[HOSPITAL / HEALTH AUTHORITY NAME]

EMERGENCY DEPARTMENT TRIAGE AND RETRIAGE PROTOCOL

Protocol 2: Acuity-Based Prioritization Using the Interagency Integrated Triage Tool

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

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Related policy	ED-PRO-001: Emergency Department Patient Journey Protocol
Effective date	[To be inserted after approval]
Review date	[12 months after implementation, then every 2-3 years or sooner if the IITT changes]
Approved by	[Medical Executive / Nursing Executive / Hospital Board]
Applies to	All personnel receiving, triaging, monitoring, directing, or treating ED patients
Supersedes	[Insert previous triage policy, if applicable]

Important: *The official WHO adult and paediatric Interagency Integrated Triage Tool (IITT) posters are the controlling clinical decision-support tools. They should be displayed at the triage point and used without changing their clinical wording. This protocol governs local workflow, accountability, standing actions, reassessment, escalation, and audit. All nursing actions require approval under local scopes of practice and standing orders.*

Contents

Every person presenting for unscheduled emergency care shall be clinically triaged before registration or payment. Red patients shall be moved immediately to the resuscitation area and receive an immediate clinical response. No patient shall be assigned a lower priority because of crowding, bed shortage, social status, referral source, or ability to pay.

1. Purpose

To establish a standardized, equitable, and auditable process for rapidly identifying patients who require immediate or urgent emergency care.

To operationalize the WHO-ICRC-MSF Interagency Integrated Triage Tool within the hospital while defining local responsibilities, standing actions, reassessment, escalation, and quality assurance.

To prevent harm arising from delayed recognition, under-triage, waiting-area deterioration, inconsistent prioritization, or unclear responsibility.

2. Scope

This protocol applies 24 hours a day to all patients presenting to the Emergency Department, including walk-in arrivals, ambulance arrivals, referrals, persons brought by police or other agencies, pregnant patients, children, trauma patients, and persons with behavioural or mental-health emergencies.

This protocol governs routine emergency-unit triage. It does not replace the hospital mass-casualty plan. Routine IITT is replaced by the approved mass-casualty triage process only after formal activation of that plan.

3. Core policy statements

Triage is a rapid prioritization process, not a diagnosis, complete medical assessment, discharge decision, or substitute for clinical judgment.

Triage shall be performed by a trained clinical worker. Registration, security, financial, or clerical personnel shall not independently assign clinical triage categories.

Any staff member may request immediate reassessment or up-triage. A patient shall never be down-triaged solely to manage crowding.

Clinical concern may justify a higher category even when listed criteria or vital-sign thresholds are not met. If uncertain between two categories, use the higher category and seek senior review.

The assigned colour identifies urgency. It does not guarantee a diagnosis, treatment location, admission decision, or order of care among patients whose conditions subsequently change.

4. Definitions

IITT: The Interagency Integrated Triage Tool developed by the World Health Organization, International Committee of the Red Cross, and Medecins Sans Frontieres.

Red: High-acuity emergency. Immediate movement to the resuscitation or designated red area and immediate clinical response.

Yellow: Moderate-acuity urgent condition. Movement to the designated clinical treatment or observed waiting area, timely first-line care, and active surveillance.

Green: Low-acuity condition with no red criterion, yellow criterion, high-risk vital sign, or overriding clinical concern. The patient may wait in the designated low-acuity area with safety instructions and retriage.

Up-triage: Reclassification to a higher-acuity category because of criteria, abnormal vital signs, deterioration, new information, or clinical concern.

Down-triage: Reclassification to a lower-acuity category after documented reassessment by an appropriately experienced clinician and confirmation that higher-acuity criteria are no longer present.

Retriage: A repeat structured assessment of a waiting or changing patient to determine whether priority, location, monitoring, or treatment must change.

High-risk vital sign: A vital-sign or consciousness threshold listed by the IITT that requires up-triage or immediate supervising-clinician review.

First-line management: The initial assessment and actions needed to identify and treat immediate threats, based on ABCDE and applicable clinical pathways.

Clinical concern: A professional judgment that a patient appears more seriously ill or vulnerable than the listed criteria alone indicate.

5. Roles and accountability

Role	Accountability
Hospital executive / clinical governance	Approve the triage system, staffing model, standing orders, response targets, training requirements, audit programme, and escalation plan.
ED medical director	Own the clinical content; ensure senior medical response to red patients; review under-triage, waiting-area deterioration, and serious incidents.
ED nurse manager	Ensure competent triage staffing, equipment readiness, visible posters, retriage processes, and operational escalation during crowding.

