

[HOSPITAL / HEALTH AUTHORITY NAME]

EMERGENCY DEPARTMENT PATIENT JOURNEY PROTOCOL

*Protocol 1: Management of Every Patient from Presentation to Discharge,
Admission, or Transfer*

DRAFT FOR CLINICAL, NURSING, ADMINISTRATIVE, LEGAL, AND PATIENT-SAFETY REVIEW

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Approved by	[Medical Executive / Nursing Executive / Hospital Board]
Applies to	All staff working in or supporting the Emergency Department
Supersedes	[Insert previous policy, if applicable]

***Important:** This document is a draft institutional protocol. Before implementation, it must be adapted to local staffing, equipment, laboratory and imaging capacity, medication formularies, referral arrangements, legislation, and professional scopes of practice. It does not replace clinical judgment or condition-specific emergency pathways.*

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Core policy statement

Every patient shall receive timely acuity-based triage, immediate treatment of life threats, structured clinical assessment, documented reassessment, and an explicit transfer of responsibility before leaving the Emergency Department. Administrative, financial, diagnostic, bed-management, or communication processes shall not interrupt time-critical stabilization.

1. Purpose

To establish one standardized pathway for all persons presenting to the Emergency Department (ED), from first contact through discharge, admission, transfer, or death.

To reduce avoidable harm caused by delayed recognition of critical illness, incomplete assessment, failure to reassess, missed investigation results, unclear responsibility, and unsafe transitions of care.

To provide the common operational foundation upon which condition-specific pathways will be built.

2. Scope

This protocol applies to adults, children, pregnant patients, trauma patients, persons with mental-health or behavioural emergencies, patients arriving by ambulance, walk-in patients, referrals from other facilities, and persons brought by police or other agencies.

It applies to clinical and non-clinical staff whose work affects the patient journey, including registration, security, portering, nursing, medical staff, ambulance personnel, laboratory, radiology, pharmacy, ward teams, bed management, social work, and administration.

3. Policy principles

Principle	Operational meaning
Acuity before sequence	Patients are prioritized by clinical urgency, not order of arrival, social position, personal connections, or ability to navigate the institution.
Treatment before paperwork when necessary	Registration and financial processes proceed in parallel and must not delay recognition or stabilization of life-threatening illness or injury.
One continuous episode of responsibility	At every point, the patient must have an identifiable responsible nurse and clinician or an explicitly assigned team.
Triage is dynamic	Triage priority can change. Any deterioration, new information, abnormal observation, or staff concern requires immediate reassessment.
Assessment is iterative	The ED process is a loop: assess, intervene, reassess, revise the working diagnosis and plan.
Communication is closed-loop	Critical instructions, results, and handovers are acknowledged and confirmed.
Disposition is a clinical transition	A patient has not safely left the ED until responsibility and the care plan have been transferred to the patient/caregiver or an accepting clinical team.
Dignity and equity	Privacy, communication needs, disability, cultural needs, pain, safeguarding concerns, and social barriers are addressed throughout care.

4. Definitions

First clinical contact: The first interaction with a trained staff member able to recognize immediate danger and activate an emergency response.

Triage: A rapid clinical process that assigns priority according to acuity. Triage is not a definitive diagnosis or a substitute for clinician assessment.

Retriage: Repeat assessment of a waiting or changing patient to determine whether acuity or location of care must change.

Primary survey: A structured ABCDE assessment used to identify and treat immediate threats to life.

Responsible clinician: The clinician currently accountable for the diagnostic and treatment plan until responsibility is formally transferred.

Disposition: The documented decision and completed process by which a patient is discharged, admitted, transferred, placed in observation, leaves before completion, or dies.

Handover: A structured transfer of clinical information, authority, and responsibility from one person or team to another.

Critical result: A laboratory, imaging, bedside-test, or clinical finding requiring urgent acknowledgment and action under local policy.

