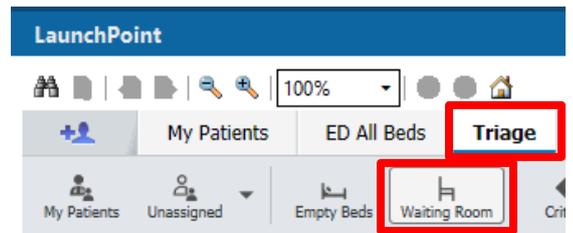




## This Quick Reference Guide will explain how to:

Complete a nursing Triage in FirstNet

1. Once the patient has been added to FirstNet via **Quick Registration**, locate the patient in the **Triage Zone**. Ensure the **Waiting Room** filter is selected.



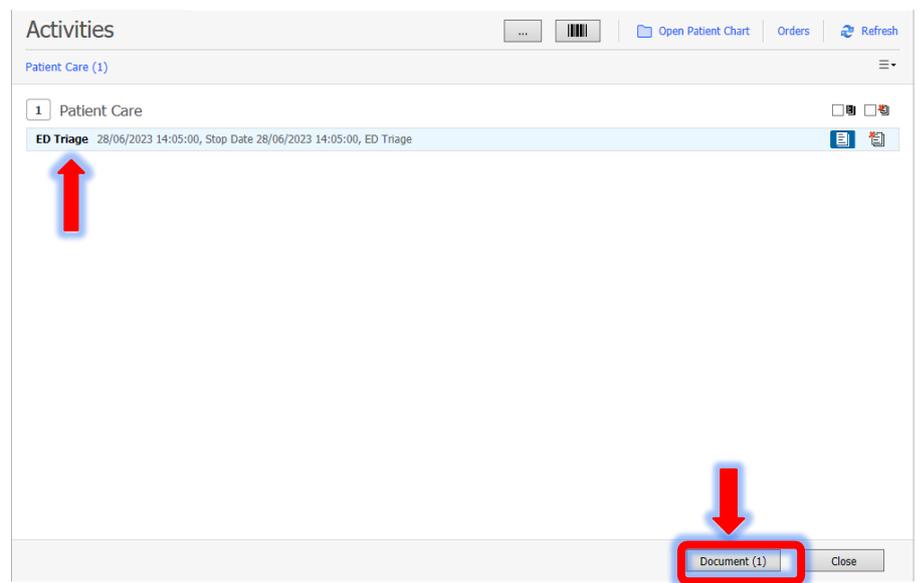
2. **REFRESH** the page from the top right hand corner of the page



3. Click on the number in the **'Nursing Activities'** column.



4. The outstanding Activities window will display. Highlight **'ED Triage'** in blue and click on **'Document'** at the bottom right of the page, which opens the Triage Assessment form.



- Commence triage including the **Presenting Problem/Assessment**, **Visit Complaint**, **Triage Category**, and **Infectious Risk Screening**, which are yellow mandatory fields.

Note: The triage assessment form contains one assessment text box with a separate drop down visit complaint.

The screenshot shows the 'Triage Assessment' form. At the top, it displays the date and time: 'Performed on: 01/08/2023 11:02 AEST' and the user: 'By: WHSTEST, Nursing P2 4 - CLIN'. The form is divided into several sections:

