call back if symptoms worsen

Take available analgesia for pain control (dependent on gestation)
Maintain hydration with clear fluids or oral rehydration therapy
Call back or contact midwife/antenatal ward if symptoms worsen or new symptoms develop

Airway compromise
Inadequate breathing
Heavy PV blood loss
PV blood loss and 20 weeks pregnant or more
Currently fitting
In active labour
Presenting foetal parts
Very hot
Severe pain

PV blood loss
History of trauma
Persistent vomiting
High blood pressure
Hot
Shoulder tip pain

Unresolved pain
Unresolved vomiting

Contact antenatal ward or midwife for advice
Take available analgesia for pain control (dependent on gestation)
Pregnancy

See also  Chart notes

PV bleeding  This is a presentation-defined flow diagram. Pregnant women may access Emergency care at all stages of pregnancy and with a variety of complaints. Some may be unaware of their pregnancy. A number of general discriminators have been used including Pain and Conscious Level. Specific discriminators are designed to allow early recognition of complications of pregnancy at all stages

Specific discriminators  Explanation

Heavy PV blood loss  PV loss is extremely difficult to assess. The presence of large clots or constant flow fulfils this criterion. The use of a large number of sanitary towels is suggestive of heavy loss

PV blood loss and 20 weeks pregnant or more  Any loss of blood per vaginum in a woman known to be beyond the 20th week of pregnancy

In active labour  A woman who has regular and frequent painful contractions fulfils this criterion

Presenting foetal parts  Crowning or presentation of any other foetal part in the vagina

PV blood loss  Any loss of blood PV

History of trauma  A history of a recent physically traumatic event

High blood pressure  A history of raised blood pressure or a raised blood pressure on examination

Shoulder tip pain  Pain felt in the tip of the shoulder. This often indicates diaphragmatic irritation
Airway compromise, inadequate breathing or shock:
- If unconscious place in the recovery position, if conscious try to reassure
- Provide Life Support Advice if required
- Take available analgesia for pain control
- Provide delivery advice if needed

PV Bleeding

PtF Now
Airway compromise
Inadequate breathing
Altered conscious level
Heavy PV blood loss
PV loss and 20 weeks pregnant or more
Very hot
Severe pain

PtF Soon
History of trauma
Possibly pregnant
Hot
Abdominal pain
Shoulder tip pain

PtF Later
Unresolved pain
Recent problem

Advice only

Advice
Take available analgesia for pain control
If pregnant refer EPAU/antenatal ward
Call back if symptoms worsen

Advice
Take available analgesia for pain control
If pregnant refer EPAU/antenatal ward
Call back if symptoms worsen or new symptoms develop

Advice
See GP if symptoms persist

PtF

PV Bleeding

Advice
PV bleeding

See also

Abdominal pain
Pregnancy

Chart notes
This is a presentation-defined flow diagram. PV bleeding may occur in pregnant and non-pregnant women and may have a large number of undefined causes. A number of general discriminators are used including Life Threat, Haemorrhage and Pain.

Specific discriminators

<table>
<thead>
<tr>
<th>Specific discriminators</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heavy PV blood loss</td>
<td>PV loss is extremely difficult to assess. The presence of large clots or constant flow fulfils this criterion. The use of a large number of sanitary towels is suggestive of heavy loss</td>
</tr>
<tr>
<td>PV blood loss and 20 weeks pregnant or more</td>
<td>Any loss of blood PV in a woman known to be beyond the 20th week of pregnancy</td>
</tr>
<tr>
<td>Possibly pregnant</td>
<td>Any woman whose normal menstruation has failed to occur is possibly pregnant. Furthermore, any woman of childbearing age who has unprotected sex should be considered to be potentially pregnant</td>
</tr>
<tr>
<td>Abdominal pain</td>
<td>Any pain felt in the abdomen. Abdominal pain associated with back pain may indicate abdominal aortic aneurysm, whilst association with PV bleeding may indicate ectopic pregnancy or miscarriage</td>
</tr>
<tr>
<td>Shoulder tip pain</td>
<td>Pain felt in the tip of the shoulder. This often indicates diaphragmatic irritation</td>
</tr>
</tbody>
</table>
Airway compromise, inadequate breathing or shock:
- if unconscious place in the recovery position, if conscious try to reassure

Acutely short of breath, unable to talk in sentences:
- if possible sit down and lean slightly forward
- Provide Life Support Advice if required
- Take available analgesia for pain control
- Take antihistamine if available if caused by allergen

Caused by allergen:
- Take available analgesia for pain/temperature control
- Take antihistamine if available if caused by allergen
- Caused by allergen call back if symptoms worsen

Take available analgesia for pain control
- See pharmacist for otc medications/creams
- Call back or see GP if symptoms worsen or new symptoms develop

Recent problem
- Unresolved itch
- Unresolved pain

Avoid scratching, especially in children
- Apply soothing lotions such as calamine to reduce itching
- See pharmacist or GP if symptoms persist or worsen
## Rashes

### See also

- Allergy
- Bites and stings
- Unwell adult
- Unwell child

### Chart notes

This is a presentation-defined flow diagram. A rash may signify serious disease such as meningococcal septicaemia or may be a sign of a chronic non-acute problem such as psoriasis. Two general discriminators—Life Threat and Temperature—are used in this chart. A larger number of specific discriminators are included in the ‘face to face Now’ and ‘face to face Soon’ categories to ensure that more serious conditions are suitably triaged. In particular, non-blanching rash and associations of acute anaphylaxis appear at the ‘face to face Now’ level.

### Specific discriminators

<table>
<thead>
<tr>
<th>Specific discriminators</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stridor</td>
<td>This may be an inspiratory or expiratory noise or both. Stridor is heard best on breathing with the mouth open.</td>
</tr>
<tr>
<td>Oedema of the tongue</td>
<td>Swelling of the tongue of any degree</td>
</tr>
<tr>
<td>Facial oedema</td>
<td>Diffuse swelling around the face usually involving the lips</td>
</tr>
<tr>
<td>Acutely short of breath</td>
<td>Shortness of breath that comes on suddenly or a sudden exacerbation of chronic shortness of breath</td>
</tr>
<tr>
<td>Non-blanching rash</td>
<td>A rash that does not blanch (go white) when pressure is applied to it. Often tested using a glass tumbler to apply pressure as any colour change can be observed through the bottom of the tumbler</td>
</tr>
<tr>
<td>Widespread discharge or blistering</td>
<td>Any discharging or blistering eruption covering more than 10% body surface area</td>
</tr>
</tbody>
</table>
Airway compromise, inadequate breathing or shock:
- if unconscious place in the recovery position, if conscious try to reassure

Acutely short of breath, unable to talk in sentences:
- if possible sit down and lean slightly forward
- Provide Life Support Advice if required
- Apply pressure appropriate to injury to control major haemorrhage
- Maintain own safety – it may be necessary to withdraw from the patient if risk of harm
- Take available analgesia for pain control

Uncontrollable minor haemorrhage
- Marked distress
- Significant psychiatric history

Uncontrollable major haemorrhage
- Altered conscious level
- Risk of further self-harm
- Significant mechanism of injury
- Severe pain

Acutely short of breath, unable to talk in sentences:
- if possible sit down and lean slightly forward
- Provide Life Support Advice if required
- Apply pressure appropriate to injury to control major haemorrhage
- Maintain own safety – it may be necessary to withdraw from the patient if risk of harm
- Take available analgesia for pain control
Self-harm

See also

Overdose and poisoning
Mental illness

Chart notes

This is a presentation-defined flow diagram. This flow diagram has been designed to allow accurate prioritisation of patients who have caused physical harm to themselves. This chart is designed to allow assessment of both physical and psychiatric aspects of the presentation.

A number of general discriminators are used including Life Threat, Haemorrhage, Conscious Level and Pain. Specific discriminators are included to allow accurate prioritisation of patients with the significant mechanism of injury and those who have risk of further self-harm.

Specific discriminators

<table>
<thead>
<tr>
<th>Specific discriminators</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acutely short of breath</td>
<td>Shortness of breath that comes on suddenly or a sudden exacerbation of chronic shortness of breath</td>
</tr>
<tr>
<td>Risk of further harm</td>
<td>The potential of the patient to actively attempt further self-harm. If in doubt, assume a high risk</td>
</tr>
<tr>
<td>Significant mechanism of injury</td>
<td>Penetrating injuries (stab or gunshot) and injuries with high energy transfer</td>
</tr>
<tr>
<td>Marked distress</td>
<td>Patients who are markedly physically or emotionally upset fulfil this criterion</td>
</tr>
<tr>
<td>Significant psychiatric history</td>
<td>A history of a major psychiatric illness or event</td>
</tr>
</tbody>
</table>
**Presentational Flow Charts**

**Sexually Acquired Infection**

- **Airway compromise, inadequate breathing or shock:**
  - If unconscious place in the recovery position, if conscious try to reassure
  - Provide Life Support Advice if required
  - Take available analgesia for pain control

- **Take available analgesia for pain/temperature control**
  - Provide details of local Sexual Health clinics
  - Call back if symptoms worsen

- **Take available analgesia for pain control**
  - Provide details of local Sexual Health clinics
  - Encourage safe sexual behaviour
  - Call GP/sexual health clinic if symptoms worsen or new symptoms develop

- **Discharge**
  - Unresolved pain
  - Unresolved rash

- **Advice only**
  - Provide details of local Sexual Health clinics
  - Encourage safe sexual behaviour

**FtF Now**

- Airway compromise
- Inadequate breathing
- Altered conscious level
- Non-blanching rash
- Severe pain
- Known or likely immunosuppression
- Very hot

**FtF Soon**

- Widespread discharge or blistering
- Hot joint
- Pain on joint movement
- Testicular pain

**FtF Later**

- Advice
Sexually-acquired infection

Chart notes

This is a presentation-defined flow diagram which has been included to allow prioritisation of patients who present with known or obvious sexually acquired infection. A number of general discriminators are used including *Life Threat, Pain* and *Temperature*. Specific discriminators have been added to allow identification of more urgent conditions such as gonococcaemia. It is important to ensure that preconceptions about disposal of these patients do not prevent appropriate triage.