Role	Accountability
Charge nurse / shift leader	Assign a trained triage clinician; maintain oversight of red, yellow, and green areas; respond to disputes; activate surge escalation; ensure handover of waiting patients.
Triage clinician	Perform rapid screening and IITT categorization; document findings; initiate authorized actions; direct the patient to the correct area; communicate red cases; schedule and perform retriage.
Receiving ED clinician	Respond according to category; reassess acuity; initiate definitive assessment; provide feedback when triage concerns or discrepancies are identified.
Registration staff	Register after clinical triage without delaying care; create temporary identifiers when necessary; immediately alert clinical staff if deterioration is observed.
Security and portering staff	Support safe access and movement but do not make clinical triage decisions; immediately summon clinical staff for any person who appears unwell.
All staff	Treat a request for reassessment as a safety signal. No person should assume somebody else has noticed deterioration.

6. Triage-area readiness

- Triage point positioned before registration and visible from all routine entry routes, including ambulance access.
- Official current WHO IITT adult poster (age 12 years and older) and paediatric poster (younger than 12 years) displayed at eye level.
- Direct, unobstructed route to a designated resuscitation area that is visible to ED clinical staff.
- Clock or electronic time display synchronized with ED documentation systems.
- Seating or trolley access that permits privacy, infection-control separation, disability access, and immediate transfer.
- Reliable communication method to activate the red response and summon senior help.
- Basic examination and vital-sign equipment checked at the beginning of each shift.
- Standardized triage record and retriage record, including downtime paper forms.
- Colour identifiers or electronic status indicators that do not compromise patient privacy.
- Current escalation directory, infection-screening instructions, safeguarding contacts, and mass-casualty activation process.

Triage must remain operational even when every patient appears likely to receive a bed. A bed assignment does not ensure timely clinician assessment and does not replace an acuity category.

7. Routine triage procedure

7.1 Receive and visually screen immediately

At first clinical contact, perform a rapid visual assessment for unresponsiveness, severe breathing difficulty, major haemorrhage, seizure, collapse, extreme agitation, or any other obvious threat. Begin lifesaving action and activate the red response without waiting to complete the triage record.

7.2 Screen for public-health risk

Ask or observe for locally defined symptoms or exposures requiring isolation. Apply appropriate source control and personal protective equipment, then continue triage in the designated isolation pathway. Isolation shall not delay emergency stabilization.

7.3 Confirm whether the patient arrived alive

If there are signs of life or uncertainty, move to the resuscitation area and assess immediately. When death on arrival is confirmed according to local policy, follow the death-on-arrival and medicolegal procedure; routine colour assignment is not required.

7.4 Select the age-specific IITT pathway

Use the adult reference card for patients aged 12 years and older and the paediatric reference card for patients younger than 12 years. This age split is specific to the IITT and may differ from the hospital administrative definition of a paediatric patient.

7.5 Check red criteria first

Ask focused questions and observe the patient for any red criterion. A single red criterion is sufficient. Do not delay red transfer to obtain a full history, complete registration, or obtain all vital signs.

7.6 If no red criterion, check yellow criteria

A single yellow criterion is sufficient for yellow categorization. A yellow patient may still deteriorate and requires an observed location and scheduled reassessment.

7.7 If no red or yellow criterion, check high-risk vital signs

Measure the IITT vital signs and consciousness criteria. High-risk values require up-triage or immediate review by a supervising clinician. Equipment failure or inability to obtain a measurement shall not be interpreted as a normal result.

7.8 Apply clinical concern

Up-triage when the patient appears seriously ill, unusually vulnerable, rapidly changing, or inconsistent with the calculated category. Examples include frailty, very young age, immunosuppression, communication barriers, concerning mechanism, repeated presentation, or caregiver concern.

7.9 Assign, document, direct, and communicate

Record category, findings, time, and triage clinician. Direct the patient to the correct area. For red patients, use a clear activation phrase and provide a brief handover while moving the patient.

7.10 Initiate authorized first-line actions

Begin only actions approved under local standing orders and within professional scope. Triage shall not become a prolonged treatment station when other patients are waiting to be categorized.

7.11 Set the retriage plan

Document the next reassessment time before the patient leaves the triage point. Ensure the patient and caregiver know how to summon help and what changes must be reported immediately.

7.12 Resolve uncertainty safely

When uncertain, choose the higher category and request senior review. Disagreement must never delay transfer of a possible red patient.

Proposed operational response targets

Category	Destination	Response expectation	Draft local measure
RED	Resuscitation / red area	Immediate movement and immediate clinical response. The WHO poster's 10-minute first-line benchmark is a ceiling, not permission to wait.	Arrival-to-red-area and arrival-to-first intervention.
YELLOW	Clinical treatment / observed waiting area	Urgent first-line management; WHO example target within 2 hours, subject to local approval.	Arrival-to-clinician and arrival-to-first-line care.
GREEN	Low-acuity / waiting area or approved OPD pathway	May wait with active safety-netting and retriage; WHO poster example target within 4 hours.	Arrival-to-clinician, retriage completion, and leaving-before-seen rate.