5. Roles and responsibilities

Role	Minimum responsibilities
ED clinical lead / medical director	Approves clinical pathways; defines escalation and consultation arrangements; ensures medical staffing, training, audit, and case review.
ED nurse manager / charge nurse	Maintains triage and resuscitation readiness; assigns nursing responsibility; manages patient flow; escalates crowding, staffing, equipment, and bed-delay risks.
First-contact / triage nurse	Performs the immediate safety screen, assigns and documents triage category using the approved tool, initiates permitted first-line actions, and ensures retriage.
ED physician or authorized clinician	Performs structured assessment, establishes and updates the working diagnosis, orders and reviews investigations, prescribes treatment, reassesses response, consults, and determines disposition.
Primary / bedside nurse	Administers and records care, monitors the patient, communicates deterioration, confirms orders, supports reassessment, and participates in handover and discharge education.
Registration staff	Create or verify the patient record without delaying urgent clinical care; use approved temporary identification for unknown patients; alert clinical staff to any deterioration observed.
Laboratory and radiology staff	Prioritize emergency requests according to local rules; communicate critical results directly; record read-back or acknowledgment; escalate unresolved communication.
Receiving ward / theatre / critical-care team	Confirm acceptance, participate in structured handover, clarify pending actions, and assume responsibility at the agreed point of transfer.
All staff	Activate help when concerned. No staff member should assume that another person has noticed a deteriorating patient.

6. Required infrastructure and readiness

- ☐ A clearly identified triage point visible from the entrance.
- ☐ A resuscitation area with immediately available oxygen, suction, bag-mask ventilation, age-appropriate airway equipment, defibrillation, vascular-access supplies, essential emergency medicines, monitoring, and personal protective equipment.
- ☐ Posted adult and paediatric versions of the approved triage tool.
- ☐ A standardized ED clinical record that captures arrival, triage, assessment, treatment, reassessment, and disposition.
- ☐ A reliable method for communicating critical results and documenting acknowledgment.

- ☐ A visible escalation directory containing on-call services, senior decision-makers, referral centres, ambulance contacts, and transfer arrangements.
- ☐ A downtime process for power, electronic-record, laboratory, imaging, oxygen, communications, or transport failure.
- ☐ An ED status board or equivalent that identifies patient location, acuity, responsible staff, pending investigations, and disposition plan while protecting confidentiality.

***Evidence base:** The WHO Emergency Care Toolkit combines acuity-based triage, standardized clinical forms, checklists, and registry tools to support systematic emergency care, particularly in resource-limited hospitals. The WHO standardized forms are designed to guide a structured approach while simultaneously improving documentation and data collection.*

7. Procedure: the Emergency Department patient journey

7.1 Arrival and immediate safety screen

Every arriving person must be visually and verbally screened without delay by a trained staff member. The screen occurs before or alongside registration.

Immediate danger signs include unresponsiveness, airway obstruction, severe respiratory distress, cyanosis, major haemorrhage, shock, active seizure, severe chest pain with instability, acute stroke features, anaphylaxis, obstetric collapse or major bleeding, severe trauma, or any appearance that causes serious staff concern.

When an immediate danger is identified, the staff member shall call for help, move the patient to the resuscitation or high-acuity area, and initiate actions within scope. Formal registration must not delay this response.

Potentially infectious patients shall be masked, separated, or isolated according to the infection-prevention policy without delaying necessary resuscitation.

Arrival time and mode of arrival shall be recorded as soon as practicable.

7.2 Identification and registration

Use at least two approved identifiers whenever identity is known. Room or bed number is not an identifier.

For an unidentified patient, assign a unique temporary identifier immediately and apply it consistently to wristband, samples, imaging, medication records, and documentation until formal reconciliation occurs.

Duplicate records, identity discrepancies, or inability to apply an identification band shall be escalated promptly.

Registration staff must notify the clinical team if a waiting patient appears to deteriorate.

7.3 Triage and initial actions

Triage shall use the institutionally approved acuity tool. This draft recommends adoption or local adaptation of the WHO-ICRC-MSF Interagency Integrated Triage Tool (IITT), with the paediatric pathway for patients younger than 12 years and the adult pathway for patients aged 12 years and older.

