

Triage – keep it simple, swift, safe and scientific

To the Editor: In her editorial, Molyneux^[1] joins with the authors of 'An adapted triage tool (ETAT) at Red Cross War Memorial Children's Hospital Medical Emergency Unit, Cape Town: An evaluation',^[2] Their evaluation of ETAT implied that the inclusion of physiological parameters was superfluous and, in the triage of a paediatric patient, was 'time-consuming to perform and, if manually and hastily undertaken, could be incorrect'. Summarily doing away with an entire aspect of medical evaluation has a sense of throwing the baby out with the bathwater. There can be no question regarding the value of physiological measures in the assessment of acuity.^[3-5] There is agreement on the problems related to blood pressure measurement, which is why it was removed from the Triage Early Warning Score

(TEWS) component of the paediatric South African Triage Scale (SATS) as long ago as 2007.

While Molyneux states that the 'RCCH [Red Cross Hospital] team compared ETAT triage results with those from the South African Triage Scoring System'^[1] and the RCCH group state that 'it was believed that an ETAT-based process would be more appropriate than ... SATS',^[2] this study neither compared the two tools nor proved 'appropriateness' of one over the other; rather it showed the effect and validity of the introduction of the ETAT tool/framework into a 'triage-naïve' setting. There is no argument against the superiority of almost any kind of triage system over no systematic prioritisation, and ETAT has been shown, unsurprisingly, to be a better system than no system at all.

The latest version of SATS was developed over 12 months, building onto the 'emergency triage' component of the ETAT through a consultative consensus approach, customising the emergency signs to the local context and validating these subjective clinical signs in conjunction with the objective TEWS in Cape Town in 2011.^[6]

The validation showed that the combination of clinical signs (as used in emergency triage from ETAT) and the TEWS (the composite physiological score underpinning SATS) is far superior in both sensitivity and negative predictive value to either taken in isolation. The SATS tool – which is in its third version and has now combined the best of both SATS and ETAT – allows for rapid movement of patients into resuscitation as the first emergency sign is found (the ABCcD of ETAT), bypassing measurement of TEWS at triage. For children less obviously ill, but nevertheless as ill, the TEWS acts as a safety net, catching 'red' patients who slip through the clinical signs net, adding finesse and increasing sensitivity from 57% to 91%,^[6] at the cost of a maximum extra 2 - 4 minutes per patient (although the ETAT study^[2] is the first to report such times: over 100 other sites use the SATS, including resource-constrained sites such as Médecins Sans Frontières field hospitals, and we have not recorded such lengthy processes, nor inaccurate triage due to excessive speed, in any of them). If this cost in time is not deemed feasible, doing away with the weighing of patients at triage is recommended – a routine practice and part of the adapted ETAT for Red Cross Hospital, but as yet unproven in effectiveness as a triage component – rather assessing respiratory rate and pulse within the time frame.

This is an important debate, and presenting only one side of the evidence does not help to inform or encourage robust debate.

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