8. Adult IITT criteria: age 12 years and older

> ***Controlling tool:*** *Use the current official WHO IITT adult poster. The following operational summary supports training and documentation; where wording differs, the official poster governs.*

8.1 Red criteria

Domain	Criteria requiring this category
Immediate appearance	Unresponsive.
Airway / breathing	Stridor; severe respiratory distress; or central cyanosis.
Circulation	Capillary refill longer than 3 seconds; weak rapid pulse; heavy bleeding; or heart rate below 50 or above 150 beats/min.
Disability	Active convulsion; known hypoglycaemia; or at least two of altered mental state, stiff neck, fever/hypothermia, and headache.
High-risk conditions	High-risk trauma; important poisoning, ingestion, or dangerous chemical exposure; threatened limb; snakebite; severe acute chest or abdominal pain in a person older than 50; ECG evidence of acute ischaemia if already obtained; or violent/aggressive behaviour requiring urgent clinical control.
Pregnancy	Heavy bleeding; severe abdominal pain; seizure or altered mental state; severe headache; visual change; systolic pressure at least 160 or diastolic pressure at least 110; active labour; or trauma.

8.2 Yellow criteria

Domain	Criteria requiring this category
Airway / breathing	Swelling or mass involving the mouth, throat, or neck; or wheeze without a red criterion.
Circulation / hydration	Persistent vomiting or diarrhoea; inability to drink or feed; severe pallor without red features; ongoing bleeding without red features; or recent fainting.
Disability / symptoms	Altered mental state or agitation without red features; acute generalized weakness; focal neurological complaint; acute visual disturbance; or severe pain without red features.
Trauma / surgical	New limb deformity, open fracture, suspected dislocation, other trauma or burns without red features, or a known condition requiring urgent surgery.
Other time-sensitive conditions	Rapidly worsening or peeling rash; sexual assault; acute scrotal/testicular pain or priapism; inability to pass urine; exposure needing time-sensitive prophylaxis; or pregnancy referred because of complications.

8.3 Adult high-risk vital signs

Measurement	High-risk threshold
Heart rate	Below 60 or above 130 beats/min
Respiratory rate	Below 10 or above 30 breaths/min
Temperature	Below 36 C or above 39 C
Oxygen saturation	Below 92%
Consciousness	AVPU response other than Alert

> ***Rule:*** *A patient with no listed red or yellow criterion but with a high-risk vital sign requires up-triage or immediate supervising-clinician review. Vital signs must never be used to downgrade a patient who meets a clinical criterion.*

8.4 Adult reference definitions

Respiratory distress: Very fast or very slow breathing; inability to speak or walk without assistance; confusion, drowsiness, or agitation; or marked accessory-muscle use.

Threatened limb: A pulseless limb, or a painful limb accompanied by pallor, weakness, numbness, or massive swelling after trauma.

High-risk trauma: Fall from approximately twice the person's height; penetrating injury other than a distal limb injury with controlled bleeding; crush injury; injuries in multiple body regions; pregnancy; bleeding disorder or anticoagulation; high-speed vehicle collision; pedestrian/cyclist struck; death of another occupant; or entrapment/ejection.

Major burn: Partial- or full-thickness burn exceeding about 15% body surface area; circumferential burn; face/neck burn; inhalation injury; or any burn in a child under 2 or adult over 70.

High-risk ingestion or exposure: Up-triage to red for early clinical assessment when the substance, amount, route, timing, symptoms, or uncertainty suggests a time-dependent hazard.

9. Paediatric IITT criteria: younger than 12 years

Controlling tool: *Use the current official WHO IITT paediatric poster. Children can deteriorate rapidly; age, feeding, caregiver concern, and behaviour must be interpreted together.*

9.1 Red criteria

Domain	Criteria requiring this category
Immediate appearance	Unresponsive.
Airway / breathing	Stridor; severe respiratory distress; or central cyanosis.
Circulation / dehydration	Capillary refill longer than 3 seconds; weak rapid pulse; heavy bleeding; cold extremities; or at least two of lethargy, sunken eyes, very slow skin recoil, and poor drinking.
Disability	Active convulsion; known hypoglycaemia; or altered mental state accompanied by stiff neck, fever, or hypothermia.
Age / temperature	Any infant younger than 8 days; or infant younger than 2 months with temperature below 36 C or above 39 C.
Other time-sensitive conditions	High-risk trauma; hypoglycaemia; threatened limb; acute scrotal/testicular pain or priapism; snakebite; important poisoning/ingestion/chemical exposure; or pregnancy with any adult red criterion.

