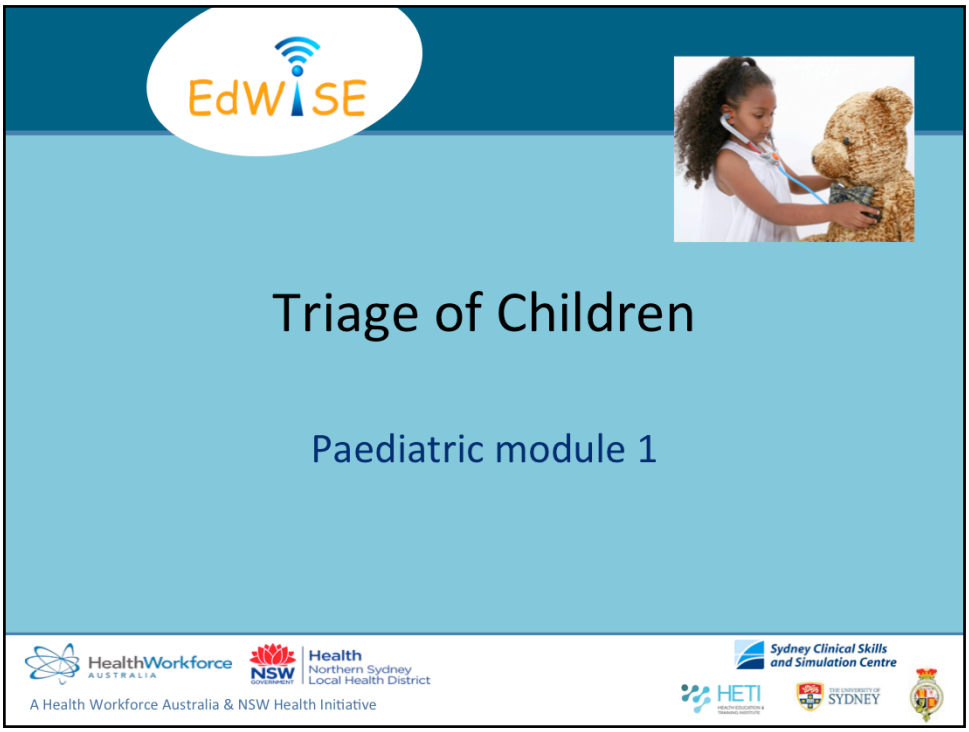
EdWiSE
Triage of Children
Paediatric module 1
HealthWorkforce AUSTRALIA
NSW GOVERNMENT Health Northern Sydney Local Health District
A Health Workforce Australia & NSW Health Initiative
Sydney Clinical Skills and Simulation Centre
HETI
THE UNIVERSITY OF SYDNEY

Sponsor

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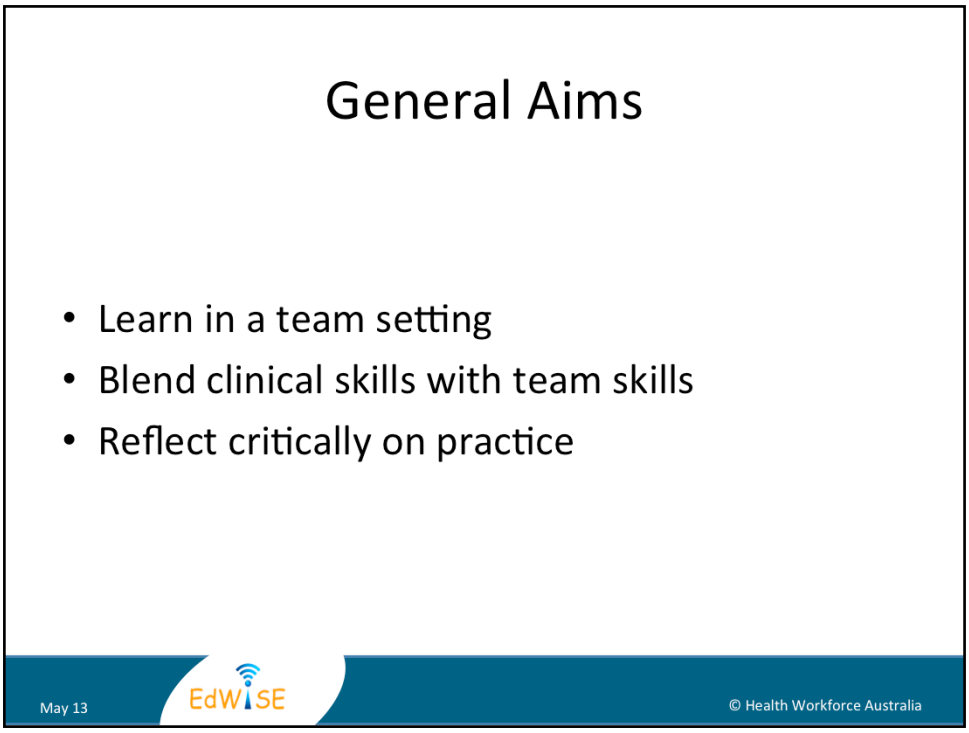
Very quick round the room to assess stage of professional development for each participant.