Red patients require immediate clinical assessment and resuscitative care. Yellow patients require prompt assessment in an appropriate clinical area. Green patients may wait but remain under ED responsibility and must receive safety advice and retriage.

The triage record must include the chief complaint in the patient's own words where possible, vital signs, pain, consciousness, major bleeding, mobility, pregnancy status where relevant, infection risk, triage category, time, and triage officer.

Triage staff shall initiate approved nurse-driven actions, such as haemorrhage control, oxygen when indicated, glucose testing, electrocardiography, analgesia, isolation, or emergency activation, according to separate standing orders.

7.4 Proposed operational response and retriage targets

The following are draft service targets for local validation. They are not permission to delay care when concern exists and should be shortened when staffing and capacity permit.

Category	Proposed response target	Proposed retriage minimum
Red	Immediate movement to resuscitation/high-acuity care; clinician response without delay	Continuous observation appropriate to condition
Yellow	Clinical assessment target within 30 minutes	At least every 30 minutes while waiting, and immediately if symptoms change
Green	Clinical assessment target within 120 minutes	At least every 60 minutes while waiting, and immediately if symptoms change

7.5 Allocation of care area and staff responsibility

The charge nurse or delegate assigns the patient to the safest available care area according to acuity, monitoring needs, infection risk, age, behavioural risk, and available resources.

The receiving nurse confirms responsibility. The responsible clinician must be identifiable on the clinical record or ED tracking system.

When no appropriate space is available, the charge nurse shall activate the crowding/escalation process rather than allowing an unmonitored high-risk patient to remain in an unsuitable area.

7.6 Primary survey and immediate stabilization

All critically ill or injured patients shall undergo an ABCDE primary survey: Airway with cervical-spine protection when relevant; Breathing; Circulation and haemorrhage control; Disability including consciousness and glucose when indicated; Exposure and environmental control.

Life-threatening findings are treated as they are identified. The clinician should not postpone immediate intervention until the full history, examination, registration, or diagnostic work-up is complete.

After any major intervention or change in condition, repeat the primary survey.

Use the WHO Medical Emergency Checklist or Trauma Care Checklist for high-acuity patients after the primary and secondary surveys and before the clinician leaves the patient or completes disposition.

7.7 Structured history and examination

Once immediate threats are addressed, obtain a focused history using an approved structure such as SAMPLE: Symptoms and signs; Allergies; Medications; Past history and pregnancy; Last oral intake or relevant event; Events and environment.

Document onset, progression, previous treatment, functional status, relevant social circumstances, safeguarding concerns, and factors that may make discharge unsafe.

Complete and document focused examination, repeat vital signs, pain assessment, and a provisional diagnostic formulation.

The clinical formulation shall state the working diagnosis or syndrome, important time-critical diagnoses considered, planned investigations, treatment, monitoring, reassessment, and likely disposition.

7.8 Investigations and result ownership

Order only investigations that contribute to immediate management, disposition, or a defined follow-up plan.

Every ordered test must have an identifiable clinician responsible for reviewing and acting on the result.

Specimens shall be labelled at the bedside or point of collection using approved identifiers. Unlabelled or mismatched specimens shall be managed under laboratory safety policy.

Critical results must be communicated directly, acknowledged, documented, and acted upon. Failure to contact the responsible clinician shall trigger escalation to the charge nurse and senior clinician.

Before disposition, all results necessary for the decision must be reviewed. Any outstanding result requires a named reviewer, documented follow-up mechanism, and communication plan.

7.9 Treatment, medication, and monitoring

Treatment shall follow approved clinical pathways, formularies, standing orders, and professional scopes of practice.

Before medication administration, verify patient identity, allergy status, medicine, dose, route, time, indication, contraindications, and relevant weight, renal, hepatic, pregnancy, or interaction considerations.

Document treatment time, response, adverse events, and any refusal or inability to administer.

Monitoring frequency and location must match acuity and treatment risk. A patient requiring monitoring unavailable in the current area must be relocated or escalated.