9.2 Yellow criteria

Domain	Criteria requiring this category
Airway / breathing	Swelling or mass involving the mouth, throat, or neck; or wheeze without red features.
Feeding / circulation	Unable to feed or drink; vomits everything; ongoing diarrhoea; dehydration; or severe pallor without red features.
Disability / pain	Restless, continuously irritable, or lethargic; or severe pain without red features.
Age / nutrition	Any infant from 8 days through 6 months; visible severe wasting; or swelling of both feet suggestive of severe malnutrition.
Other time-sensitive conditions	Trauma or burns without red features; sexual assault; known condition needing urgent surgery; rapidly worsening or peeling rash; exposure needing time-sensitive prophylaxis; pregnancy without red features; or headache without red features.

9.3 Paediatric high-risk vital signs

Age	Respiratory rate: low	Respiratory rate: high	Heart rate: low	Heart rate: high
<1 year	<25	>50	<90	>180
1-4 years	<20	>40	<80	>160
5-12 years	<10	>30	<70	>140

All paediatric ages: temperature below 36 C or above 39 C; oxygen saturation below 92%; or AVPU response other than Alert.

Rule: *Any high-risk paediatric vital sign requires up-triage or immediate supervising-clinician review. A child who looks critically ill is red regardless of measured values.*

9.4 Paediatric respiratory distress

Features include very fast or very slow breathing, inability to speak/eat/breastfeed, nasal flaring, grunting, head nodding, chest indrawing, or other marked accessory-muscle use.

10. Standing actions by triage category

The actions below are a governance template. Before implementation, the hospital must approve exactly which actions each staff category may perform, under what standing order, and what documentation is required.

Category	Mandatory operational actions	Potential locally authorized clinical actions	Prohibited shortcuts
RED	Move immediately to resuscitation/red area; activate red response; give concise handover; assign nurse and clinician; begin ABCDE; maintain continuous observation; document times.	Positioning and airway opening; spinal precautions when indicated; bleeding control; oxygen according to protocol; bedside glucose for altered consciousness; monitoring; vascular access, ECG, specimen collection, or other pathway actions where authorized.	Do not wait for registration, payment, complete vital signs, full history, bed allocation, consent paperwork, or routine queue.
YELLOW	Move to clinical treatment or directly observed area; record complete baseline observations; notify responsible team; initiate the retriage clock; maintain visibility; escalate any worsening.	Pain-relief pathway; glucose, ECG, pregnancy testing, wound care, immobilization, oral rehydration, infection-control actions, or other nurse-initiated pathways where approved.	Do not place in an unobserved waiting area, assume stable because ambulant, or delay escalation when observations or appearance worsen.
GREEN	Direct to designated low-acuity area or approved OPD pathway; provide instructions to report change; record next retriage time; preserve access to clinical reassessment.	Simple comfort measures, basic wound covering, oral fluids when safe, and approved symptom pathways within scope.	Do not discharge solely from triage, omit observations required by the tool, or allow registration/payment processes to prevent reassessment.

10.1 Red activation handover

Use one clear local phrase, for example: “RED PATIENT TO RESUSCITATION.” While moving, communicate identity if known, age, main problem, key red criterion, immediate intervention, and relevant hazard such as trauma, pregnancy, poisoning, or infection risk.

10.2 Triage-treatment boundary

When arrivals are waiting, the triage clinician must not become absorbed in non-lifesaving treatment of one yellow or green patient. After immediate authorized action, hand care to the assigned treatment team and resume categorization unless the charge nurse provides relief.

11. Retriage and waiting-area surveillance

Triage reflects a single point in time; the patient’s condition is dynamic. Every waiting patient remains under ED responsibility and must have a documented next reassessment time.

Retriage includes appearance, symptoms, pain, mental state, relevant vital signs, new information, treatment response, and whether the original category and location remain safe.

Any deterioration, new red or yellow feature, high-risk vital sign, repeated request for help, caregiver concern, or staff concern triggers immediate reassessment rather than waiting for the scheduled interval.

Up-triage takes effect immediately. Down-triage requires documented reassessment and approval by an experienced clinician defined by local policy.

At shift handover, the outgoing and incoming triage clinicians shall jointly account for all patients still waiting, their categories, elapsed wait, next retriage time, and specific risks.