<table>
<thead>
<tr>
<th>Specific discriminators</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-blanching rash</td>
<td>A rash that does not blanch (go white) when pressure is applied to it. Often tested using a glass tumbler to apply pressure as any colour change can be observed through the bottom of the tumbler.</td>
</tr>
<tr>
<td>Known or likely immunosuppression</td>
<td>Any patient who is known or likely to be immunosuppressed including those on immunosuppressive drugs (including long-term steroids).</td>
</tr>
<tr>
<td>Widespread discharge and blistering</td>
<td>Any discharging or blistering eruption covering more than 10% body surface area.</td>
</tr>
<tr>
<td>Hot joint</td>
<td>Any warmth around a joint fulfils this criterion. Often accompanied by redness.</td>
</tr>
<tr>
<td>Pain on joint movement</td>
<td>This can be pain on either active (patient) movement or passive (examiner) movement.</td>
</tr>
<tr>
<td>Testicular pain</td>
<td>Pain in the testicles.</td>
</tr>
<tr>
<td>Discharge</td>
<td>In the context of sexually-acquired infection, this is any discharge from the penis or abnormal discharge from the vagina.</td>
</tr>
</tbody>
</table>
Shortness of Breath in Adults

Airway compromise, inadequate breathing or shock:
- If unconscious place in the recovery position, if conscious try to reassure

Acutely short of breath, unable to talk in sentences, very low PEFR:
- If possible sit down and lean slightly forward. Take a nebuliser if available
- Provide Life Support Advice if required
- If possible sit down and lean slightly forward
- Take nebuliser/own medication if available
- Take available analgesia for pain control

Auscultation:
- Observe for movements of the chest
- Stridor
- Drooling
- Inadequate breathing
- Unable to talk in sentences
- Exhaustion
- Altered conscious level
- Significant respiratory history
- Acute onset after injury
- Cardiac pain
- Very hot

Wheeze:
- Chest injury
- Pleuritic pain
- Hot

Productive cough:
- Recent problem

Advice:
- Take available analgesia for pain/temperature control
- If possible sit down and lean slightly forward
- Take nebuliser/own medication if available
- Call back if symptoms worsen or concerned
- Take available analgesia for pain control
- Advise breathing exercises to prevent chest infection
- Maintain hydration with clear fluids or oral rehydration therapy
- Call back or see GP if symptoms worsen or new symptoms develop
- Take paracetamol qds for pain control
- Take ibuprofen tds if required
- Ensure if environment is cool and ventilated
- Extra pillow at night
- See GP if symptoms persist
- See GP/pharmacy for OTC medications linctus, etc.
Shortness of breath in adults

See also

Asthma
Shortness of breath in children
Unwell adult

Chart notes

This is a presentation-defined flow diagram. Shortness of breath may be the presenting symptom for a number of cardiovascular and respiratory problems. A number of general discriminators are used including Life Threat and Temperature. Specific discriminators include those which are present in severe asthma, chronic obstructive pulmonary disease and ischaemic heart disease.

Specific discriminators

<table>
<thead>
<tr>
<th>Specific discriminators</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stridor</td>
<td>This may be an inspiratory or expiratory noise or both. Stridor is heard best on breathing with the mouth open</td>
</tr>
<tr>
<td>Drooling</td>
<td>Saliva running from the mouth as a result of being unable to swallow</td>
</tr>
<tr>
<td>Unable to talk in sentences</td>
<td>Patients who are so breathless that they cannot complete relatively short sentences in one breath</td>
</tr>
<tr>
<td>Exhaustion</td>
<td>Exhausted patients appear to reduce the effort they make to breathe despite continuing respiratory insufficiency. This is preterminal</td>
</tr>
<tr>
<td>Significant respiratory history</td>
<td>A history of previous life-threatening episodes of a respiratory condition (e.g. COPD) is significant as is brittle asthma</td>
</tr>
<tr>
<td>Acute onset after injury</td>
<td>Onset of symptoms immediately within 24 hours of a physically traumatic event</td>
</tr>
<tr>
<td>Cardiac pain</td>
<td>Classically a severe dull ‘gripping’ or ‘heavy’ pain in the centre of the chest, radiating to the left arm or to the neck. May be associated with sweating and nausea</td>
</tr>
<tr>
<td>Wheeze</td>
<td>This can be audible wheeze or a feeling of wheeze. Very severe airway obstruction is silent (no air can move)</td>
</tr>
<tr>
<td>Chest injury</td>
<td>Any injury to the area below the clavicles and above the level of the lowest rib. Injury to the lower part of the chest can cause underlying damage to abdominal organs</td>
</tr>
<tr>
<td>Pleuritic pain</td>
<td>A sharp, localised pain in the chest that worsens on breathing, coughing or sneezing</td>
</tr>
<tr>
<td>Productive cough</td>
<td>A cough which is productive of phlegm, whatever the colour</td>
</tr>
</tbody>
</table>
Shortness of Breath in Children

**Airway compromise, inadequate breathing or shock:**
- If unconscious place in the recovery position, if conscious try to reassure

**Acutely short of breath, unable to talk in sentences, very low PEFR:**
- If possible sit down and lean slightly forward. Take a nebuliser if available
- Provide Life Support Advice if required
- If possible sit down and lean slightly forward
- Take nebuliser if available

**Advice only**

**Wheeze**
- Chest injury
- Pleuritic pain
- Hot
- Unable to feed

**Airway compromise**
- Stridor
- Drooling
- Inadequate breathing
- Unable to talk in sentences
- Exhaustion
- Altered conscious level
- Significant respiratory history
- Acute onset after injury
- Hot baby
- Very hot

**Advice**

**Productive cough**
- Recent problem

**Advice**

**Take available analgesia for pain/temperature control**
- Take nebuliser/own medication if available
- Call back if symptoms worsen or concerned

**Advice**

**Take paracetamol qds for pain control**
- Take ibuprofen tds if required
- Ensure environment cool and ventilated
- Extra pillow at night
- Do not smoke around children
- See GP if Symptoms persist
- See GP/pharmacy for otc medications

**Advice**
# Shortness of breath in children

<table>
<thead>
<tr>
<th>See also</th>
<th>Chart notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>This is a presentation-defined flow diagram which applies to children. A number of general discriminators are used including <em>Life Threat</em> and <em>Temperature</em>. Specific discriminators have been included to allow accurate identification of children who suffer from the severe effects of asthma and those in whom there is more serious pathology.</td>
</tr>
<tr>
<td>Unwell child</td>
<td></td>
</tr>
</tbody>
</table>

## Specific discriminators

<table>
<thead>
<tr>
<th>Specific discriminators</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stridor</td>
<td>This may be an inspiratory or expiratory noise or both. Stridor is heard best on breathing with the mouth open.</td>
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<tr>
<td>Drooling</td>
<td>Saliva running from the mouth as a result of being unable to swallow.</td>
</tr>
<tr>
<td>Unable to talk in sentences</td>
<td>Patients who are so breathless that they cannot complete relatively short sentences in one breath.</td>
</tr>
<tr>
<td>Exhaustion</td>
<td>Exhausted patients appear to reduce the effort they make to breathe despite continuing respiratory insufficiency. This is pre-terminal.</td>
</tr>
<tr>
<td>Significant respiratory history</td>
<td>A history of previous life-threatening episodes of a respiratory condition (e.g. COPD) is significant as is brittle asthma.</td>
</tr>
<tr>
<td>Acute onset after injury</td>
<td>Onset of symptoms immediately within 24 hours of a physically traumatic event.</td>
</tr>
<tr>
<td>Wheeze</td>
<td>This can be audible wheeze or a feeling of wheeze. Very severe airway obstruction is silent (no air can move).</td>
</tr>
<tr>
<td>Chest injury</td>
<td>Any injury to the area below the clavicles and above the level of the lowest rib. Injury to the lower part of the chest can cause underlying damage to abdominal organs</td>
</tr>
<tr>
<td>Pleuritic pain</td>
<td>A sharp, localised pain in the chest that worsens on breathing, coughing or sneezing.</td>
</tr>
<tr>
<td>Productive cough</td>
<td>A cough which is productive of phlegm, whatever the colour.</td>
</tr>
</tbody>
</table>
Sore Throat

Airway compromise, inadequate breathing or shock:
- if unconscious place in the recovery position, if conscious try to reassure

Acutely short of breath, unable to talk in sentences:
- if possible sit down and lean slightly forward
- Provide Life Support Advice if required
- If possible sit down and lean slightly forward
- Take available analgesia for pain control

Take available analgesia for pain/temperature control
- Call back if symptoms worsen or concerned

Rapid onset
- Hot

History of recent foreign travel
- Recent problem

See GP or pharmacist if symptoms persist
- Avoid smoking

Advice only
# Sore throat

## See also
- Shortness of breath in adults
- Shortness of breath in children
- Unwell adult
- Unwell child

## Chart notes
This is a presentation-defined flow diagram designed to allow accurate prioritisation for patients presenting with sore throat. As problems with the throat can affect the airway, there are a number of conditions which have this presentation and have a high priority. A number of general discriminators are used including Life Threat, Pain and Temperature. Specific discriminators have been included to indicate high chance of more serious pathology.

## Specific discriminators

<table>
<thead>
<tr>
<th>Specific discriminators</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stridor</td>
<td>This may be an inspiratory or expiratory noise or both. Stridor is heard best on breathing with the mouth open</td>
</tr>
<tr>
<td>Drooling</td>
<td>Saliva running from the mouth as a result of being unable to swallow</td>
</tr>
<tr>
<td>Known or likely immunosuppression</td>
<td>Any patient who is known or likely to be immunosuppressed including those on immunosuppressive drugs (including long-term steroids)</td>
</tr>
<tr>
<td>Special risk of infection</td>
<td>Known exposure to a dangerous pathogen or travel to an area with an identified, current serious infectious risk</td>
</tr>
<tr>
<td>Rapid onset</td>
<td>Onset within the preceding 12 hours</td>
</tr>
<tr>
<td>History of recent foreign travel</td>
<td>Recent significant foreign travel (within 2 weeks)</td>
</tr>
</tbody>
</table>
Testicular Pain

Airway compromise, inadequate breathing or shock:
- if unconscious place in the recovery position, if conscious try to reassure

Acutely short of breath, unable to talk in sentences:
- if possible sit down and lean slightly forward
- Provide Life Support Advice if required
- Take available analgesia for pain control

Take available analgesia for pain control
- Maintain hydration with clear fluids or oral rehydration therapy
- Call back if symptoms worsen

Airway compromise
Inadequate breathing
Scrotal gangrene
Very hot
Severe pain

Scrotal cellulitis
Age less than 25 years
Persistent vomiting
Hot
Colicky pain

Scrotal trauma
Unresolved vomiting
Unresolved pain

Promote testicular self-examination and see GP if concerned

Advice only

Advice

Acutely short of breath, unable to talk in sentences:
- if possible sit down and lean slightly forward
- Provide Life Support Advice if required
- Take available analgesia for pain control
# Testicular pain