These aims are the same for all sessions – please do not modify

Speakers' notes

- This session, and package as a whole, involves learning together. Learning with the teams that you work with helps that team to function more efficiently and effectively. It allows you to learn from each other, explore different perspectives and to understand the importance of all members of the team.
- We are targeting higher level learning – applied skills and performance in contextualised events. This is through team discussion and also through working through simulated scenarios as a team. It also allows you to put into practice knowledge attained from the eLearning and other solo learning environments.
- To review and reflect upon our own practice and current best practice standards. During our feedback sessions we will facilitate this but we would also encourage you to reflect on your practice and experience after these sessions.

These aims are the same for all sessions – please do not modify

Speakers notes

- Challenge of video conferencing tips: don't change your seat, speak up nice & clearly
- Details collected and de-identified for reporting purposes
- Signed form, don't speak outside about how people performed as not necessarily indicative of real life. This is a chance to try new things, don't tell anyone about the scenarios as they are used again on subsequent courses.
- We try to use best evidence practice and strive to include as up-to-date material as possible. Please do refer to your local policies, guidelines and protocols.
- Debriefing is a chance to reflect upon what we did and how that translates to the workplace. Please use this time to explore the complexities of performance and decision making. Please contribute, we will all learn from each other's experiences.
- Like most things in life, the more that you put in the more you will take away with you.
- It is an open forum where everyone's ideas and thoughts are to be valued.
- If you could please switch your phones off or to silent or vibrate for the duration of the course.

Session Objectives

- Discuss the principles of paediatric emergency care and triage
- Demonstrate use of equipment and tools required for paediatric assessment
- Demonstrate history taking and assessment of a paediatric patient at triage

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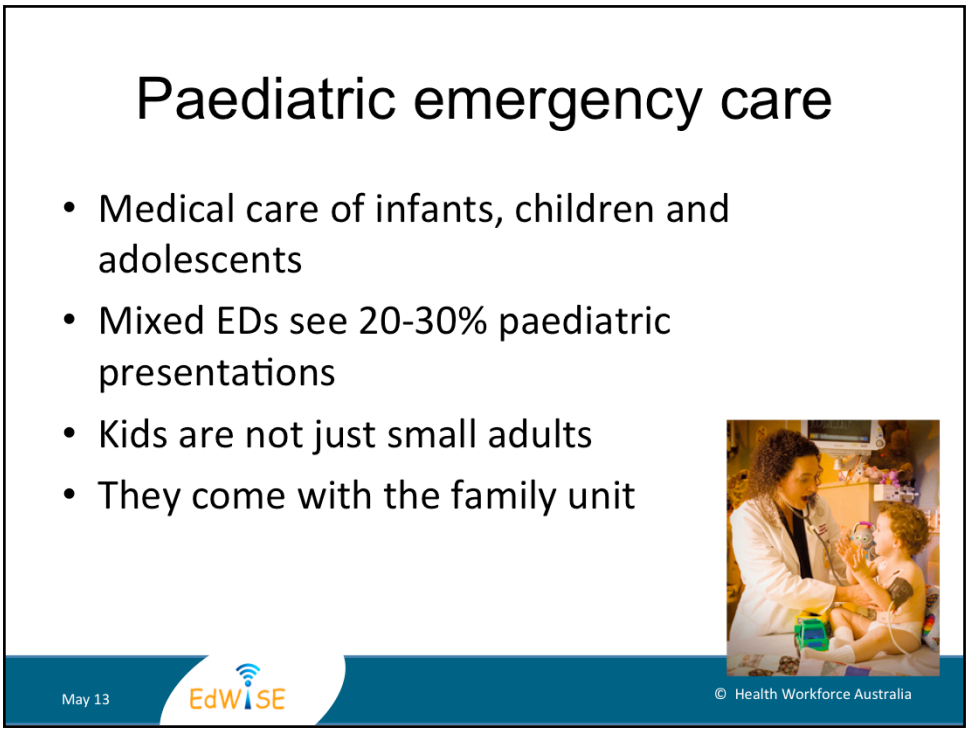