11.1 Draft local minimum intervals for validation

Category	Minimum surveillance	Scheduled formal reassessment	Immediate reassessment triggers
RED	Continuous observation in resuscitation area.	ABCDE and vital-sign frequency determined by the resuscitation team and intervention performed.	Any change; after each major intervention; before movement from resuscitation.
YELLOW	Directly visible or monitored according to condition.	At least every 30 minutes while awaiting initial clinician assessment, unless a shorter interval is ordered.	Worsening pain, breathing, bleeding, consciousness, perfusion, new neurological sign, new vital-sign abnormality, patient/caregiver concern.
GREEN	Accessible waiting area with clear route to staff.	At least every 60 minutes while awaiting initial clinician assessment, unless a shorter interval is indicated.	Any new symptom, inability to cope, repeated presentation to desk, abnormal vital sign, or concern from any person.

> ***Local approval required:*** *WHO requires reassessment when waits are prolonged but does not prescribe routine intervals. These conservative draft intervals must be tested against staffing, patient volumes, layout, and electronic alerts before approval. They must not be lengthened merely because the ED is crowded; crowding requires escalation.*

11.2 Waiting-area safety instructions

- Explain the assigned area without suggesting that “green” means nothing is wrong.
- Tell the patient/caregiver exactly how to summon help.
- Ask them to report worsening breathing, chest or abdominal pain, bleeding, faintness, confusion, seizure, weakness, visual change, inability to drink, or any new concern.

- Ensure communication support for hearing, visual, language, cognitive, and mobility needs.
- Do not rely on a patient with altered cognition, intoxication, severe pain, or young age to self-report deterioration.

12. Special situations

12.1 Ambulance pre-alert

Use pre-alert information to prepare staff and space, but perform and document facility triage on arrival. The ambulance category does not automatically replace the ED category.

12.2 Infection or outbreak concern

Apply source control and isolation while continuing IITT triage. A patient with both infection risk and red criteria goes to a resuscitation space capable of appropriate precautions.

12.3 Pregnancy

Apply the adult pregnancy red criteria. Active labour is red under the IITT. Activate obstetric support early while continuing stabilization; do not redirect an unstable patient without handover.

12.4 Sexual assault

This is at least yellow under the IITT. Protect privacy, use trauma-informed communication, avoid repeated questioning, preserve evidence according to policy, and activate safeguarding/forensic services.

12.5 Violent, aggressive, or acutely disturbed behaviour

Violent or aggressive presentation is a red criterion. Protect staff and other patients, use the least restrictive safe approach, summon clinical and security support, and urgently assess medical causes. Security containment never replaces clinical assessment.

12.6 Poisoning and chemical exposure

High-risk exposures may require red categorization before symptoms develop. Protect staff from contamination, identify the substance if safe, contact toxicology/poison resources, and follow decontamination procedures.

12.7 Trauma

Control catastrophic external haemorrhage immediately. Maintain spinal precautions when indicated. Mechanism and vulnerability can justify up-triage even when initial physiology appears normal.

12.8 Frailty, disability, and communication barriers

Use clinical concern to up-triage when baseline function, atypical presentation, inability to communicate, or social vulnerability makes deterioration harder to recognize. Provide reasonable adjustments and an accompanying observer when necessary.

12.9 Repeat attendance or recent discharge

Do not assign a lower category because the patient was previously assessed. Consider progression, failed treatment, evolving diagnosis, and the reason for return.

12.10 Children without a caregiver or safeguarding concern

Do not delay emergency care. Activate safeguarding procedures, preserve privacy, document accompanying persons, and avoid leaving the child unattended.

12.11 Patient leaving before assessment

Attempt immediate clinical reassessment, explain risks, provide return advice, document last known category and condition, and follow the separate leaving-before-completion protocol.

12.12 Mass-casualty conditions

Continue routine IITT until the authorized mass-casualty plan is activated. Once activated, use the approved mass-casualty triage process and designated zones. Do not improvise a different system independently.

13. Escalation, crowding, and system failure

- Any red patient without immediate resuscitation space or available response team.
- Yellow patients waiting beyond the approved target or unable to remain directly observed.
- Retriage becoming overdue or the waiting area exceeding the safe nurse-to-patient capacity.
- Untriaged arrivals accumulating at the entrance.
- Failure of vital-sign equipment, oxygen, communications, electronic records, power, laboratory, imaging, or transport that affects safe triage.
- Multiple simultaneous high-acuity arrivals or suspected mass-casualty event.
- Inability to separate suspected infectious patients safely.
- Any waiting-area deterioration, collapse, elopement of a high-risk patient, or serious complaint about delay.