<table>
<thead>
<tr>
<th>See also</th>
<th>Chart notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal pain</td>
<td>This is a presentation-defined flow diagram. Testicular pain may have a number of pathologies, the most urgent of which is testicular torsion. A number of general discriminators are used including <em>Life Threat</em>, <em>Pain</em> and <em>Temperature</em>. Specific discriminators included in the ‘face to face Now’ and ‘face to face Soon’ category are designed to indicate those patients who have a high chance or torsion of the testes and the most severe infections.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specific discriminators</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scrotal gangrene</td>
<td>Dead blackened skin around the scrotum and groin. Early gangrene may not be black but may appear like a full thickness burn with or without flaking.</td>
</tr>
<tr>
<td>Scrotal cellulitis</td>
<td>Redness and swelling around the scrotum</td>
</tr>
<tr>
<td>Age 25 years or less</td>
<td>A person aged 25 years or less</td>
</tr>
<tr>
<td>Persistent vomiting</td>
<td>Vomiting that is continuous or that occurs without any respite between episodes</td>
</tr>
<tr>
<td>Colicky pain</td>
<td>Pain that comes and goes in waves. Renal colic tends to come and go over 20 minutes or so</td>
</tr>
<tr>
<td>Scrotal trauma</td>
<td>Any recent physically traumatic event involving the scrotum</td>
</tr>
</tbody>
</table>
Airway compromise, inadequate breathing or shock:
if unconscious place in the recovery position, if conscious try to reassure

Acute short of breath, unable to talk in sentences:
if possible sit down and lean slightly forward
Provide Life Support Advice if required
Apply pressure appropriate to injury to control major haemorrhage
Apply clean damp covering to evisceration
Take available analgesia for pain control

Take available analgesia for pain control
Apply dressing or pressure if required to stem any bleeding
Call back if symptoms worsen

Take available analgesia for pain control
Call back or see GP if symptoms worsen or new symptoms develop

See GP if new symptoms develop
## Torso injury

### See also

<table>
<thead>
<tr>
<th>Assault</th>
<th>Chart notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major trauma</td>
<td>This is a presentation-defined flow diagram designed to allow accurate prioritisation of patients who have suffered injuries to the front or back of the chest and abdomen. A number of general discriminators are used including Life Threat, Haemorrhage and Pain. Specific discriminators have been used to allow identification of patients who suffer from less obvious but severe internal injury. These would include patients who are acutely short of breath and those with a history suggestive of significant trauma</td>
</tr>
<tr>
<td>Wounds</td>
<td></td>
</tr>
</tbody>
</table>

### Specific discriminators

<table>
<thead>
<tr>
<th>Specific discriminators</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acutely short of breath</td>
<td>Shortness of breath that comes on suddenly or a sudden exacerbation of chronic shortness of breath</td>
</tr>
<tr>
<td>Externalisation of organs</td>
<td>Herniation or frank extrusion of internal organs</td>
</tr>
<tr>
<td>Significant mechanism of injury</td>
<td>Penetrating injuries (stab or gunshot) and injuries with high energy transfer</td>
</tr>
<tr>
<td>Pleuritic pain</td>
<td>A sharp, localised pain in the chest that worsens on breathing, coughing or sneezing</td>
</tr>
<tr>
<td>Local inflammation</td>
<td>Local inflammation will involve pain, swelling and redness confined to a particular site or area</td>
</tr>
</tbody>
</table>
Airway compromise, inadequate breathing or shock:
- If unconscious place in the recovery position, if conscious try to reassure

Acutely short of breath, unable to talk in sentences:
- If possible sit down and lean slightly forward
- Provide Life Support Advice if required
- Take available analgesia for pain control

New neurological deficit more than 24 hours
- Widespread rash or blistering
- Rapid onset
- Significant haematological history
- Hot
- Cold

History of recent foreign travel
- Unresolved pain
- Recent problem

Airway compromise
- Inadequate breathing
- Currently fitting
- Altered conscious level
- New neurological deficit less than 24 hours
- Signs of meningeal
- Non-blanching rash
- Known or likely immunosuppression
- Special risk of infection
- Very hot
- Severe pain

Take available analgesia for pain/temperature control
- Take antihistamine if required
- Call back if symptoms worsen

Take available analgesia for pain/temperature control
- Call back or see GP if symptoms worsen or new symptoms develop

See GP if new symptoms develop
Unwell adult

See also | Chart notes
---|---
Collapsed adult | This is a non-specific presentation-defined flow diagram. A number of general discriminators are used including Life Threat, Conscious Level, Pain and Temperature. Specific discriminators have been included to ensure that patients with, for example, meningococcaemia are placed in appropriate category

<table>
<thead>
<tr>
<th>Specific discriminators</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>New neurological deficit less than 24 hours</td>
<td>Any loss of neurological function that has come on within the previous 24 hours. This might include altered or lost sensation, weakness of the limbs (either transiently or permanently) and alterations in bladder or bowel function</td>
</tr>
<tr>
<td>Signs of meningism</td>
<td>Classically a stiff neck together with headache and photophobia</td>
</tr>
<tr>
<td>Non-blanching rash</td>
<td>A rash that does not blanch (go white) when pressure is applied to it. Often tested using a glass tumbler to apply pressure as any colour change can be observed through the bottom of the tumbler</td>
</tr>
<tr>
<td>Known or likely immunosuppression</td>
<td>Any patient who is known to be immunosuppressed including those on immunosuppressive drugs (including long-term steroids)</td>
</tr>
<tr>
<td>Special risk of infection</td>
<td>Known exposure to a dangerous pathogen or travel to an area with an identified, current serious infectious risk</td>
</tr>
<tr>
<td>New neurological deficit more than 24 hours</td>
<td>Any loss of neurological function including altered or lost sensation, weakness of the limbs (either transiently or permanently) and alterations in bladder or bowel function</td>
</tr>
<tr>
<td>Widespread rash or blistering</td>
<td>Any rash or blistering eruption covering more than 10% of the body surface area</td>
</tr>
<tr>
<td>Rapid onset</td>
<td>Onset within the preceding 12 hours</td>
</tr>
<tr>
<td>History of recent foreign travel</td>
<td>Recent significant foreign travel (within 2 weeks)</td>
</tr>
<tr>
<td>Significant haematological history</td>
<td>A patient with a haematological disorder that is known to deteriorate rapidly</td>
</tr>
</tbody>
</table>
Unwell Baby (up to 12 months)

**Airway compromise, inadequate breathing or shock:**
- if unconscious place in the recovery position, if conscious try to reassure
- **Acutely short of breath, unable to talk in sentences:**
  - if possible sit down and lean slightly forward
  - Hot: if your child is hot, take off most of their clothes
  - Provide Life Support Advice if required
- Give appropriate analgesia for pain control

**Signs of dehydration**
- Not feeding
- Not passing urine
- Significant haematological history

**Warmth**
- Signs of pain
- Recent problem

**Alert caller to red flags** – symptoms of meningitis
- Discuss causes of crying such as hunger, tiredness, colic, wind, soiled nappy, hot or cold
- Check causes above – work through
- Call back if symptoms worsen or new symptoms develop

**Give appropriate analgesia** for pain/temperature control
- Maintain hydration with clear fluids or oral rehydration therapy
- Call back if symptoms worsen

**Take available analgesia** for pain/temperature control
- Maintain hydration with clear fluids or oral rehydration therapy
- Alert caller to red flags – symptoms of meningitis
- Discuss causes of crying such as hunger, tiredness, colic, wind, soiled nappy, hot or cold
- Check causes above – work through
- Call back if symptoms worsen or new symptoms develop

**Provide Life Support Advice if required**
- Give appropriate analgesia for pain control
- Give appropriate analgesia for pain/temperature control
- Maintain hydration with clear fluids or oral rehydration therapy
- Call back if symptoms worsen

**Known or likely immunosuppression**
- Signs of meningism
- Non-blanching rash
- Hot baby
- Cold
- Signs of severe pain

**Advice**

**FtF Now**

**FtF Soon**

**FtF Later**

**Advice only**

**See GP if symptoms persist**

**Discuss approach to management of child**

**Alert caller to red flags** – symptoms of meningitis
- Discuss causes of crying such as hunger, tiredness, colic, wind, soiled nappy, hot or cold
- Check causes above – work through
Unwell baby (up to 12 months)

**Chart notes**

This is a presentation-defined flow diagram designed to allow accurate prioritisation of babies who present with non-specific illness. A number of general discriminators are used including Life Threat, Conscious Level, Pain and Temperature. A number of specific discriminators have been included to allow identification of more serious pathology such as meningococcaemia.

For any child aged 28 days or under, the unwell newborn chart should be used.

<table>
<thead>
<tr>
<th>Specific discriminators</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fails to react to parents</td>
<td>Failure to react in any way to a parent’s face or voice. Abnormal reactions and apparent lack of recognition of a parent are also worrying signs</td>
</tr>
<tr>
<td>Signs of meningism</td>
<td>Classically a stiff neck together with headache and photophobia</td>
</tr>
<tr>
<td>Known or likely immunosuppression</td>
<td>Any patient who is known or likely to be immunosuppressed including those on immunosuppressive drugs (including long-term steroids)</td>
</tr>
<tr>
<td>Non-blanching rash</td>
<td>A rash that does not blanch (go white) when pressure is applied to it. Often tested using a glass tumbler to apply pressure as any colour change can be observed through the bottom of the tumbler</td>
</tr>
<tr>
<td>Signs of dehydration</td>
<td>These include dry tongue, sunken eyes, increased skin turgor and, in small babies, a sunken anterior fontanelle. Usually associated with a low urine output</td>
</tr>
<tr>
<td>Not feeding</td>
<td>Children who do not take any solid or liquid (as appropriate) by mouth. Children who take the food but always vomit afterwards may also fulfil this criterion</td>
</tr>
<tr>
<td>Not passing urine</td>
<td>Failure to produce and pass urine. This may be difficult to judge in children (and the elderly) and reference to the number of nappies or pads used may be useful</td>
</tr>
<tr>
<td>Significant haematological history</td>
<td>A patient with a haematological disorder that is known to deteriorate rapidly</td>
</tr>
</tbody>
</table>
**Unwell Child**

- **Airway compromise, inadequate breathing or shock:**
  - If unconscious place in the recovery position, if conscious try to reassure
  - Hot: if your child is hot, take off most of their clothes
  - Provide Life Support Advice if required
  - Give appropriate analgesia for pain control

- **Not feeding, not passing urine**
  - Significant haematological history
  - Hot
  - Cold

- **Unresolved pain, recent problem**
  - Warmth

- **Alert caller to red flags – symptoms of meningitis**
  - Discuss causes of crying such as hunger, tiredness, colic, wind, soiled nappy, hot or cold
  - Check causes above – work through
  - Discuss approaches to management of child
  - See GP if symptoms persist

**Advice**

- Take available analgesia for pain control
- Maintain hydration with clear fluids or oral rehydration therapy
- Alert caller to red flags – symptoms of meningitis
- Discuss causes of crying such as hunger, tiredness, colic, wind, soiled nappy, hot or cold
- Check causes above – work through
- Call back if symptoms worsen or new symptoms develop

**Advice**

- Give appropriate analgesia for pain/temperature control
- Provide Life Support Advice if required
- Give appropriate analgesia for pain control
- Maintain hydration with clear fluids or oral rehydration therapy
- Alert caller to red flags – symptoms of meningitis
- Discuss causes of crying such as hunger, tiredness, colic, wind, soiled nappy, hot or cold
- Check causes above – work through
- Discuss approaches to management of child
- See GP if symptoms persist
### Unwell child

**See also**

- Crying baby
- Irritable child
- Worried parent

**Chart notes**

This is a presentation-defined flow diagram designed to allow accurate prioritisation of children aged over 12 months who present with non-specific illness. A number of general discriminators are used including Life Threat, Conscious Level, Pain and Temperature. A number of specific discriminators have been included to allow identification of more serious pathology such as meningococcal meningitis.