Paediatrics is the branch of medicine that deals with the medical care of infants, children, and adolescents. In New South Wales (NSW) Australia the age limit of such patients ranges from birth to16 years of age.
Within mixed Emergency departments in NSW Paediatric's can represent between 20-30% of daily presentations.
It's an old saying in medical management of paediatric patients that "Kids are not just small adults". They are a diverse group of people. They vary enormously in weight, size, shape, intellectual ability and emotional response. At birth a child is on average 3.5kg, 50cm long individual with small respiratory and cardiovascular reserves and an immature immune system. They are capable of limited movement, exhibit limited emotional responses and are dependant upon adults for all there needs, Fourteen or more years later the adolescent is 50kg, 160cm tall and looks like an adult.
The key differences to consider in children are;
1. Weight
2. Anatomical- size and shape
3. Physiological – cardiovascular, respiratory, immune function
4. Psychological – intellectual ability and emotional response.

Competent management of the ill or injured paediatric patient who may fall anywhere between the two extremes requires a knowledge of the anatomical, physiological and emotional differences, and the strategies on how to deal with

Triage

- Determine the urgency of need for emergency care
- Assess ABC within 2 mins
- Allocate triage within 3-5 mins
- Use Australasian Triage Score

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The term triage is derived from the word trier to pick or sort.
First used in Napoleonic wars of the late 18th century to prioritise medical care.
National triage system was implemented only in 1993 & then underwent refinement in the late 1990's & became the ATS
Essential skill which underpins the delivery of care in ED.

Australasian triage score

- Category 1 – immediate
- Category 2 - < 10 mins
- Category 3 - < 30 mins
- Category 4 - < 1 hour
- Category 5 – within 2 hours

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The five-tiered triage scales have been shown to be a valid & reliable method of categorising people who present to the emergency department.

The following table is the ATS categories for treatment acuity & performance thresholds. Performance thresholds are the benchmarks set for achieving time to treatment within each category. For example, it is expected that 100% of patients who present to ED and are given a category 1 should achieve treatment immediately as there is a significant threat to life or limb.

Consider cases that may fit into each of these categories in the paediatric population.

Remind the team that if in doubt the patient should be discussed with a senior colleague or triaged to a higher priority to reduce the risk of under triaging the patient.

Assessment

- Recognise the potential for a life threatening situation
- Do not disregard parental concerns.
- Assessment includes:
  - Airway
  - Breathing
  - Circulation
  - Disability
  - Fluids in, fluids out
  - Vital signs are vital
- Clinical indicators and red flags

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Triage decision making is an inherently complex & dynamic process.
It is done in a time sensitive environment, with limited information with pts who generally do not have a medical diagnosis.

The triage nurse requires specialised knowledge with extensive experience in order to be able to recognise potential life threatening situations.
A full set of observations should be taken on all patients as part of the triage process and risk assessed based on the normal values for the age of the child, consider using the SAGO chart to help with this.

Airway assessment – noises, stridor, talking/crying
Breathing – count the rate for ½ - 1 minute while assessing the work of breathing & listening to air entry
Circulation – count heart rate ½ - 1 minute, assess colour, warmth, perfusion

There are some “red flags” or “high risk” indicators that the triage nurse must consider while assessing infants and young children. Any child presenting who may fit into one of these categories should be up-triaged to ensure prompt time to treatment.

Mechanism of injury
Co morbidity
Age < 3 months
Preceding events
Parental concerns
Social Risk

The following table further defines the particular indicators in each category that must be taken into consideration in order to determine the appropriate triage score. Any child that presents with a history of a “high risk” indicator would be triaged as a category 3 or above.

History

- Requires highly skilled interpersonal and communication skills
  - Polite
  - Professional
  - Reassuring
- Focused history to determine clinical urgency