7.10 Reassessment loop

Reassessment is mandatory after significant treatment, after critical investigation results, when symptoms change, before consultation decisions, and before disposition.

Document whether the patient is improving, unchanged, or deteriorating; repeat relevant vital signs and examination; review pain and function; reconsider the differential diagnosis; and revise the plan.

Persistent abnormal vital signs, unexplained pain, new confusion, reduced mobility, inability to tolerate oral intake, or staff/family concern must not be dismissed solely because initial tests are reassuring.

When expected improvement does not occur, escalate to a senior clinician and reconsider diagnosis, treatment, monitoring, consultation, or transfer.

7.11 Consultation and escalation

Consultations must state the clinical question, urgency, relevant findings, treatment already provided, and required response.

Time of request, person contacted, advice, expected review time, and any failure to respond shall be documented.

When the requested service is unavailable or delayed beyond what is clinically safe, the responsible clinician shall escalate through the approved chain and consider alternative local management or transfer.

Disagreement about disposition shall be escalated to the senior ED clinician and senior receiving-service clinician. The patient must not be left without ongoing care while responsibility is disputed.

7.12 Disposition decision

The responsible clinician shall make and document one disposition: discharge; observation; admission to ward; critical-care admission; transfer to theatre/procedure; interfacility or overseas transfer; left before completion; left against advice; or death.

Before disposition, confirm reassessment, latest vital signs, review of necessary results, medication reconciliation, infection precautions, mobility and transport needs, safeguarding and social concerns, and clarity of responsibility.

Boarding patients awaiting a bed or transport remain ED patients until formal handover and must continue to receive monitoring, medication, nutrition, toileting, pressure-area care, and reassessment appropriate to their condition.

7.13 Safe discharge

Discharge is appropriate only when the patient is clinically stable for the intended environment, time-critical conditions have been reasonably addressed, necessary results are reviewed, symptoms are acceptably controlled, and a safe follow-up plan exists.

Provide verbal and written information in language the patient or caregiver can understand: working diagnosis; uncertainty; treatment received; medicines; activity or wound advice; follow-up; outstanding results; specific warning signs; and where and when to return.

Use teach-back: ask the patient or caregiver to explain the plan and warning signs in their own words. Address transport, supervision, mobility, communication, medication access, and safeguarding barriers.

Document the final diagnosis or working diagnosis, latest observations, condition at discharge, prescriptions, follow-up, return precautions, person accompanying the patient, and departure time.

7.14 Admission and transfer to a ward, theatre, or critical-care area

Obtain acceptance from the receiving service and confirm destination.

Continue stabilization and time-critical treatment while awaiting movement. Admission decisions do not suspend ED care.

Use a structured handover such as ISBAR: Identification, Situation, Background, Assessment, Recommendation. Include allergies, infection status, current observations, lines and devices, medicines and infusions, treatment response, pending results, deterioration risks, and required next actions.

The receiving nurse or clinician should acknowledge and clarify the handover. Document accepting clinician/service, handover time, destination, transfer observations, escort, and departure time.

Responsibility transfers only at the locally defined point, such as completion of bedside handover in the receiving area, not merely when a bed is requested.

7.15 Interfacility or overseas transfer

Confirm the clinical reason, required service, accepting clinician and facility, urgency, and mode of transport.

Stabilize as far as reasonably possible without causing harmful delay. Determine escort competency, monitoring, oxygen, medicines, fluids, blood products, equipment, and contingency plans required during transport.

Send legible records, investigation results, imaging or access instructions, medication and infusion chart, allergy and infection information, contact details, and transfer summary.

Communicate with the patient or family, while ensuring administrative arrangements do not interrupt time-critical clinical care.

Record acceptance, departure condition and time, escort, transport service, documents sent, and method for confirming arrival.

7.16 Patient leaving before completion of care

When a patient wishes to leave, assess decision-making capacity, explain the recommended care and material risks, explore reasons and safer alternatives, offer treatment and follow-up the patient will accept, and provide return precautions.