<table>
<thead>
<tr>
<th>Specific discriminators</th>
<th>Explanation</th>
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<tbody>
<tr>
<td>Fails to react to parents</td>
<td>Failure to react in any way to a parent’s face or voice. Abnormal reactions and apparent lack of recognition of a parent are also worrying signs</td>
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<td>Signs of meningism</td>
<td>Classically a stiff neck together with headache and photophobia</td>
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<td>Non-blanching rash</td>
<td>A rash that does not blanch (go white) when pressure is applied to it. Often tested using a glass tumbler to apply pressure as any colour change can be observed through the bottom of the tumbler</td>
</tr>
<tr>
<td>Known or likely immunosuppression</td>
<td>Any patient who is known or likely to be immunosuppressed including those on immunosuppressive drugs (including long-term steroids)</td>
</tr>
<tr>
<td>Not feeding</td>
<td>Children who do not take any solid or liquid (as appropriate) by mouth. Children who take the food but always vomit afterwards may also fulfil this criterion</td>
</tr>
<tr>
<td>Not passing urine</td>
<td>Failure to produce and pass urine. This may be difficult to judge in children (and the elderly) and reference to the number of nappies or pads used may be useful</td>
</tr>
<tr>
<td>Significant haematological history</td>
<td>A patient with a haematological disorder that is known to deteriorate rapidly</td>
</tr>
</tbody>
</table>
Unwell Newborn (up to 28 days)

- **Airway compromise**
  - Inadequate breathing
  - Currently fitting
  - Altered conscious level
  - Signs of dehydration in newborn
  - Fails to react to parents
  - Non-blanching rash
  - Hot baby
  - Cold
  - Signs of severe pain
  - **FtF Now**

- **Not feeding**
  - Not passing urine
  - Jaundice
  - Warm newborn
  - **FtF Soon**

- **Signs of pain**
  - Recent problem
  - **FtF Later**

- **Provide Life Support Advice if required**
  - **Advice**

- **Give appropriate analgesia for pain/temperature control**
  - Maintain hydration
  - Call back if symptoms worsen
  - **Advice**

- **Take available analgesia for pain control**
  - Maintain hydration
  - Alert caller to red flags – symptoms of meningitis
  - Discuss causes of crying such as hunger, tiredness, colic, wind, soiled nappy, hot or cold
  - Check causes above – work through
  - Call back if symptoms worsen or new symptoms develop
  - **Advice**
Unwell newborn (up to 28 days)

Chart notes

This is a presentation-defined flow diagram designed to allow accurate prioritisation of newborns (up to 28 days) who present with non-specific illness. A number of general discriminators are used including Life Threat, Conscious Level, Pain and Temperature. A number of specific discriminators have been included to allow identification of more serious pathology such as meningococcaemia.

<table>
<thead>
<tr>
<th>Specific discriminators</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Signs of dehydration</td>
<td>These include dry tongue, sunken eyes, increased skin turgor and, in small babies, a sunken anterior fontanelle. Usually associated with a low urine output</td>
</tr>
<tr>
<td>Fails to react to parents</td>
<td>Failure to react in any way to a parent’s face or voice. Abnormal reactions and apparent lack of recognition of a parent are also worrying signs</td>
</tr>
<tr>
<td>Non-blanching rash</td>
<td>A rash that does not blanch (go white) when pressure is applied to it. Often tested using a glass tumbler to apply pressure as any colour change can be observed through the bottom of the tumbler</td>
</tr>
<tr>
<td>Signs of severe pain</td>
<td>Young children and babies in severe pain cannot complain. They will usually cry out continuously and inconsolably and be tachycardic. They may well exhibit signs such as pallor and sweating</td>
</tr>
<tr>
<td>Not feeding</td>
<td>Children who do not take any solid or liquid (as appropriate) by mouth. Children who take the food but always vomit afterwards may also fulfil this criterion</td>
</tr>
<tr>
<td>Not passing urine</td>
<td>Failure to produce and pass urine. This may be difficult to judge in children (and the elderly) and reference to the number of nappies or pads used may be useful</td>
</tr>
<tr>
<td>Jaundice</td>
<td>Neonatal jaundice</td>
</tr>
</tbody>
</table>


Airway compromise, inadequate breathing or shock:
- If unconscious place in the recovery position, if conscious try to reassure
- Provide Life Support Advice if required
- Priapism – advise ice packs
- Take available analgesia for pain control

Urinary Problems

Airway compromise
Inadequate breathing
Altered conscious level
Priapism
Very hot
Known or likely immunosuppression
Severe pain

FtF Now

Frank haematuria
Persistent vomiting
Retention of urine
Hot
Colicky pain

FtF Soon

Unresolved vomiting
Dysuria
Unresolved pain

FtF Later

Take available analgesia for pain control
Maintain hydration with clear fluids or oral rehydration therapy
Call back if symptoms worsen

Take paracetamol qds for pain control
Take ibuprofen tds if required
Ensure if fluid intake is maintained
Avoid irritants
Washing hygiene – wipe front to back
Empty bladder – post-coital
See pharmacist for OTC medicines

Maintain hydration with clear fluids or oral rehydration therapy
Call back or see GP if symptoms worsen or new symptoms develop

Advice only
Urinary problems

See also

Sexually acquired infection

Testicular pain

Chart notes

This is a presentation-defined flow diagram. A lot of patients who present with urinary problems complain of pain and some may have serious underlying pathology. A number of general discriminators are used including Life Threat, Pain and Temperature. Specific discriminators have been included to ensure that patients suffering from urinary retention and those with infections are included in appropriate categories.

Specific discriminators

<table>
<thead>
<tr>
<th>Discriminator</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priapism</td>
<td>Sustained penile erection</td>
</tr>
<tr>
<td>Known or likely immunosuppression</td>
<td>Any patient who is known to be immunosuppressed including those on immunosuppressive drugs (including long-term steroids)</td>
</tr>
<tr>
<td>Frank haematuria</td>
<td>Red discolouration of the urine caused by blood</td>
</tr>
<tr>
<td>Persistent vomiting</td>
<td>Vomiting that is continuous or that occurs without any respite between episodes</td>
</tr>
<tr>
<td>Retention of urine</td>
<td>Inability to pass urine per urethra associated with an enlarged bladder. This condition is usually very painful unless there is altered sensation</td>
</tr>
<tr>
<td>Colicky pain</td>
<td>Pain that comes and goes in waves. Renal colic tends to come and go over 20 minutes or so</td>
</tr>
<tr>
<td>Dysuria</td>
<td>Pain or difficulty in passing urine. Pain is typically described as stinging or hot</td>
</tr>
</tbody>
</table>
Airway compromise, inadequate breathing or shock:
- If unconscious: place in the recovery position, if conscious: try to reassure.
- Provide Life Support and give advice if required.
- Give appropriate analgesia for pain control.

Worried Parents

**FtF Now**
- Airway compromise
- Inadequate breathing
- Altered conscious level
- Floppy
- Fails to react to parents
- Non-blanching rash
- History of overdose or poisoning
- Known or likely immunosuppression
- Hot baby
- Very hot
- Signs of severe pain

**FtF Soon**
- Signs of dehydration
- Not feeding
- Not passing urine
- Inconsolable by parents
- Prolonged or uninterrupted crying
- Hot

**FtF Later**
- Atypical behaviour
- Signs of pain
- Warmth

Advice only

Alert caller to red flags – symptoms of meningitis
- Discuss causes of crying such as hunger, tiredness, colic, wind, soiled nappy, hot or cold
- Check causes above – work through
- Discuss approach to management of child and provide reassurance
- See GP if symptoms persist or worsen

Take available analgesia for pain control
- Maintain hydration with clear fluids or ORT
- Try to calm and reassure caller: this will help calm the child
- Call back if symptoms worsen

Take available analgesia for pain control
- Alert caller to red flags – symptoms of meningitis
- Try to calm and reassure caller: this will help calm the child
- Contact health visitor (over 10 days old) or midwife (up to 10 days old)
- Call back or see GP if symptoms worsen or new symptoms develop.
Worried parent

<table>
<thead>
<tr>
<th>See also</th>
<th>Chart notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crying baby</td>
<td>This is a presentation-defined flow diagram which has been designed to allow accurate prioritisation of children who are brought to the attention of the service because of parental worry. Parents know their children better than anyone else, and although many of these children will not have serious pathology, it is essential that these presentations are taken seriously. A number of general discriminators are used including Life Threat, Conscious Level, Pain and Temperature. Specific discriminators have been added to the chart to allow identification of more serious pathologies which are apparent or may potentially exist. For any child aged 28 days or under, the unwell newborn chart should be used.</td>
</tr>
<tr>
<td>Irritable child</td>
<td></td>
</tr>
<tr>
<td>Unwell child</td>
<td></td>
</tr>
</tbody>
</table>