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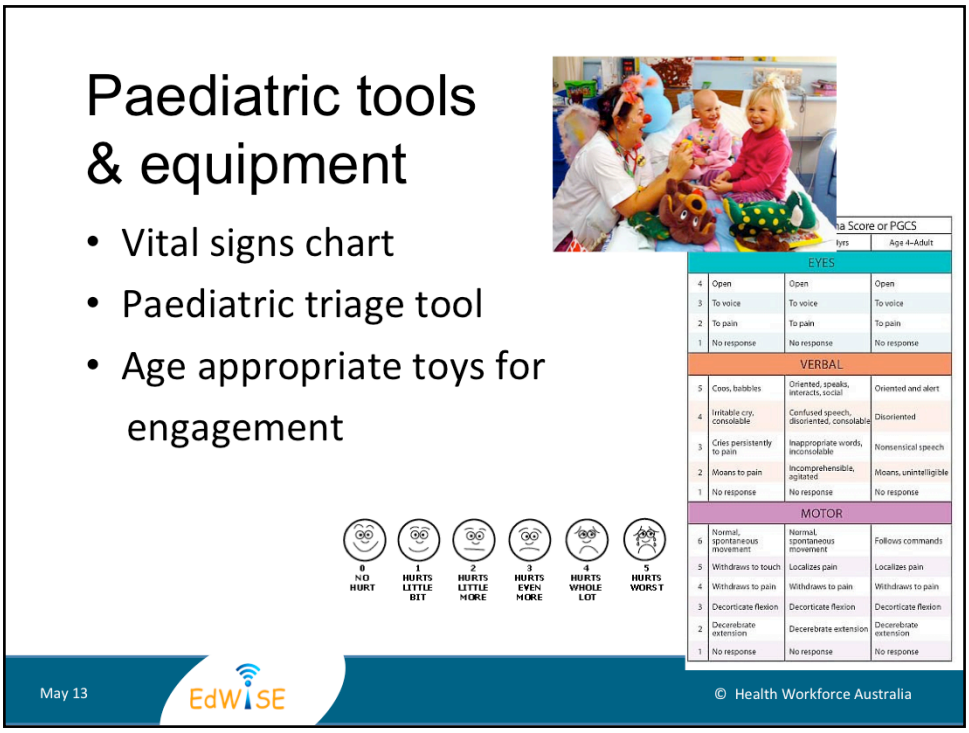

Children in general do not like coming to hospital. They will often be frightened of what might happen to them and scared of you as a stranger. A key component to paediatric triage is engaging the child, developing a rapport and hopefully some trust in both the child and parents. Using appropriate toys or bubbles depending on the age of the child and employing appropriate language & conversation will help the triage nurse develop the trusting relationship.

Engaging both the child & parent is vital. This can be done by introducing yourself to both the child and parent, giving thorough explanations of what will happen along with potential time frames to prepare them for waits and what lies ahead.
Get down to eye level to illicit information, engage, and assess yet be careful not to invade their personal space. Gentle touch of “non-tender” parts of the body should be done first with explanations prior to touching and assessing.
Distraction with toys, music, songs, rhymes are all great ways to “de-stress” the child, there by allowing a more accurate clinical picture to be obtained.
Allowing choice is useful however sometimes you will need to set limits, or take control by simply stating what it is you are going to do. Offer only appropriate rewards eg don’t offer an ice-block to a child that needs to be nil by mouth for theatres!
Using humour & stories to try to engage children is a wonderful tool. They may have brought their favourite teddy to hospital with then and this is the perfect opportunity

Lets Rehearse!

- 2 year old Angie has had a fever for 3 days
- Today she is not taking anything to drink and is very lethargic, last passed urine this morning
- She is alert but quiet in Mum's arms, RR 30, nil work of breathing, HR 140,

What triage category will you give her?

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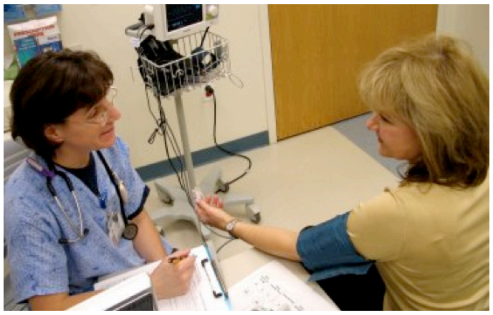
Discuss this case with the participants and ask them to consider the factors that will affect the triage category they will give her. What would make them more concerned? Less concerned?

Is there any immediate management that the triage nurse should advise the nursing and medical team to commence?