13.1 Required escalation actions

- Notify charge nurse and senior ED clinician immediately.
- Deploy additional trained triage/reassessment staff and open pre-identified surge areas.
- Prioritize clearing the resuscitation area and expedite safe disposition of stabilized patients.
- Inform bed management, diagnostics, administration, and on-call services according to the escalation plan.
- Use downtime documentation and manual communication if electronic systems fail.
- Consider activation of the hospital surge or mass-casualty plan when demand exceeds routine capacity.
- Record activation time, actions, unresolved risks, and de-escalation decision.

Crowding is a system hazard, not a reason to dilute triage criteria. Never relabel a patient as lower acuity to make the queue appear safer.

14. Documentation standards

- Arrival date and time; mode of arrival; referral or pre-alert details.
- Patient identifiers or approved temporary identifier.
- Triage start and completion time; age pathway used.
- Chief complaint and onset or key mechanism.
- Public-health/isolation screen and precautions initiated.
- Red criteria assessed and any present; yellow criteria assessed and any present.
- Vital signs required by the tool, pain score where applicable, and AVPU.
- Clinical concern, vulnerability, or reason for discretionary up-triage.
- Assigned category and destination area.
- Standing actions initiated and response.
- Name, designation, and signature/electronic identifier of triage clinician.
- Next retriage time and each reassessment, including category changes and authorizing clinician.
- Times of red activation, movement, first clinical response, and significant delay.
- Patient/caregiver safety instructions and communication support provided.

Documentation rule: *Clinical care takes priority during an immediate threat, but omitted triage details must be completed as soon as the patient is stabilized. Never invent a normal value that was not measured.*

15. Quality indicators and audit

Indicator domain	Suggested measure
Coverage	Percentage of ED arrivals with a documented triage category.
Triage before registration	Percentage clinically triaged before registration/payment processes.
Timeliness	Median and 90th percentile arrival-to-triage time; percentage completed within locally approved threshold.
Red response	Percentage of red patients moved immediately; arrival-to-red-area; arrival-to-first documented intervention; senior-clinician response.
Yellow and green care	Percentage receiving first-line management within approved target.
Retriage	Percentage of waiting patients reassessed within approved interval; number and duration of overdue reassessments.
Safety events	Waiting-area deterioration, collapse, cardiac arrest, ICU admission after prolonged wait, unplanned transfer, or death potentially related to delay.
Accuracy	Structured review of under-triage and over-triage using diagnosis, interventions, disposition, and expert review.
Leaving before assessment	Rate by category, time of day, and wait duration; documented contact attempts for higher-risk patients.
Equity	Compare waits and category changes by age, sex, disability/communication needs, mode of arrival, and other locally appropriate equity measures.
Readiness	Percentage of shifts with trained triage coverage, functioning equipment, current posters, and completed readiness check.

All deaths, cardiac arrests, unexpected ICU transfers, serious deterioration in the waiting area, and complaints alleging delayed recognition should be screened for triage-system contribution. Findings should generate system actions rather than blame-based responses.

16. Training and implementation

Phase 1: Local configuration: Confirm patient flow, resuscitation location, age pathway, category destinations, response targets, retriage intervals, standing orders, escalation contacts, documentation system, and mass-casualty interface.

Phase 2: Readiness: Post current official IITT posters; equip triage and resuscitation areas; create paper downtime forms; synchronize clocks; establish colour and communication systems.

Phase 3: Competency training: Train all relevant clinical staff in IITT use, rapid appearance assessment, vital signs, AVPU, ABCDE, paediatric assessment, pregnancy criteria, trauma, infection control, safeguarding, communication, and documentation.

Phase 4: Simulation: Run scenarios involving simultaneous arrivals, paediatric respiratory distress, active labour, poisoning, behavioural emergency, waiting-area deterioration, system failure, and mass-casualty activation.

Phase 5: Pilot and feedback: Pilot on all shifts, provide direct coaching, capture classification disagreements, and adjust processes without altering official clinical criteria.

Phase 6: Audit and sustainment: Review indicators weekly during rollout, then monthly. Reassess individual competency at least annually and after prolonged absence, serious incident, or major tool update.

Minimum competency assessment

- Correctly apply adult and paediatric IITT criteria in written and simulated cases.
- Recognize red appearance before complete observations.
- Measure and interpret adult and age-specific paediatric high-risk vital signs.
- Activate red response and deliver a concise handover.
- Document category, rationale, action, and retriage plan.
- Demonstrate safe discretionary up-triage and escalation of uncertainty.
- Distinguish routine IITT from mass-casualty triage.