Do not use stigmatizing or punitive language. A signed form does not replace capacity assessment, communication, reasonable risk reduction, and documentation.

For a patient who leaves before being seen, document triage category, last known condition, attempts to locate or contact, known high-risk features, and advice provided where contact is possible.

When a child, dependent adult, person lacking capacity, or person under legal custody attempts to leave, follow safeguarding and legal escalation procedures.

7.17 Death in the Emergency Department

Continue resuscitation, limitation, or cessation decisions according to approved resuscitation and end-of-life policies.

Confirm and document death according to law and professional policy; notify the responsible senior clinician; communicate compassionately with family; preserve dignity; and follow coroner, police, organ/tissue donation, property, infection-control, and mortuary procedures as applicable.

Unexpected or potentially preventable deaths should be referred for structured case review.

8. Escalation and safety-net rules

Any staff member may escalate care. The following require immediate clinical review or senior escalation:

- ⚠ Any IITT Red criterion or new deterioration in airway, breathing, circulation, consciousness, major bleeding, seizure, or severe pain.
- ⚠ Persistent or worsening abnormal observations, even when initial investigations appear reassuring.
- ⚠ Concern expressed by a nurse, clinician, patient, caregiver, ambulance provider, or other staff member.
- ⚠ Unexplained delay in initial assessment, investigation, treatment, consultation, bed placement, or transfer that could cause harm.
- ⚠ Inability to provide the required monitoring, oxygen, medication, staffing, infection isolation, or physical safety.
- ⚠ Unreviewed critical result or inability to identify the responsible clinician.
- ⚠ Uncertainty regarding capacity, safeguarding, violence risk, self-harm, abuse, neglect, or safe discharge.
- ⚠ Disagreement between teams that leaves the patient without an active plan or accountable clinician.
- ⚠ ED crowding, multiple simultaneous high-acuity patients, equipment failure, or staffing below the approved safe minimum.

Safety rule: “Normal tests” do not overrule a deteriorating patient. Clinical trajectory and repeated assessment take precedence over a single snapshot.

9. Special populations and safeguarding

Population	Minimum additional safeguards
Children	Use paediatric triage criteria, age-appropriate observations and equipment, weight-based medication systems, caregiver communication, and safeguarding procedures. A child’s condition may deteriorate rapidly; low threshold for senior review.
Pregnancy and postpartum	Identify pregnancy status and gestation where relevant. Escalate haemorrhage, severe abdominal pain, hypertension symptoms, seizure, dyspnoea, sepsis, reduced fetal movement, labour, or postpartum deterioration according to obstetric pathways.

Population	Minimum additional safeguards
Older or frail adults	Assess baseline function, cognition, falls, polypharmacy, hydration, mobility, delirium, caregiver support, and whether “normal” vital signs may conceal serious illness. Avoid discharge based only on disease labels without confirming functional safety.
Mental-health or behavioural emergencies	Address physical illness and injury first; assess self-harm, violence, intoxication, capacity, safeguarding, and environmental safety; use the least restrictive intervention consistent with safety.
Disability, language, or communication barriers	Provide reasonable accommodations, interpreters or communication aids where available. Do not rely on minors as interpreters for complex or sensitive decisions except in immediate necessity.
Violence, abuse, neglect, trafficking, or unsafe home	Ensure privacy, document objectively, treat injuries, activate safeguarding pathways, and avoid discharge back into immediate danger without senior review.
Persons in custody	Clinical priority is based on acuity. Preserve confidentiality and dignity while managing security risks and legal requirements.
Frequent attenders or known chronic disease	Avoid diagnostic overshadowing. Previous attendance does not exclude new critical illness. Review individualized plans where available but reassess the current presentation independently.