Triage



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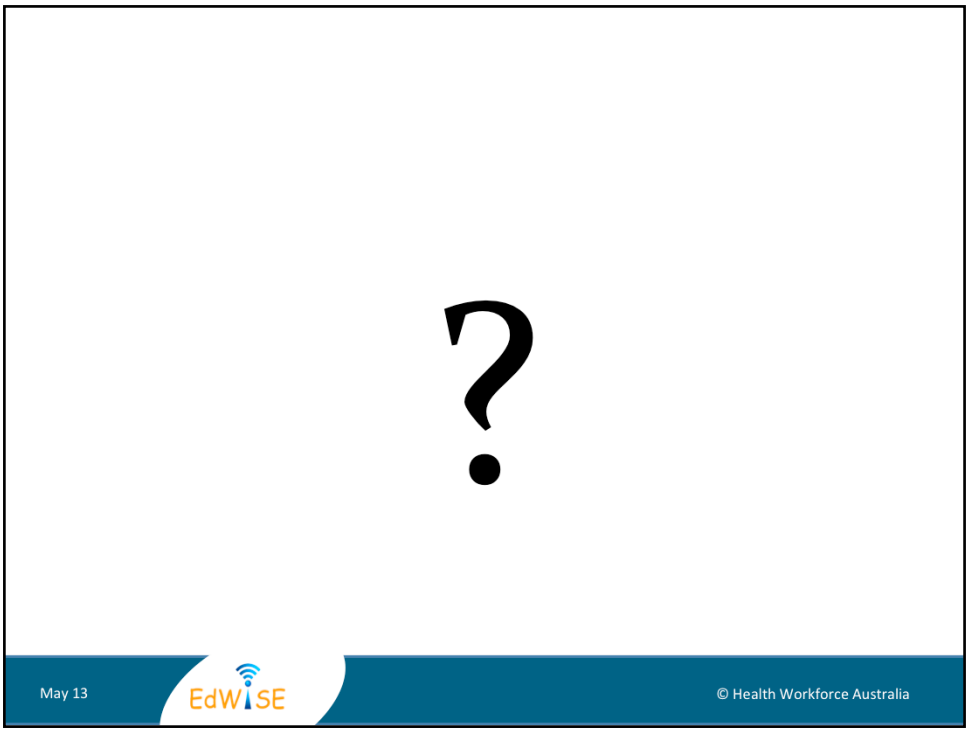
Three scenarios will be enacted at this point with the team triaging three children with their parents.

After each scenario there will be a short debrief.



Any Questions or discussion points?

Summary

- Triage determines clinical urgency for emergency care
- Assessment at *first look* is important
- Listen to the concerns of the parents
- Know what is *'normal''*

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Acknowledgments

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P1 Simulation session author: Jane Cichero

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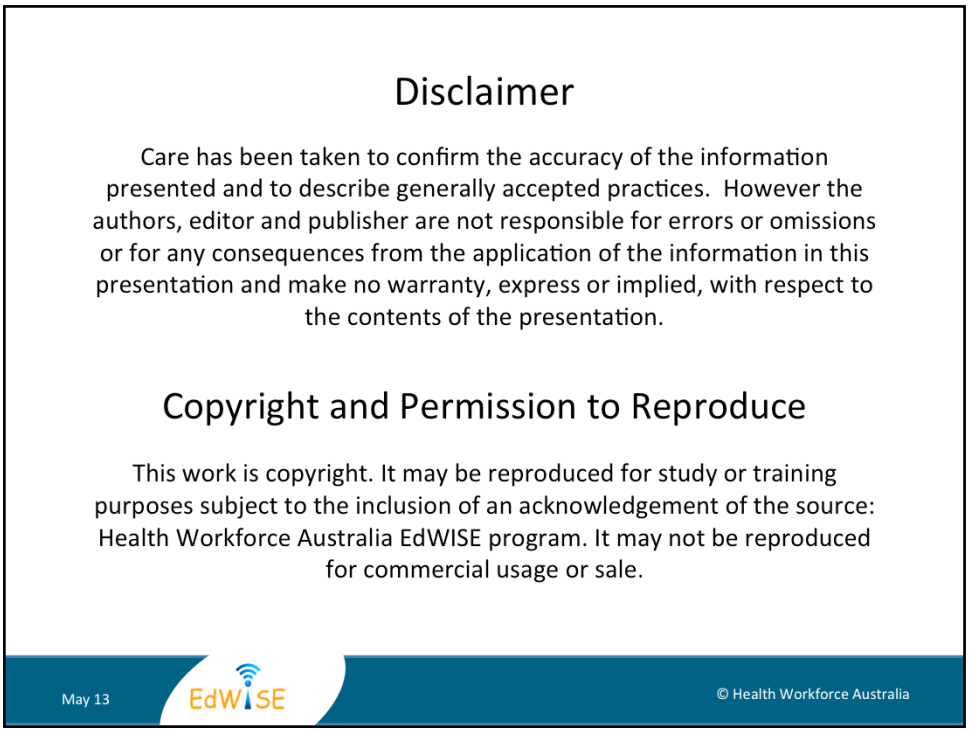

Same for all presentations