**Specific discriminators**

<table>
<thead>
<tr>
<th>Specific discriminators</th>
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<tbody>
<tr>
<td>Floppy</td>
<td>Parents may describe their children as floppy. Tone is generally reduced – the most noticeable sign is often lolling of the head.</td>
</tr>
<tr>
<td>Fails to react to parents</td>
<td>Failure to react in any way to a parent's face or voice. Abnormal reactions and apparent lack of recognition of a parent are also worrying signs.</td>
</tr>
<tr>
<td>Non-blanching rash</td>
<td>A rash that does not blanch (go white) when pressure is applied to it. Often tested using a glass tumbler to apply pressure as any colour change can be observed through the bottom of the tumbler.</td>
</tr>
<tr>
<td>History of overdose or poisoning</td>
<td>This information may come from others or may be deduced if medication is missing.</td>
</tr>
<tr>
<td>Known or likely immunosuppression</td>
<td>Any patient who is known to be immunosuppressed including those on immunosuppressive drugs (including long-term steroids).</td>
</tr>
<tr>
<td>Signs of dehydration</td>
<td>These include dry tongue, sunken eyes, increased skin turgor and, in small babies, a sunken anterior fontanelle. Usually associated with a low urine output.</td>
</tr>
<tr>
<td>Not feeding</td>
<td>Children who do take any solid or liquid (as appropriate) by mouth. Children who take the food but always vomit afterwards may also fulfil this criterion.</td>
</tr>
<tr>
<td>Not passing urine</td>
<td>Failure to produce and pass urine. This may be difficult to judge in children (and the elderly) and reference to the number of nappies or pads used may be useful.</td>
</tr>
<tr>
<td>Inconsolable by parents</td>
<td>Children whose crying or distress does not respond to attempts by their parents to comfort them fulfil this criterion.</td>
</tr>
<tr>
<td>Prolonged or uninterrupted crying</td>
<td>A child who has cried continuously for 2 hours or more fulfils this criterion.</td>
</tr>
<tr>
<td>Atypical behaviour</td>
<td>Children who behave in a way that is not usual in the given situation. The carers will often volunteer this information. Such children are often referred to as fractious or ‘out of sorts’.</td>
</tr>
</tbody>
</table>
Airway compromise, inadequate breathing or shock:
  if unconscious place in the recovery position, if conscious try to reassure
  Provide Life Support Advice if required
Apply pressure appropriate to injury to control major haemorrhage
Take available analgesia for pain control

Take available analgesia for pain control
Apply dressing or pressure if required to stem bleeding
Call back if symptoms worsen

Take available analgesia for pain control
Clean wound and apply dressing if required or attend practice nurse
Call back or see GP if symptoms worsen or new symptoms develop

See your GP if new symptoms develop
  Injury prevention advice
  Observe for signs of infection; see GP as antibiotics may be required
  Establish tetanus status

Airway compromise
Inadequate breathing
Uncontrollable major haemorrhage
Distal vascular compromise
Altered conscious level
New neurological deficit less than 24 hours
Very hot
Severe pain

Uncontrollable minor haemorrhage
New neurological deficit more than 24 hours
Vaginal trauma
Hot

Local inflammation
Unresolved pain

Advice only
# Wounds

**See also**: This is a presentation-defined flow diagram. Many patients present to emergency care suffering from wounds of various nature. These vary from severe life-threatening lacerations to minor abrasions. This chart is designed to allow an accurate prioritisation of these patients.

A number of general discriminators have been used including *Life Threat*, *Haemorrhage* and *Pain*. Specific discriminators have been included to allow identification of patients with signs and symptoms suggesting injuries which pose a threat to function.

## Specific discriminators

<table>
<thead>
<tr>
<th>Specific discriminators</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distal vascular compromise</td>
<td>There will be a combination of pallor, coldness, altered sensation and pain with or without absent pulses distal to the injury</td>
</tr>
<tr>
<td>New neurological deficit less than 24 hours old</td>
<td>Any loss of neurological function that has come on within the previous 24 hours. This might include altered or lost sensation, weakness of the limbs (either transiently or permanently) and alterations in bladder or bowel function</td>
</tr>
<tr>
<td>New neurological deficit more than 24 hours</td>
<td>Any loss of neurological function that has come on within the previous 24 hours. This might include altered or lost sensation, weakness of the limbs (either transiently or permanently) and alterations in bladder or bowel function</td>
</tr>
<tr>
<td>Vaginal trauma</td>
<td>Any history or other evidence of direct trauma to the vagina fulfils this criterion</td>
</tr>
<tr>
<td>Local inflammation</td>
<td>Local inflammation will involve pain, swelling and redness confined to a particular site or area</td>
</tr>
</tbody>
</table>
## Discriminator and question dictionary

<table>
<thead>
<tr>
<th>Discriminator</th>
<th>Questions</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal pain</td>
<td>Do you have pain in your tummy?</td>
<td>Any pain felt in the abdomen. Abdominal pain associated with back pain may indicate abdominal aortic aneurysm, whilst association with PV bleeding may indicate ectopic pregnancy or miscarriage</td>
</tr>
<tr>
<td>Abrupt onset</td>
<td>How long ago did it start?</td>
<td>Onset within seconds or minutes. May cause waking from sleep</td>
</tr>
<tr>
<td>Acute chemical eye injury</td>
<td>Any substance splashed into or placed into the eye within the past 12 hours that caused stinging, burning or reduced vision should be assumed to have caused chemical injury</td>
<td></td>
</tr>
<tr>
<td>Acute complete loss of vision</td>
<td>Loss of vision in one or both eyes within the preceding 24 hours which has not returned to normal</td>
<td></td>
</tr>
<tr>
<td>Acute onset after injury</td>
<td>Did this start after you fell/were hit, etc.?</td>
<td>Onset of symptoms immediately within 24 hours of a physically traumatic event</td>
</tr>
<tr>
<td>Discriminator</td>
<td>Questions</td>
<td>Definition</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Acutely avulsed tooth</td>
<td>When did your tooth come out?</td>
<td>A tooth that has been avulsed intact within the previous 24 hours</td>
</tr>
<tr>
<td></td>
<td>Was this the result of injury?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Is it complete with a root?</td>
<td></td>
</tr>
<tr>
<td>Acutely short of breath</td>
<td>Have you suddenly become short of breath?</td>
<td>Shortness of breath that comes on suddenly or a sudden exacerbation of chronic shortness of breath</td>
</tr>
<tr>
<td></td>
<td>Are you more short of breath than normal?</td>
<td></td>
</tr>
<tr>
<td>Age less than 25 years</td>
<td>How old are you?</td>
<td>Less than 25 years old</td>
</tr>
<tr>
<td>Airway compromise</td>
<td>Are they awake?</td>
<td>An airway may be compromised either because it cannot be kept open or because the airway protective reflexes (that stop inhalation) have been lost. Failure to keep the airway open will result either in intermittent total obstruction or in partial obstruction. This will manifest itself as snoring or bubbling sounds during breathing</td>
</tr>
<tr>
<td></td>
<td>Can they get their breath in?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Do they make a gurgling sound when they breathe?</td>
<td></td>
</tr>
<tr>
<td>Altered blood</td>
<td>Do they open their eyes or move when you speak to them or gently shake their shoulders?</td>
<td>Darker than fresh blood and often smelling more like melaena</td>
</tr>
<tr>
<td>Altered conscious level</td>
<td>Will they open their eyes when you speak to them or gently shake them by the shoulder?</td>
<td>Not fully alert. Either responding to voice or pain only or unresponsive</td>
</tr>
<tr>
<td>wholly attributable to alcohol</td>
<td>Do you know why they are ill?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Do they have diabetes?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Have they had a blow on the head?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Have they had alcohol?</td>
<td></td>
</tr>
<tr>
<td>Altered conscious level not wholly attributable to alcohol</td>
<td>Will they open their eyes when you speak to them or gently shake them by the shoulder?</td>
<td>A patient who is not fully alert, with a clear history of alcohol ingestion and in whom there is no doubt that all other causes of reduced conscious level have been excluded</td>
</tr>
<tr>
<td></td>
<td>Do you know why they are ill?</td>
<td></td>
</tr>
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<td></td>
</tr>
<tr>
<td></td>
<td>Have they had alcohol?</td>
<td></td>
</tr>
<tr>
<td>Altered facial sensation</td>
<td>Any alteration of sensation on the face</td>
<td></td>
</tr>
</tbody>
</table>

(Continued)
<table>
<thead>
<tr>
<th>Discriminator</th>
<th>Questions</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atypical behaviour</td>
<td>Is he behaving normally? Is he listless? Is he ‘out of sorts’?</td>
<td>Children who behave in a way that is not usual in the given situation. The carers will often volunteer this information. Such children are often referred to as fractious or ‘out of sorts’</td>
</tr>
<tr>
<td>Auricular haematoma</td>
<td>Have you had a blow on your ear? Did your ear swell up after you were hit on it? Is it painful?</td>
<td>A tense haematoma (usually post traumatic) in the outer ear</td>
</tr>
<tr>
<td>Black stool</td>
<td>What does the stool look like?</td>
<td>Any blackness fulfils this criteria</td>
</tr>
<tr>
<td>Bleeding disorder</td>
<td>Do you know of any reason why your blood doesn’t clot normally?</td>
<td>Congenital or acquired bleeding disorder</td>
</tr>
<tr>
<td>Cardiac pain</td>
<td>Where is the pain? Have you had pain like this before? What is it like? Does it go to your arm or neck?</td>
<td>Classically, a severe dull ‘gripping’ or ‘heavy’ pain in the centre of the chest, radiating to the left arm or to the neck. May be associated with sweating and nausea</td>
</tr>
<tr>
<td>Chest injury</td>
<td>Have you injured your chest?</td>
<td>Any injury to the area below the clavicles and above the level of the lowest rib. Injury to the lower part of the chest can cause underlying damage to abdominal organs</td>
</tr>
<tr>
<td>Cold</td>
<td>What is their temperature? Do they feel cold to touch?</td>
<td>If the skin feels cold, the patient is clinically said to be cold. The temperature should be taken as soon as possible – a core temperature of less than 35°C is cold</td>
</tr>
<tr>
<td>Colicky pain</td>
<td>Do you have pain? Does it come and go in waves?</td>
<td>Pain that comes and goes in waves. Renal colic tends to come and go over 20 minutes or so</td>
</tr>
<tr>
<td>Critical skin</td>
<td></td>
<td>A fracture or dislocation may leave fragments or ends of bone pressing so hard against the skin that the viability of the skin is threatened. The skin will be white and under tension</td>
</tr>
<tr>
<td>Current palpitation</td>
<td></td>
<td>A feeling of the heart racing (often described as a fluttering) that is still present</td>
</tr>
<tr>
<td>Discriminator</td>
<td>Questions</td>
<td>Definition</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Currently fitting</td>
<td>Are they having a fit?</td>
<td>Patients who are in the tonic or clonic stages of a grand mal convolution and patients currently experiencing partial fits</td>
</tr>
<tr>
<td></td>
<td>What do they look like at the moment?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Are their limbs jerking or shaking?</td>
<td></td>
</tr>
<tr>
<td>Deformity</td>
<td>Does it look the normal shape?</td>
<td>This will always be subjective. Abnormal angulation or rotation is implied</td>
</tr>
<tr>
<td>Diplopia</td>
<td></td>
<td>Double vision that resolves when one eye is closed</td>
</tr>
<tr>
<td>Direct trauma to the back</td>
<td>Have you been hit on your back?</td>
<td>This may be top to bottom (loading), for instance, when someone falls and lands on their feet, bending (forwards, backwards or to the side) or twisting</td>
</tr>
<tr>
<td></td>
<td>What exactly happened?</td>
<td></td>
</tr>
<tr>
<td>Direct trauma to the neck</td>
<td>Have you been hit on your neck?</td>
<td>This may be top to bottom (loading), for instance, when something falls on the head, bending (forwards, backwards or to the side) or twisting, or distracting such as in hanging</td>
</tr>
<tr>
<td></td>
<td>What exactly happened?</td>
<td></td>
</tr>
<tr>
<td>Disruptive</td>
<td>Are they being disruptive?</td>
<td>Disruptive behaviour is behaviour that affects other people. It may or may not be threatening</td>
</tr>
<tr>
<td>Discharge</td>
<td></td>
<td>In the context of sexually acquired infection, this is any discharge from the penis or abnormal discharge from the vagina</td>
</tr>
<tr>
<td>Distal vascular compromise</td>
<td>Does the limb look a different colour below the injury or when you compare it to the other side?</td>
<td>There will be a combination of pallor, coldness, altered sensation and pain with or without absent pulses distal to the injury</td>
</tr>
<tr>
<td></td>
<td>Is the far part limb/area pale or blue?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Is the far part of the limb/area pale?</td>
<td></td>
</tr>
<tr>
<td>Drooling</td>
<td>Is the spit dribbling from their mouth?</td>
<td>Saliva running from the mouth as a result of being unable to swallow</td>
</tr>
<tr>
<td>Dysuria</td>
<td>Does it burn or sting when you pass urine?</td>
<td>Pain or difficulty on passing urine. Pain is typically described as stinging or hot</td>
</tr>
</tbody>
</table>