Annex A. One-page triage workflow

ARRIVAL → IMMEDIATE VISUAL SCREEN → PUBLIC-HEALTH SCREEN → AGE-SPECIFIC IITT → RED CRITERIA? → YELLOW CRITERIA? → HIGH-RISK VITAL SIGNS / CLINICAL CONCERN? → CATEGORY, DESTINATION, ACTION, RETRIAGE

Step	Decision / action	Operational rule
1	**Triage before registration**	A trained clinical worker receives every patient. Treat obvious life threats immediately.
2	**Screen for isolation**	Use appropriate PPE and route safely without delaying stabilization.
3	**Choose age card**	Age 12 or older: adult card. Younger than 12: paediatric card.
4	**Any red criterion?**	YES: RED. Move immediately to resuscitation, activate response, begin ABCDE.
5	**Any yellow criterion?**	YES: YELLOW. Move to treatment/observed area, begin authorized first-line care.
6	**High-risk vital sign or concern?**	YES: up-triage or immediate supervising-clinician review.
7	**No red, yellow, high-risk vital, or concern**	GREEN. Move to low-acuity area, provide safety instructions, schedule retriage.
8	**While waiting**	Reassess at scheduled interval and immediately for any change. Up-triage without delay.
9	**During crowding**	Activate escalation. Do not weaken criteria or conceal risk through down-triage.

Annex B. Adult quick-reference checklist

This checklist supports documentation. It does not replace the official adult IITT poster.

RED - any one criterion

☐ Unresponsive; stridor; severe respiratory distress or central cyanosis.
☐ Capillary refill >3 seconds; weak rapid pulse; heavy bleeding; HR <50 or >150.
☐ Active seizure; hypoglycaemia; or two of altered mental state, stiff neck, fever/hypothermia, headache.
☐ High-risk trauma; important poisoning/chemical exposure; threatened limb; snakebite.
☐ Severe acute chest or abdominal pain in person >50; acute ischaemia on ECG if already obtained; violent/aggressive presentation.
☐ Pregnancy with heavy bleeding, severe abdominal pain, seizure/altered state, severe headache, visual change, BP >=160 systolic or >=110 diastolic, active labour, or trauma.

YELLOW - any one criterion when no red feature

☐ Mouth/throat/neck swelling; wheeze.
☐ Persistent vomiting/diarrhoea; unable to drink/feed; severe pallor; ongoing bleeding; recent fainting.
☐ Altered state/agitation; acute weakness; focal neurological complaint; acute visual disturbance; severe pain.
☐ Rapidly worsening/peeling rash; limb deformity; open fracture; suspected dislocation; other trauma/burn.
☐ Known urgent surgical condition; sexual assault; acute scrotal pain/priapism; urinary retention.
☐ Exposure needing time-sensitive prophylaxis; pregnancy referred for complications.

HIGH-RISK VITAL SIGNS - up-triage or immediate review

☐ HR <60 or >130; RR <10 or >30; temperature <36 C or >39 C; SpO2 <92%; AVPU other than Alert.

Annex C. Paediatric quick-reference checklist

This checklist supports documentation. It does not replace the official paediatric IITT poster.

RED - any one criterion

☐ Unresponsive; stridor; severe respiratory distress or central cyanosis.
☐ Capillary refill >3 seconds; weak rapid pulse; heavy bleeding; cold extremities.
☐ Two dehydration/shock features: lethargy, sunken eyes, very slow skin recoil, drinks poorly.
☐ Active seizure; known hypoglycaemia; or altered state with stiff neck, fever, or hypothermia.
☐ Any infant <8 days; or age <2 months with temperature <36 C or >39 C.
☐ High-risk trauma; threatened limb; acute scrotal pain/priapism; snakebite; important ingestion/chemical exposure; pregnancy with adult red criteria.

YELLOW - any one criterion when no red feature

☐ Mouth/throat/neck swelling; wheeze.
☐ Unable to feed/drink; vomits everything; ongoing diarrhoea; dehydration; severe pallor.
☐ Restless, continuously irritable, or lethargic; severe pain.
☐ Infant 8 days to 6 months; visible severe wasting or oedema of both feet.
☐ Trauma/burn; sexual assault; known urgent surgical condition; rapidly worsening/peeling rash.
☐ Exposure needing time-sensitive prophylaxis; pregnancy without red features; headache without red features.

HIGH-RISK VITAL SIGNS - up-triage or immediate review

☐ <1 year: RR <25 or >50; HR <90 or >180.
☐ 1-4 years: RR <20 or >40; HR <80 or >160.
☐ 5-12 years: RR <10 or >30; HR <70 or >140.
☐ All ages: temperature <36 C or >39 C; SpO2 <92%; AVPU other than Alert.

Annex D. Proposed local response and retriage targets

Complete and approve this table before go-live. The draft values below are proposed for testing, not automatic institutional policy.