10. Documentation standards

- ☐ Patient identifiers and contact person where available.
- ☐ Arrival date, time, mode, referral source, and prehospital handover.
- ☐ Chief complaint and relevant history.
- ☐ Triage category, triage observations, pain, infection risk, triage time, and staff member.
- ☐ Date and time of first clinician assessment.
- ☐ ABCDE findings for high-acuity patients and treatments initiated.
- ☐ Working diagnosis, dangerous alternatives considered, investigation and treatment plan.
- ☐ Medications, procedures, blood products, oxygen, fluids, response, and adverse events.
- ☐ Investigation results, time reviewed, critical-result communication, and action.
- ☐ Repeated observations, reassessment findings, and changes in plan.
- ☐ Consultations requested, response, advice, and escalation.
- ☐ Disposition decision, condition, latest observations, handover or discharge communication, accepting team, destination, and departure time.
- ☐ Outstanding results, named reviewer, and follow-up mechanism.
- ☐ Refusals, capacity assessment, safeguarding concerns, incidents, and deviations from protocol.

Recommended documentation tool: Adapt the WHO Standardized Emergency Unit Form: General and Trauma, or configure the electronic record to capture equivalent data without duplicate documentation.

11. Quality indicators and audit

The ED should review these indicators monthly or quarterly, stratified where possible by age, sex, arrival mode, triage category, time of day, and disposition. Targets must be approved locally after baseline measurement.

Indicator	Definition / purpose
Triage coverage	Percentage of ED attendances with documented triage category and triage time.
Time to triage	Median and 90th percentile arrival-to-triage time.
Red response	Percentage of Red patients moved to resuscitation/high-acuity care immediately and assessed without delay.
Initial clinician assessment	Median arrival-to-clinician time by triage category.
Retriage compliance	Percentage of waiting Yellow and Green patients retriaged within the approved interval.
Vital signs at disposition	Percentage with a documented final set of observations before discharge, admission, or transfer.
Reassessment after treatment	Percentage of selected high-risk cases with documented response and revised plan.
Critical-result closure	Percentage of critical results with documented communication, acknowledgment, and action.
Handover completeness	Percentage of admissions/transfers with documented accepting service, structured handover, and departure condition.
Discharge communication	Percentage of discharged patients with diagnosis/working diagnosis, medicines, follow-up, and return precautions documented.
Left before completion	Rate of leaving before being seen and leaving against advice, by triage category and waiting time.
ED length of stay and boarding	Median length of stay; number and duration of admitted patients remaining in ED.
Unplanned return	72-hour return rate, with review of returns leading to admission, critical care, transfer, or death.
Safety outcomes	Unexpected death, cardiac arrest outside resuscitation area, delayed sepsis/trauma/stroke recognition, medication harm, falls, restraint events, and serious complaints.

12. Training and implementation

1. Complete a baseline ED capacity and workflow assessment, including staffing, patient flow, equipment, monitoring, documentation, referral, and bed-delay risks.
2. Approve the triage tool and local response/retriage targets.
3. Adapt and pilot the ED clinical form and patient tracking system.

4. Train all staff in immediate danger recognition, triage, ABCDE, escalation, critical-result communication, handover, discharge education, and safeguarding.
5. Run multidisciplinary simulations for adult and paediatric deterioration, trauma, sepsis, obstetric emergency, behavioural emergency, crowding, equipment failure, and interfacility transfer.
6. Pilot the protocol on selected shifts, obtain staff and patient feedback, correct workflow problems, then implement department-wide.
7. Conduct early audits at 30, 60, and 90 days. Review serious incidents and near misses without blame, focusing on system repair.
8. Update condition-specific protocols so they align with this master patient journey.

Annex A. One-page Emergency Department patient journey

1. ARRIVAL	Immediate visual safety screen. Do not delay time-critical care for registration.
2. TRIAGE	Assign Red / Yellow / Green using approved adult or paediatric tool. Start permitted first-line actions.
3. PLACE + RESPONSIBILITY	Move to the appropriate care area. Assign nurse and responsible clinician. Apply infection and safety precautions.
4. STABILIZE	ABCDE. Treat immediate life threats as found. Repeat after major interventions.
5. ASSESS	Focused history, examination, observations, working diagnosis, dangerous alternatives, plan.
6. INVESTIGATE + TREAT	Order purposefully. Track all results. Deliver treatment and monitoring matched to acuity.
7. REASSESS	Improving, unchanged, or deteriorating? Repeat observations and examination; revise diagnosis and plan.
8. DISPOSITION	Discharge, observe, admit, transfer, theatre/critical care, leave before completion, or death.
9. SAFE EXIT	Final observations. Results reviewed. Medicines reconciled. Handover or discharge teaching completed. Responsibility transferred and departure documented.