(Continued)
**Discriminator and question dictionary**

(Continued)

<table>
<thead>
<tr>
<th>Discriminator</th>
<th>Questions</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electrical injury</td>
<td>Have you had an electric shock?</td>
<td>Any injury caused or possibly caused by electric current. This includes AC and DC and both artificial and natural sources</td>
</tr>
<tr>
<td>Exhaustion</td>
<td>Do they look exhausted?</td>
<td>An exhausted patient appears to reduce the effort they make to breathe despite continuing respiratory insufficiency. This is preterminal</td>
</tr>
<tr>
<td>Exsanguinating haemorrhage</td>
<td>Is the bleeding torrential?</td>
<td>Haemorrhage which occurs at such a rate that death will ensue unless bleeding is stopped</td>
</tr>
<tr>
<td>Exsanguinating haemorrhage</td>
<td>Can you stop the bleeding?</td>
<td>Haemorrhage which occurs at such a rate that death will ensue unless bleeding is stopped</td>
</tr>
<tr>
<td>Exsanguinating haemorrhage</td>
<td>Is the blood pumping out?</td>
<td>Haemorrhage which occurs at such a rate that death will ensue unless bleeding is stopped</td>
</tr>
<tr>
<td>Externalisation of organs</td>
<td>Can you see their guts hanging out?</td>
<td>Herniation or frank extrusion of internal organs</td>
</tr>
<tr>
<td>Facial oedema</td>
<td>Is your face swollen?</td>
<td>Diffuse swelling around the face usually involving the lips</td>
</tr>
<tr>
<td>Facial oedema</td>
<td>Is it swollen in a particular place or all over?</td>
<td>Diffuse swelling around the face usually involving the lips</td>
</tr>
<tr>
<td>Facial oedema</td>
<td>How swollen is it?</td>
<td>Diffuse swelling around the face usually involving the lips</td>
</tr>
<tr>
<td>Facial swelling</td>
<td></td>
<td>Swelling around the face which may be localised or diffuse</td>
</tr>
<tr>
<td>Fails to react to parents</td>
<td>Does he react to you at all?</td>
<td>Failure to react in any way to a parents face or voice. Abnormal reactions and apparent lack of recognition of a parent are also worrying signs</td>
</tr>
<tr>
<td>Fails to react to parents</td>
<td>Is the reaction normal?</td>
<td>Failure to react in any way to a parents face or voice. Abnormal reactions and apparent lack of recognition of a parent are also worrying signs</td>
</tr>
<tr>
<td>Floppy</td>
<td>Are they floppy?</td>
<td>Parents may describe their children as floppy. Tone is generally reduced – the most noticeable sign is often lolling of the head</td>
</tr>
<tr>
<td>Foreign body sensation</td>
<td></td>
<td>A sensation of something in the eye, often expressed as scraping or grittiness</td>
</tr>
<tr>
<td>Frank haematuria</td>
<td>Is there blood in your urine?</td>
<td>Red discolouration of the urine caused by blood</td>
</tr>
<tr>
<td>Frank haematuria</td>
<td>Is your urine red?</td>
<td>Red discolouration of the urine caused by blood</td>
</tr>
<tr>
<td>Gross deformity</td>
<td></td>
<td>This will always be subjective. Gross and abnormal angulation or rotation is implied</td>
</tr>
<tr>
<td>Gross deformity</td>
<td></td>
<td>This will always be subjective. Gross and abnormal angulation or rotation is implied</td>
</tr>
<tr>
<td>Headache</td>
<td>Do you have a headache?</td>
<td>Any pain around the head that is not related to a particular anatomical structure. Facial pain is not included</td>
</tr>
<tr>
<td>Head injury</td>
<td>Have you banged your head?</td>
<td>Any traumatic event involving the head</td>
</tr>
<tr>
<td>Head injury</td>
<td>Have you been hit on the head?</td>
<td>Any traumatic event involving the head</td>
</tr>
<tr>
<td>Discriminator</td>
<td>Questions</td>
<td>Definition</td>
</tr>
<tr>
<td>------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Heavy PV blood loss</td>
<td>How much blood are you losing?</td>
<td>PV loss is extremely difficult to assess. The presence of large clots or constant flow fulfils this criterion. The use of large numbers of sanitary towels is suggestive of heavy loss</td>
</tr>
<tr>
<td></td>
<td>How many towels are you using?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Is this normal for you?</td>
<td></td>
</tr>
<tr>
<td>High blood pressure</td>
<td>Do you have high blood pressure?</td>
<td>A history of raised blood pressure or a raised blood pressure on examination</td>
</tr>
<tr>
<td></td>
<td>Are you taking medicine for high blood pressure?</td>
<td></td>
</tr>
<tr>
<td>High lethality</td>
<td></td>
<td>Lethality is the potential of the substance taken to cause harm. Advice from a poisons centre may be required to establish the level of risk of serious illness or death. If in doubt, assume a high risk</td>
</tr>
<tr>
<td>High lethality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>envenomation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High lethality chemical</td>
<td></td>
<td>Lethality is the potential of the chemical to cause harm. Advice may be required to establish the level of risk. If in doubt, assume a high risk</td>
</tr>
<tr>
<td>History of recent</td>
<td>Have you travelled abroad lately?</td>
<td>Recent significant foreign travel (within 2 weeks)</td>
</tr>
<tr>
<td>foreign travel</td>
<td>Where have you been?</td>
<td></td>
</tr>
<tr>
<td>History of head injury</td>
<td>Have you banged your head?</td>
<td>A history of a recent physically traumatic event involving the head. Usually this will be reported by the patient but, if the patient has been unconscious, this history should be sought from a reliable witness</td>
</tr>
<tr>
<td></td>
<td>Have you been hit on the head?</td>
<td></td>
</tr>
<tr>
<td>History of trauma</td>
<td>Have you hurt yourself?</td>
<td>A history of a recent physically traumatic event</td>
</tr>
<tr>
<td></td>
<td>Have you fallen or been involved in an accident?</td>
<td></td>
</tr>
</tbody>
</table>

(Continued)
Discriminator | Questions | Definition
--- | --- | ---
History of unconsciousness | Were you (they) unconscious? Have you (they) been knocked out? | There may be a reliable witness who can state whether the patient was unconscious (and for how long). If not, a patient who is unable to remember the incident should be assumed to have been unconscious.
History of acutely vomiting blood | Have you vomited any blood? Have you vomited up any brown stuff? | Frank haematemesis, vomiting of altered blood (coffee ground) or of blood mixed in the vomit within the past 24 hours.
History of overdose or poisoning | | This information may come from others or may be deduced if medication is missing.
Hot joint | Is (are) your joint(s) hot to touch? | Any warmth around a joint fulfils this criterion. Often accompanied by redness.
Hot | Have you taken your temperature? What is it? Do you feel hot? | If the skin feels hot, the patient is clinically said to be hot. A temperature of 38.5°C and greater is hot. Other clinical features of pyrexia should be taken into account.
Hot baby | | If the skin is hot, the child is clinically said to be hot. The temperature should be taken as soon as possible – a temperature of 38.5°C and greater is hot. A baby is a child less than 1 year old.
Hyperglycaemia | | Glucose greater than 17 mmol/l
Hyperglycaemia with ketosis | | Glucose greater than 11 mmol/l with urinary ketones or signs of acidosis (deep sighing respiration, etc.)
Hypoglycaemia | | Glucose less than 3 mmol/l
In active labour | Are you getting contractions? Do you feel labour has started? | A woman who is having regular frequent painful contractions fulfils this criterion.
<table>
<thead>
<tr>
<th>Discriminator</th>
<th>Questions</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadequate breathing</td>
<td>Are they breathing?</td>
<td>Patients who are failing to breathe well enough to maintain adequate oxygenation have inadequate breathing. There may be an increased work of breathing, signs of inadequate breathing or exhaustion.</td>
</tr>
<tr>
<td></td>
<td>What is the colour of their lips and tongue?</td>
<td></td>
</tr>
<tr>
<td>Inappropriate history</td>
<td></td>
<td>When the history (story) given does not explain the physical findings, it is termed inappropriate. This is important as it is a marker of safeguarding concerns in both adults and children.</td>
</tr>
<tr>
<td>Inconsolable by parent</td>
<td>Can you calm them down at all?</td>
<td>Children whose crying or distress does not respond to attempts by their parents to comfort them, fulfil this criterion.</td>
</tr>
<tr>
<td></td>
<td>Do they settle at all when you cuddle them?</td>
<td></td>
</tr>
<tr>
<td>Inhalational injury</td>
<td>Were they (you) confined in a place that was filled with smoke?</td>
<td>A history of being confined in a smoke filled space is the most reliable indicator of smoke inhalation. Carbon deposits around the mouth and nose and hoarse voice may be present. History is also the most reliable way of diagnosing inhalation of chemicals – there will not necessarily be any signs.</td>
</tr>
<tr>
<td></td>
<td>Is there any soot in the nostrils or mouth?</td>
<td></td>
</tr>
<tr>
<td>Jaundice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Known abdominal or aortic aneurysm</td>
<td>Have you (has the patient) ever had investigations for an aneurysm in your belly?</td>
<td>Self (or caller) reported to have abdominal or aortic aneurysm.</td>
</tr>
<tr>
<td>Known or likely immunosuppression</td>
<td>Do you take any medicines?</td>
<td>Any patient who is known or likely to be immunosuppressed including those on immunosuppressive drugs (including long term steroids).</td>
</tr>
<tr>
<td></td>
<td>What are they?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Do you have any illnesses that affect your immunity?</td>
<td></td>
</tr>
<tr>
<td>Lack of medication causing exacerbation or relapse of condition</td>
<td></td>
<td>Lack of regular medications such as insulin which may cause exacerbation or relapse of condition if not obtained soon.</td>
</tr>
</tbody>
</table>
### Discriminator and Question Dictionary (Continued)