- Triage Assessment Header:** A blue bar with the title 'Triage Assessment'.
- Presenting Problem/Assessment:** A large yellow text area for the main assessment, highlighted with a red box. To its right are dropdown menus for 'Triage Category', 'Visit Complaint', 'Tracking Team', 'Triage Date' (set to 01/08/2023 11:02), and 'Team Allocation' (set to ED Sunshine Tracking Group).
- Infectious Risk Screening:** Radio buttons for 'Yes', 'Unable to ascertain', 'High Risk', and 'Low Risk'.
- COVID Risk Assessment:** Radio buttons for 'High Risk' and 'Low Risk'.
- MH?, AOD?, Allergies/ADRs to Document?:** Radio buttons for 'Yes' and 'No'.
- Existing Problems/Alerts and Existing Allergies/ADR:** Text areas with the message 'No qualifying data available.'
- Please Enter Nursing Vital Signs, NOT AV Vital Signs:** A grid of input fields for various vital signs including AVPU, Temperature, Oxygen Delivery, Blood Pressure, GCS Eyes Open, GCS Score, Respiratory Rate, Oxygen Flow Rate, BSL, GCS Voice, Heart Rate, BOC Score, Ketones, GCS Motor, SpO2, Pain Score, Weight, and Capillary Refill.
- ED Behaviours of Concern Risk Assessment:** A list of behaviors including Confused, Irritable, Boisterous, Verbal Threats, Physical Threats, and Attacking Objects.
- Triage AV Comments:** A text area at the bottom left, highlighted with a red box. A red arrow points from this box to a larger, detailed view of the 'Triage AV Comments' text area at the bottom right of the page.

- Any additional information provided by AV during triage can be documented in the **'Triage AV Comments'** box at the bottom of the form.

**Triage AV Comments**

A large, empty text area for documenting additional information provided by AV during triage.

7. Clicking ‘Yes’ on infectious screening will pop up with a separate risk screening form to complete. COVID Risk Assessment is separate. Note: Fill in the top 6 questions that are mandatory. The return arrow  takes you back to the triage form. Click ‘Unable to ascertain’ if unable to complete identification of infectious risk at the time of triage. This will then be automatically be tasked to be completed by the bedside nurse.

8. The triage assessment form allows for early streaming for of **MH** and **AOD** for consults. Selecting **Yes** or **No** to Allergies opens the EMR Allergies window.

9. Entering NURSING observations (Vital Signs/BOC/GCS) taken in either front or AV triage will populate onto the patient observation chart. Any critical Vital Signs will flag for review as either urgent, 15 or 30 minutes. This replaces paper based documentation, and will allow for earlier detection of clinical deterioration.

10. Click green tick in upper left corner of triage assessment form when completed, click blue circle to cancel charting and return to LaunchPoint.



11. The ED Triage task will drop off the nursing activities and the patient will no longer show in the 'Triage Zone'

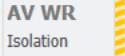
12. To locate the patient in the waiting room select the appropriate **waiting room zone** for the campus you work at. See below Footscray 'WR' Zone. The patient Status will now change from 'Triage Needed' to 'Unassigned' until a treating clinician or nurse picks up the patient.

The screenshot shows the LaunchPoint interface. At the top, there's a navigation bar with 'WR' highlighted. Below it, a 'Waiting Room' button is highlighted with a red box. On the right, a 'Triage Needed' status indicator shows a timer at 144:28. A red arrow points from this indicator to a patient row in the table below. The patient row has 'WR' in the 'Room' column, a BOC score of '2' in a red box, and a time of '06:38' in a red box. The patient information is '\*UNKNOWN, FEMALE...' with URN '7100289'. The 'Status' column shows 'Unassigned' with a timer at '06:38' in a red box.

T	Room	LOS	Patient Information	URN	Status
	WR	2 06:38	*UNKNOWN, FEMALE... 01/01/50 73y F	7100289	Unassigned 06:38



## IMPORTANT

- 1) Visit complaint is the drop down box where common presenting complaints are listed in alphabetical order. Typing the first letters of presenting complaint expedite search.
- 2) Any BOC score of >2 will display red on the 'Room' column once triage completed. 
- 3) Selection of 'High Risk' for COVID will trigger an ED isolation alert, displays on 'Room' column. 
- 4) To Re Categorise patient (up or down grade) you must complete the 'Re Triage' process (QRG).
- 5) To amend you Triage form follow the 'FirstNet - How to Access, Modify and Unchart PowerForms' QRG.