






ORIGINAL RESEARCH PAPER

Rapid triage performed by nurses: Signs and symptoms associated with identifying critically ill patients in the emergency department

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Abstract

Aim: Aim of this study is to identify signs and symptoms associated with identifying critically ill patients by rapid triage assessment performed by nurses in an emergency department.

Background: In some emergency services, the immediate assessment of critically ill patients occurs before opening the hospital formal registration and it is based on the nurse's experience. Studies on the topic are essential to improve this process.

Design: This is a cross-sectional, quantitative study.

Methods: This study was conducted in a Brazilian emergency department in 2017. Adult patients who presented potentially life-threatening symptoms underwent rapid triage to determine the medical urgency. Those identified as being critically ill were classified as high priority and streamed to the emergency room.

Results: A total of 154 (84.6%) patients were classified as high priority from the total of 182 evaluations. Altered state of consciousness (35.2%) and altered skin perfusion (25.3%) were frequently identified. Signs and symptoms associated with identifying critically ill patients by rapid triage were alterations in ventilation (OR 6.09; $p = 0.028$), neurological dysfunction (OR 44.96; $p < 0.001$) and pain (OR 5.80; $p = 0.004$).

Conclusion: Nurses should value neurological and ventilation alterations and pain in patients during rapid triage, since these signs and symptoms are associated with high care priority.

KEYWORDS

critical illness, emergency department, nursing, patient acuity, triage

Summary statement

What is already known about this topic?

- Research carried out in different countries highlights the importance of triage and risk classification systems, especially in the context of overcrowding in the emergency department.

- The time that a critically ill patient waits to receive effective treatment is one of the most significant predictors of unsatisfactory clinical outcomes.
- There are very few studies which have utilized a simple quick-look method of triage in relation to other studies which commonly used a five-level triage system in the emergency department.

What this paper adds?

- In this study, we analysed the rapid triage performed by emergency nurses of patients' self-reporting severe complaints in the emergency department.
- The results showed that some signs and symptoms identified by nurses during the rapid triage were associated with identifying critically ill patients in the emergency department.
- Knowing characteristics of rapid triage is essential to direct strategies for improvement in the early and safe identification of critically ill patients who seek care in the emergency service, enhancing the chances of survival.

The implications of this paper for practice:

- Emergency nurses must remain vigilant for acute alterations in patient neurological, respiratory and pain status, as these may potentially herald critical illness and poor patient outcomes.
- Early detection of patients with critically illness optimizes utilization of finite resources and stabilizes care flows.

1 | INTRODUCTION

The increase in the number of patients seeking urgent and emergency care is a global phenomenon (Bahadori et al., 2017; Patey et al., 2019; Sacoman et al., 2019; Steirner et al., 2016; Zlotnik et al., 2016). Approximately 9 million people sought emergency care in Brazil only in 2020 (Ministry of Health of Brazil, 2020). In this context of high patient demand for emergency care, triage systems aim to optimize the care of those in the most urgent situations (Lauridsen, 2019; Sacoman et al., 2019; Steirner et al., 2016) and ensure that human and technological resources are applied efficiently (Sacoman et al., 2019).

The vital question is, however, how much time and what number of resources are needed to safely triage undifferentiated patients without jeopardizing timely access to emergency care (Betz et al., 2016). One study has shown that long wait times negatively impact clinical outcomes, especially for those affected by life-threatening conditions (Steirner et al., 2016). The presence of queues resulting from high patient demand for emergency care (Chianca et al., 2016) and long wait times between hospital registration and commencement of triage can impede timely access to medical care and limit the ability to achieve quality care indicators (Souza et al., 2018).

One method to facilitate early identification of potentially critically ill patients prior to formal hospital registration has been explored in some emergency care services (Anziliero et al., 2016). A

Swiss study identified that critically ill patients were immediately referred to the emergency room by a 'quick look nurse' (Lauks et al., 2016). This rapid assessment care model performed by emergency nurses aims to identify the early severity of patients, even before triage routine.

Recent study showed that the accuracy of triage decision of emergency nurses was moderate (Varndell, Hodge, et al., 2019). On the other hand, another investigation (Betz et al., 2016) found that triage nurses seem to give generally accurate perceptions of how ill patients are doing seconds after emergency presentations, and the initial impression of a triage nurse is quite reliable. These contradictory results may be related to the variability in the preparation models and education requirements of triage nurses (Varndell, Hodge, & Fry, 2019).