<table>
<thead>
<tr>
<th>Discriminator</th>
<th>Questions</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lethality</td>
<td></td>
<td>The potential of the substance taken to cause illness or death. Advice from a Poisons Centre may be required to establish this. If in doubt assume a high risk.</td>
</tr>
<tr>
<td>Local inflammation</td>
<td>Is it red?</td>
<td>Local inflammation will involve pain, swelling and redness confined to a particular site or area.</td>
</tr>
<tr>
<td></td>
<td>Is it warm to touch?</td>
<td></td>
</tr>
<tr>
<td>Marked distress</td>
<td>How do you feel?</td>
<td>Patients who are markedly physically or emotionally upset fulfil this criterion.</td>
</tr>
<tr>
<td></td>
<td>How are you?</td>
<td></td>
</tr>
<tr>
<td>Moderate lethality</td>
<td></td>
<td>Lethality is the potential of the chemical to cause harm. Advice may be required to establish the level of risk. If in doubt, assume a high risk.</td>
</tr>
<tr>
<td>chemical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate lethality</td>
<td></td>
<td>Lethality is the potential of the substance taken to cause serious illness or death. Advice from a Poisons Centre may be required to establish the level of risk to the patient</td>
</tr>
<tr>
<td>envenomation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New abnormal pulse</td>
<td></td>
<td>A bradycardia (less than 60/ minutes in adults), a tachycardia (more than 100/minutes in adults) or an irregular rhythm. Age appropriate definitions of bradycardia and tachycardia should be used in children</td>
</tr>
<tr>
<td>New neurological deficit less than 24 hours old</td>
<td>Can you move all your arms and legs?</td>
<td>Any loss of neurological function that has come on within the previous 24 hours. This might include altered or lost sensation, weakness of the limbs (either transiently or permanently) and alterations in bladder or bowel function</td>
</tr>
<tr>
<td></td>
<td>Do you have any tingling or numbness?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>When did this start?</td>
<td></td>
</tr>
<tr>
<td>Discriminator</td>
<td>Questions</td>
<td>Definition</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>--------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>New neurological deficit more than 24 hours old</td>
<td></td>
<td>Any loss of neurological function including altered or lost sensation, weakness of the limbs (either transiently or permanently) and alterations in bladder or bowel function</td>
</tr>
<tr>
<td>No improvement with own asthma medications</td>
<td>Have you got better since you took your treatment?</td>
<td>This history should be available from the patient. A failure to improve with bronchodilator therapy given by the GP or paramedic is equally significant</td>
</tr>
<tr>
<td>Non-blanching rash</td>
<td></td>
<td>A rash that does not blanch (go white) when pressure is applied to it. Often tested using a glass tumbler to apply pressure as any colour change can be observed through the bottom of the tumbler</td>
</tr>
<tr>
<td>Not distractible</td>
<td>Can you calm them down?</td>
<td>Children who are distressed by pain or other things who cannot be distracted by conversation or play</td>
</tr>
<tr>
<td></td>
<td>Will they play with their toys?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Will they take an interest in anything?</td>
<td></td>
</tr>
<tr>
<td>Not feeding</td>
<td>Are they managing to eat or drink?</td>
<td>Children who will not take solid or liquid (as appropriate) by mouth. Children who will take the food but always vomit afterwards may also fulfil this criterion</td>
</tr>
<tr>
<td></td>
<td>Can they take any fluids?</td>
<td></td>
</tr>
<tr>
<td>Not passing urine</td>
<td>Are they passing any urine?</td>
<td>Failure to produce and pass urine. This may be difficult to judge in children (and the elderly) and reference to the number of nappies or pads used may be useful</td>
</tr>
<tr>
<td></td>
<td>Do they have any wet nappies?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>How many and is that normal for them?</td>
<td></td>
</tr>
<tr>
<td>Oedema of the tongue</td>
<td>Is their tongue swollen?</td>
<td>Swelling of the tongue of any degree</td>
</tr>
<tr>
<td>Open fracture</td>
<td>Is there a cut near the broken bone?</td>
<td>All wounds in the vicinity of a fracture should be regarded with suspicion. If there is any possibility of communication between the wound and the fracture, then the fracture should be assumed to be open</td>
</tr>
<tr>
<td></td>
<td>Is there bone sticking out?</td>
<td>(Continued)</td>
</tr>
<tr>
<td>Discriminator</td>
<td>Questions</td>
<td>Definition</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Pain on joint movement</td>
<td>Does it hurt when you move your joint(s)?</td>
<td>This can be pain on both active (patient) movement or passive (examiner) movement</td>
</tr>
<tr>
<td>Pain radiating to the back</td>
<td>Does the pain go through to your back?</td>
<td>Pain that is also felt in the back either intermittently or constantly</td>
</tr>
<tr>
<td>Passing fresh or altered blood PR</td>
<td>Are you passing blood from the back passage at the moment? What colour is it?</td>
<td>In active massive GI bleeding, dark red blood will be passed PR. As GI transit time increases, this becomes darker, eventually becoming melaena</td>
</tr>
<tr>
<td>Penetrating eye injury</td>
<td>Has it gone into your eye? Has anything stuck into your eye?</td>
<td>A recent physically traumatic event involving penetration of the globe</td>
</tr>
<tr>
<td>Penetrating trauma</td>
<td>Have you been shot? Have you been stabbed?</td>
<td>A recent physically traumatic event which involves discrete penetration of any body area by a knife, bullet or other object</td>
</tr>
<tr>
<td>Persistent vomiting</td>
<td>Are you vomiting all the time? Does the vomiting ever stop?</td>
<td>Vomiting that is continuous or that occurs without any respite between episodes</td>
</tr>
<tr>
<td>Pleuritic pain</td>
<td>Is the pain sharp or dull? Is it worse on coughing? Is it worse on deep breathing?</td>
<td>A sharp pain in the chest worse on breathing, coughing or sneezing</td>
</tr>
<tr>
<td>Possibly pregnant</td>
<td>Could you be pregnant? When was your last period?</td>
<td>Any woman whose normal menstruation has failed to occur is possibly pregnant. Furthermore, any woman of childbearing age who has unprotected sex should be considered to be potentially pregnant</td>
</tr>
<tr>
<td>Presenting foetal parts</td>
<td>Can you see any part of the baby? Is the baby coming out?</td>
<td>Crowning or presentation of any other foetal part in the vagina</td>
</tr>
<tr>
<td>Priapism</td>
<td>Do you (they) have an erection?</td>
<td>Sustained penile erection</td>
</tr>
<tr>
<td>Productive cough</td>
<td></td>
<td>A cough which is productive of phlegm, whatever the colour</td>
</tr>
<tr>
<td>Prolonged or uninterrupted crying</td>
<td>How long have they been crying? Do they ever stop?</td>
<td>A child who has cried continuously for 2 hours or more</td>
</tr>
<tr>
<td>Discriminator</td>
<td>Questions</td>
<td>Definition</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Purpura</td>
<td>A rash on any part of the body that is caused by small haemorrhages under the skin. A purpuric rash does not blanch (go white) when pressure is applied to it</td>
<td></td>
</tr>
<tr>
<td>PV blood loss</td>
<td>Is there any vaginal bleeding?</td>
<td>Any bleeding PV</td>
</tr>
<tr>
<td>PV blood loss and 20 weeks pregnant or more</td>
<td>Are you bleeding down below?</td>
<td>Any loss of blood PV in a woman known to be beyond the 20th week of pregnancy</td>
</tr>
<tr>
<td>Rapid onset</td>
<td>How quickly did it come on?</td>
<td>Onset within the preceding 12 hours</td>
</tr>
<tr>
<td></td>
<td>Did it come on quickly?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>How quickly?</td>
<td></td>
</tr>
<tr>
<td>Recent hearing loss</td>
<td>Has this come on in the last week?</td>
<td>Loss of hearing in one or both ears within the previous week</td>
</tr>
<tr>
<td></td>
<td>Has this got worse over the last week?</td>
<td>A problem arising in the last week</td>
</tr>
<tr>
<td>Recent reduced visual acuity</td>
<td>Any reduction in corrected visual acuity within the past 7 days</td>
<td></td>
</tr>
<tr>
<td>Red eye</td>
<td>Do you have redness of the eye?</td>
<td>Any redness to the eye. A red eye may be painful or painless and may be complete or partial</td>
</tr>
<tr>
<td></td>
<td>Is your eyeball red rather than white?</td>
<td>A dark red stool classically seen in intussusception. Absence of this type of stool does not rule out the diagnosis</td>
</tr>
<tr>
<td>Redcurrant stool</td>
<td>What does the stool look like?</td>
<td>Medication is required but there is a larger window of opportunity for obtaining it</td>
</tr>
<tr>
<td></td>
<td></td>
<td>There is a window of opportunity for post-coital contraception which best evidence suggests ends at 72 hours</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Response to a painful stimulus. Standard peripheral stimuli should be used – a pencil or pen is used to apply pressure to the finger nail bed. This stimulus should not be applied to the toes since a spinal reflex may cause flexion even in brain death. Supraorbital ridge pressure should not be used since reflex grimacing may occur</td>
</tr>
</tbody>
</table>