At every stage: recognize deterioration → call for help → treat immediate threats → reassess → document → communicate.

Annex B. Minimum triage dataset

- ☐ Arrival date and time; mode of arrival; referral source.
- ☐ Two identifiers or temporary unknown-patient identifier.
- ☐ Chief complaint and onset/time-sensitive feature.
- ☐ Airway and breathing status; respiratory rate; oxygen saturation where available.
- ☐ Pulse, blood pressure, temperature, circulation/perfusion findings.
- ☐ Level of consciousness; seizure; glucose when indicated.
- ☐ Major bleeding, trauma mechanism, pain score, mobility.

- ☐ Pregnancy/postpartum status where relevant.
- ☐ Infection/isolation risk.
- ☐ Mental-health, self-harm, violence, safeguarding, or security concern.
- ☐ Triage category, destination, actions initiated, time, and triage staff member.
- ☐ Retriage time, findings, and category change when applicable.

Annex C. CARE disposition checkpoint

Checkpoint	Required confirmation
C — Clinical status	Reassessed; latest observations documented; dangerous conditions addressed; pain, symptoms, function, and trajectory reviewed.
A — Actions completed	Necessary treatments given; results reviewed; medicines reconciled; pending actions and results assigned.
R — Responsibility transferred	Patient/caregiver understands the discharge plan, or the receiving team has accepted and acknowledged handover.
E — Exit safely documented	Destination and transport appropriate; instructions and warning signs provided; infection and safeguarding needs addressed; departure date and time recorded.

Annex D. References and source tools

1. World Health Organization. Emergency Care Toolkit. [Source](#)
2. World Health Organization, International Committee of the Red Cross, and Médecins Sans Frontières. Interagency Integrated Triage Tool. [Source](#)
3. World Health Organization and International Committee of the Red Cross. Basic Emergency Care: Approach to the Acutely Ill and Injured. [Source](#)
4. World Health Organization. Standardized Clinical Forms for emergency-unit care. [Source](#)
5. World Health Organization. Clinical Checklists: WHO Medical Emergency Checklist and Trauma Care Checklist. [Source](#)
6. World Health Organization. Communication During Patient Hand-Overs. Patient Safety Solution. [Source](#)
7. World Health Organization. WHO Clinical Registry. [Source](#)
8. World Health Organization. Hospital Emergency Unit Assessment Tool (HEAT). [Source](#)

Protocol-development note: The WHO tools are designed for local adaptation. Before approval, this draft should be tested against actual ED workflow, staffing, available monitoring, paediatric and obstetric capability, laboratory and imaging turnaround, specialist availability, ward-bed access, ambulance capacity, and regional/overseas referral processes.

Approval and review record

Role	Name	Signature	Date
ED Medical Lead			
ED Nurse Manager			
Quality / Patient Safety Lead			
Executive Approver			

Local configuration decisions

Decision	Local entry
Approved triage tool	[Insert tool/version and adult/paediatric age cut-off]
Approved response and retriage targets	[Insert locally approved targets or reference SOP]
Point at which responsibility transfers from ED	[Define for ward, theatre, critical care, and external transfer]
Critical-result communication process	[Insert contact and escalation process]
Crowding and capacity escalation chain	[Insert roles and contact sequence]
Primary referral and overseas-transfer arrangements	[Insert facilities, contacts, transport, and documentation requirements]

Revision history

Version	Date	Summary of change	Approved by
Draft 1.0	[Date]	Initial draft for multidisciplinary review	[Name / body]