Based on rapid screening models commonly used in the pre-hospital setting, for example, the triage sieve, where the primary assessment identifies the victim's ability to walk, breathing and pulse (Smith, 2012), the 'quick look nurse' (Lauks et al., 2016), and in the effect of direct communication between triage nurse and emergency physician on reducing patient door-to-doctor and initial assessment time (Rahmatullah et al., 2017), this study's object will call the nurse's rapid assessment 'rapid triage'. In other terms, rapid triage is a quick look from the nurse of an emergency patient's presentations when arriving at an emergency department (ED) with severe complaints reported by themselves or their companions (Moura & Nogueira, 2020).

Unlike the widely traditional triage protocols studies, which consider all visits to ED, no protocols were found in the literature which direct the performance of rapid triage by nurses. It is also observed that this assessment is generally based on the clinical experience (Reay et al., 2020) of the nurse and on intuitive processes. There is no doubt that correctly identifying critically ill patients through rapid triage enhances the chances of survival. Moreover, identifying noncritical patients avoids overcrowding in the ED, saving human and material resources for those who really need them. It is also important to highlight that human and material resources are often scarce in the ED, so it is essential to avoid wasting these resources on those without real serious conditions or other patients who could be treated in non-critical units (Sacoman et al., 2019).

There are many concerns about rapid triage. Some of them, which will be used as a guide for this study, are presented in the following questions: What are the signs and symptoms evaluated in patients during rapid triage performed by nurses in the ED? Are there any signs and symptoms associated with the classification of critically ill patients which can be deemed high priority? The correct identification for rapidly screening patients with high priority increases the chances of survival of this population is emphasized. On the other hand, identifying low priority patients avoids overcrowding in the ED and the diversion of human and material resources to assist those who are not in serious real conditions and who could be treated in less critical sectors.

In this sense, the main objective of this study was to identify the signs and symptoms associated with classifying critically ill patients by the rapid triage performed by nurses in the ED.

2 | METHODS

2.1 | Study design

This is an observational, cross-sectional study with a quantitative approach.

2.2 | Sample and setting

The study was developed in the adult ED of a university hospital located in São Paulo, Brazil. The hospital has 178 beds and the ED has three distinct areas for the care of obstetric, paediatric, and adult patients. The adult ED has 13 emergency offices, 11 observation beds, an emergency room, a trauma room and five triage offices.

There are two different entrances to the hospital (Figure 1). At the main entrance (entrance 1), the patients or the family members need to take an assigned number to open a hospital formal registration by attendance at reception. Then, they wait in a noncritical sector to be assessed by a triage nurse according to the Manchester Triage System (MTS). Entrance 2 or the emergency entrance receives patients with signs of instability carried by pre-hospital ambulance with a doctor and a nurse. These patients are directly evaluated by the medical team which indicates the service sector.

In cases of emergency patient presentations who arrive at the hospital self-reporting severe complaints, the companion is instructed to park their vehicle at the emergency entrance and the emergency nurse performs a brief assessment, meaning they perform rapid triage of the patient who is in the vehicle. The rapid triage aims to identify