(Continued)
<table>
<thead>
<tr>
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<th>Questions</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responds to voice</td>
<td>Do they open their eyes, talk or move when you shout at them?</td>
<td>Response to a vocal stimulus. It is not necessary to shout the patient’s name. Children may fail to respond because they are afraid.</td>
</tr>
<tr>
<td>Retention of urine</td>
<td>Can you pass water?</td>
<td>Inability to pass urine per urethra associated with an enlarged bladder. This condition is usually very painful unless there is altered sensation.</td>
</tr>
<tr>
<td>When did you last pass water?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is it painful?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk of continued contamination</td>
<td></td>
<td>If chemical exposure is likely to continue (usually due to lack of adequate decontamination) then this discriminator applies. Risks to health care workers must not be forgotten if this situation occurs.</td>
</tr>
<tr>
<td>Risk of (further) harm to others</td>
<td>What are they (you) going to do?</td>
<td>The potential of the patient to actively attempt to harm others. This may be assessed by considering the state of mind, body posture and behaviour. If in doubt, assume a high risk.</td>
</tr>
<tr>
<td>Are they being threatening?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What are they saying?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What are they doing?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do they have a weapon?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk of (further) self-harm</td>
<td>What are you (they) going to do?</td>
<td>The potential of the patient to actively attempt further self-harm. If in doubt, assume a high risk.</td>
</tr>
<tr>
<td>Do you want to kill yourself?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scrotal cellulitis</td>
<td>Is there any redness and warmth of the scrotum?</td>
<td>Redness and swelling around the scrotum</td>
</tr>
<tr>
<td>Scrotal gangrene</td>
<td>Is the scrotum black, discoloured or white and flaking?</td>
<td>Dead blackened skin around the scrotum and groin. Early gangrene may not be black but may appear like a full thickness burn with or without flaking.</td>
</tr>
<tr>
<td>Scrotal trauma</td>
<td>Have you been kicked in the testicles?</td>
<td>Any recent physically traumatic event involving the scrotum</td>
</tr>
<tr>
<td>Severe itch</td>
<td>Is the itch very bad?</td>
<td>An itch that is unbearable</td>
</tr>
<tr>
<td>How bad is the itching?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe pain</td>
<td>Can they (you) describe how bad the pain is?</td>
<td>Pain that is unbearable – often described as the worst ever.</td>
</tr>
<tr>
<td>Shoulder tip pain</td>
<td>Have you got any pain in your shoulder?</td>
<td>Pain felt in the tip of the shoulder. This often indicates diaphragmatic irritation</td>
</tr>
<tr>
<td>Discriminator</td>
<td>Questions</td>
<td>Definition</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Significant cardiac history</td>
<td>A known recurrent dysrhythmia which has life-threatening effects is significant, as is a known cardiac condition that may deteriorate rapidly</td>
<td></td>
</tr>
<tr>
<td>Significant haematological history</td>
<td>A patient with a haematological disorder that is known to deteriorate rapidly</td>
<td></td>
</tr>
<tr>
<td>Significant history of allergy</td>
<td>Have they ever had a severe reaction to anything? What happened?</td>
<td>A known sensitivity with severe reaction (e.g. to nuts or bee sting) is significant</td>
</tr>
<tr>
<td>Significant history of GI bleed</td>
<td>Any history of massive GI bleeding or of any GI bleed associated with oesophageal varices</td>
<td></td>
</tr>
<tr>
<td>Significant mechanism of injury</td>
<td>How did the injury occur? Penetrating injuries (stab or gunshot) and injuries with high energy transfer</td>
<td></td>
</tr>
<tr>
<td>Significant psychiatric history</td>
<td>Do you have a psychiatrist? A history of a major psychiatric illness or event</td>
<td></td>
</tr>
<tr>
<td>Significant respiratory history</td>
<td>A history of previous life threatening episodes of a respiratory condition (e.g. COPD) is significant as is brittle asthma</td>
<td></td>
</tr>
<tr>
<td>Signs of dehydration</td>
<td>These include dry tongue, sunken eyes, increased skin turgor and, in small babies, a sunken anterior fontanelle. Usually associated with a low urine output</td>
<td></td>
</tr>
<tr>
<td>Signs of meningism</td>
<td>Classically a stiff neck together with headache and photophobia</td>
<td></td>
</tr>
<tr>
<td>Signs of pain</td>
<td>Young children and babies in pain cannot complain. They will usually cry occasionally and may act atypically</td>
<td></td>
</tr>
<tr>
<td>Signs of severe pain</td>
<td>Young children and babies in severe pain cannot complain. They will usually cry out continuously and inconsolably and be tachycardic. They may well exhibit signs such as pallor and sweating</td>
<td></td>
</tr>
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</table>

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<thead>
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<th>Questions</th>
<th>Definition</th>
</tr>
</thead>
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<tr>
<td>Smoke exposure</td>
<td>Were you (they) stuck in a smoke filled area?</td>
<td>Smoke inhalation should be assumed if the patient has been confined in a smoke-filled space. Physical signs such as oral or nasal soot are less reliable but significant if present</td>
</tr>
<tr>
<td>Special risk of infection</td>
<td></td>
<td>Known exposure to a dangerous pathogen or a travel to an area with an identified, current serious infectious risk</td>
</tr>
<tr>
<td>Stridor</td>
<td>Do they make a noise in their throat when they breathe in or out?</td>
<td>This may be an inspiratory or expiratory noise or both. Stridor is heard best on breathing with the mouth open</td>
</tr>
<tr>
<td>Swelling</td>
<td>Has it swollen up?</td>
<td>An abnormal increase in size</td>
</tr>
<tr>
<td>Temporal scalp tenderness</td>
<td></td>
<td>Tenderness on palpation over the temporal area (especially over the artery)</td>
</tr>
<tr>
<td>Testicular pain</td>
<td>Do you have pain in the testicles?</td>
<td>Pain in the testicles</td>
</tr>
<tr>
<td>Unable to feed</td>
<td>Are they feeding normally?</td>
<td>This is usually reported by the parents. Children who will not take any solid or liquid (as appropriate) by mouth</td>
</tr>
<tr>
<td>Unable to talk in sentences</td>
<td>Are they so short of breath that they can’t talk to you?</td>
<td>Patients who are so breathless that they cannot complete relatively short sentences in one breath</td>
</tr>
<tr>
<td>Unable to walk</td>
<td>Can they walk?</td>
<td>It is important to try and distinguish between patients who have pain and difficulty walking and those who cannot walk. Only the latter can be said to be unable to walk</td>
</tr>
<tr>
<td>Uncontrollable major haemorrhage</td>
<td>Are they bleeding a lot?</td>
<td>A haemorrhage that is not rapidly controlled by the application of sustained direct pressure and which continues to bleed heavily or soak through large dressings quickly</td>
</tr>
<tr>
<td>Uncontrollable minor haemorrhage</td>
<td>Are they bleeding?</td>
<td>A haemorrhage that is not rapidly controlled by the application of sustained direct pressure and which continues to bleed slightly or ooze</td>
</tr>
<tr>
<td>Discriminator</td>
<td>Questions</td>
<td>Definition</td>
</tr>
<tr>
<td>---------------------------</td>
<td>----------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Unresolved itch</td>
<td>Itch that has not resolved despite</td>
<td>waiting an appropriate time or taking appropriate medication</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unresolved pain</td>
<td>Pain which has not resolved</td>
<td>despite waiting an appropriate time or being given appropriate analgesia</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unresolved rash</td>
<td>A rash that has not resolved</td>
<td>despite waiting an appropriate time or being given appropriate therapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unresolved vomiting</td>
<td>Vomiting which has not resolved</td>
<td>despite any appropriate actions</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unresponsive</td>
<td>Patients who fail to respond to either</td>
<td>verbal or painful stimuli are unresponsive</td>
</tr>
<tr>
<td></td>
<td>verbal or painful stimuli</td>
<td></td>
</tr>
<tr>
<td>Unresponsive child</td>
<td>Do they react to you at all?</td>
<td>A child who fails to respond to either verbal or painful stimuli is unresponsive</td>
</tr>
<tr>
<td></td>
<td>Can you waken them at all?</td>
<td></td>
</tr>
<tr>
<td>Vertigo</td>
<td>An acute feeling of spinning or</td>
<td>dizziness, possibly accompanied by nausea and vomiting</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very hot</td>
<td>Have they been shaking?</td>
<td>If the skin feels very hot, the patient is clinically said to be very hot.</td>
</tr>
<tr>
<td></td>
<td>Has the temperature been taken?</td>
<td>This should be used with caution where a core temperature is not available and other signs of pyrexia should be taken into account.</td>
</tr>
<tr>
<td></td>
<td>What is it?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>How hot do they feel when you touch</td>
<td>A temperature of 41°C or greater is very hot</td>
</tr>
<tr>
<td></td>
<td>them?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Do they say they are feeling cold?</td>
<td></td>
</tr>
<tr>
<td>Visible abdominal mass</td>
<td>A mass in the abdomen that is visible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>to the naked eye</td>
<td></td>
</tr>
<tr>
<td>Vomiting</td>
<td>Have you vomited since this happened?</td>
<td>Any emesis fulfils this criteria</td>
</tr>
<tr>
<td>Vomiting blood</td>
<td>Vomited blood may be fresh</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(bright or dark red) or coffee ground</td>
<td></td>
</tr>
<tr>
<td></td>
<td>in appearance</td>
<td></td>
</tr>
<tr>
<td>Warm newborn</td>
<td>If the skin feels warm, the patient</td>
<td></td>
</tr>
<tr>
<td></td>
<td>is clinically said to be warm.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The temperature should be taken as</td>
<td></td>
</tr>
<tr>
<td></td>
<td>as soon as possible – a child of 28</td>
<td></td>
</tr>
<tr>
<td></td>
<td>days or under with a temperature of</td>
<td></td>
</tr>
<tr>
<td></td>
<td>37.5–38.4°C is warm</td>
<td></td>
</tr>
</tbody>
</table>

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<table>
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<tr>
<th>Discriminator</th>
<th>Questions</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warmth</td>
<td>If the skin feels warm, the patient is clinically said to be warm. The temperature should be taken as soon as possible – a temperature greater than 37.5°C is warm.</td>
<td></td>
</tr>
<tr>
<td>Wheeze</td>
<td>Do they (you) sound wheezy when breathing?</td>
<td>This can be audible wheeze or a feeling of wheeze. Very severe airway obstruction is silent (no air can move).</td>
</tr>
<tr>
<td>Widespread discharge or blistering</td>
<td>Where are the blisters?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>How much of your body is covered by them?</td>
<td>Any discharging or blistering eruption covering more than 10% body surface area.</td>
</tr>
<tr>
<td></td>
<td>Are they discharging?</td>
<td></td>
</tr>
<tr>
<td>Widespread rash or blistering</td>
<td>Any rash or blistering eruption covering more than 10% of the body surface area.</td>
<td></td>
</tr>
<tr>
<td>Withdrawal possible</td>
<td>Where the lack of medication will lead to symptoms of drug/substance withdrawal or other unwanted effects.</td>
<td></td>
</tr>
</tbody>
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