Category	Destination	First-line response target	Formal retriage target	Approved local value / authority
RED	Resuscitation	Immediate; operational ceiling 10 minutes	Continuous / as ordered	[Insert]
YELLOW	Treatment or directly observed area	Within 2 hours	Every 30 minutes while waiting	[Insert]
GREEN	Low-acuity waiting or approved OPD pathway	Within 4 hours	Every 60 minutes while waiting	[Insert]

Approval considerations

- Annual ED attendance and hourly arrival patterns.
- Number and competence of triage and reassessment staff on every shift.
- Physical visibility of waiting areas and availability of monitors.
- Expected time to clinician assessment and diagnostics.
- Electronic alert capability and downtime processes.
- Ability to separate infectious, behavioural, paediatric, and vulnerable patients.
- Audit data from a time-limited pilot.

Annex E. Minimum triage and retriage record

Record section	Minimum fields
Patient	Name / temporary ID; date of birth or estimated age; sex; arrival date/time; mode of arrival.
Presenting problem	Chief complaint; onset; mechanism; pregnancy status where relevant; referral/pre-alert information.
Safety screen	Immediate appearance; public-health screen; isolation/PPE; arrived alive/dead status.
IITT assessment	Age card used; red criteria present/absent; yellow criteria present/absent; high-risk vital signs; clinical concern.
Observations	HR, RR, SpO2, temperature, AVPU; BP when clinically indicated including pregnancy; pain; glucose when indicated.
Decision	Colour, destination, time assigned, triage clinician, senior review if required.
Actions	Red activation, oxygen/bleeding control/monitoring or other locally authorized measures; response.
Retriage plan	Next due time; safety instructions; communication or safeguarding needs.
Retriage entry	Time; symptoms; appearance; observations; category; change and rationale; action; clinician.
Delay/escalation	Target breach, crowding escalation, unresolved risk, and person notified.

Annex F. Triage-area equipment checklist

Adapt locally: *This is a practical minimum list. Compare it with the current WHO Triage Area Equipment Checklist and hospital infection-control requirements.*

Domain	Required items / process	Local status / action
Decision support	Current adult and paediatric IITT posters; local standing-order matrix; escalation directory; mass-casualty activation instructions.	[Complete before implementation]
Basic observations	Clock; thermometer; pulse oximeter with adult/paediatric probes; blood-pressure devices and cuff sizes; stethoscope; watch/timer for pulse and respiratory rate.	[Complete before implementation]
Point-of-care	Blood-glucose meter, strips, lancets, quality-control supplies; access to ECG where locally required.	[Complete before implementation]
Immediate safety	Gloves and other PPE; masks for source control; hand hygiene; sharps container; basic bleeding-control supplies; wheelchair/trolley access.	[Complete before implementation]
Communication	Telephone/radio/alarm method; red activation phrase; interpreter/accessibility support process.	[Complete before implementation]
Documentation	Triage forms, retriage forms, temporary identifiers, labels, pens, downtime pack, colour/status markers.	[Complete before implementation]
Environment	Adequate lighting; privacy screen; cleanable chair/trolley; visible waiting areas; isolation route; emergency egress.	[Complete before implementation]
Readiness assurance	Beginning-of-shift check, responsible person, replacement process, fault log, and documented escalation for missing equipment.	[Complete before implementation]

Annex G. References and source tools

World Health Organization. Interagency Integrated Triage Tool landing page. Source

World Health Organization. Triage and Treatment in the Emergency Unit, age 12 years and older. Source

World Health Organization. Triage and Treatment in the Emergency Unit, younger than 12 years. Source

World Health Organization. IITT Frequently Asked Questions. Source

World Health Organization. Emergency Care Toolkit. Source

World Health Organization. Designating a Resuscitation Area in the Emergency Unit. Source

World Health Organization and International Committee of the Red Cross. Basic Emergency Care: approach to the acutely ill and injured. Source

> ***Reference-control note:*** *The ED clinical lead should confirm that displayed WHO tools remain current at each scheduled policy review. If the source tool changes, suspend use of any conflicting local quick-reference annex until reviewed and approved.*

Local configuration and approval record

Triage location and entry routes	[Insert]
Red activation phrase / alarm	[Insert]
Red response team composition	[Insert]
Yellow and green destinations	[Insert]
Approved response targets	[Insert]
Approved retriage intervals	[Insert]
Authorized nurse-initiated actions	[Insert policy / order set]
Senior review role for uncertainty/down-triage	[Insert]
Obstetric, paediatric, safeguarding and toxicology contacts	[Insert]
Crowding escalation thresholds	[Insert]
Mass-casualty activation authority	[Insert]
Documentation form / electronic module	[Insert]

Revision history

Version	Date	Change	Author	Approval
Draft 1.0	[Insert]	Initial draft for local validation	[Insert]	Pending