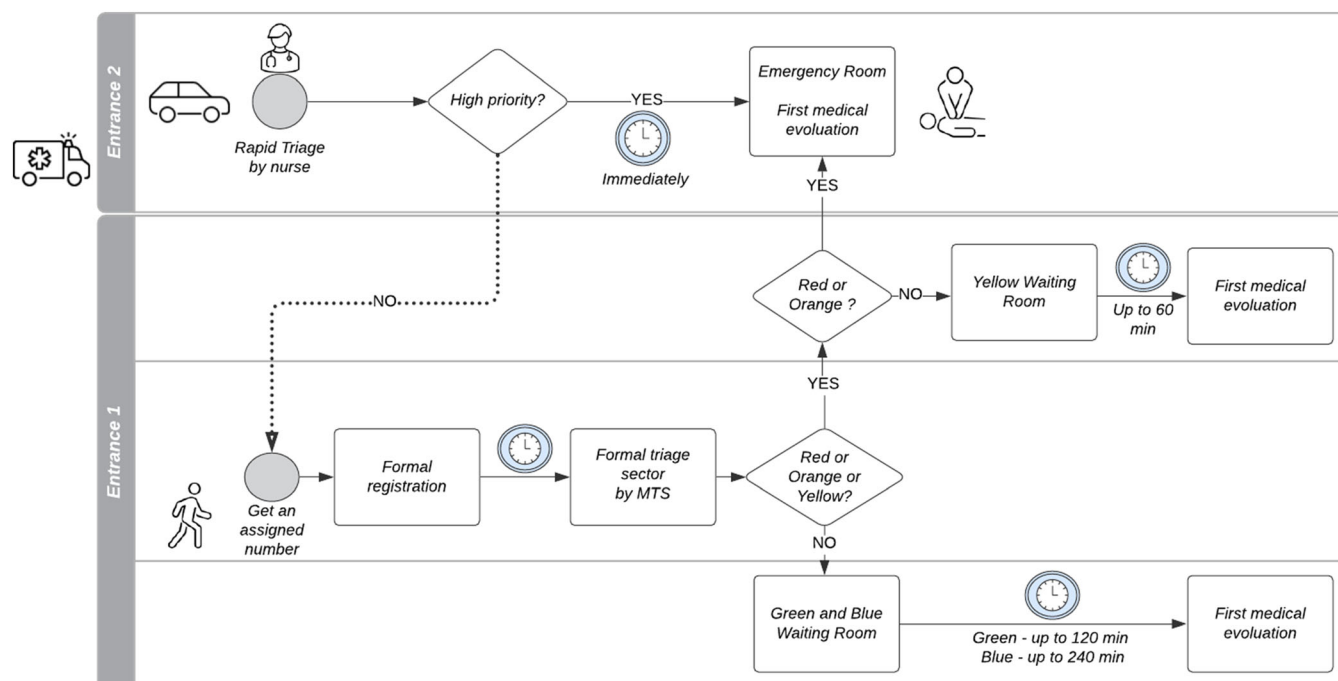


FIGURE 1 Diagram related to patient flow in the emergency department

whether it is an emergency condition and if the patient needs immediate care (referral to the emergency room) or if they can be directed to the usual flow of the institution (entrance 1). All emergency nurses of the institution are licensed by the MTS.

The sample was taken by convenience and consisted of assessments (rapid triage) carried out by emergency nurses of patients aged 18 years or older from emergency patient presentations and who arrived at the emergency entrance self-referring severity. Only triage evaluations carried out from May 1 to December 13, 2017, and from 7 am to 7 pm when MTS is applied at the hospital's ED were considered.

Women in obstetric complications or in labour were excluded from the sample because they are referred directly to the obstetric ED and are not evaluated by the emergency nurse. In addition, patients brought by the prehospital service or referred from other health institutions were not included in this investigation since they had already received treatment/evaluation by a health professional who provided the initial care.

2.3 | Variables

The variables of gender, age, number of specialist graduate certificates, Master's degree completed and length of professional experience in the emergency room were analysed in order to characterize the emergency nurses. Data on gender, age, number and type of comorbidities were investigated regarding patients.

For consultations, the signs and symptoms observed during the rapid triage performed by the emergency nurse were analysed, a priority level (severity) was assigned after rapid triage dichotomized into high priority (patients referred to the emergency room) or low priority (patients referred to the normal flow of the institution's triage—entrance 1), the clinic responsible for care, destination after being attended to in the ED, length of hospital stay (≤ 24 h or > 24 h), hospital readmission in 7 days and clinical outcome (surviving or not surviving).

2.4 | Data collection

There were three instruments used for data collection which included information about the characterization of the emergency nurse and a question to the professional regarding 'What signs and symptoms do you consider important in evaluating critically ill patients at the emergency room entrance?' (form 1), signs and symptoms analysed by emergency nurse during rapid triage at the ED (entrance 2) and priority level assigned (form 2), and characterization of patients' clinical evolution (form 3) (see Appendix A).

Form 2 is a checklist and contains the signs and symptoms according to the categories ventilation, pulse, neurological dysfunction, perfusion, pain and bleeding, injuries and deformities. In addition, space was made available to insert any other signs not included in the categories described above.

The instruments were created by the researchers in order to answer the questions of this study and were based on the previous

experience of an emergency nurse who is the main researcher of this study. The signs and symptoms were initially chosen based on the discriminators of MTS, in addition to the clinical experience of researchers. The instruments were piloted in the ED for a period of 15 days prior to beginning data collection. The viability of the instruments was then assessed during this period. However, no changes were necessary in the initially proposed versions at the end of the trial.

Data were collected by the single person (main researcher of this study) in three stages. In the first stage, form 1 was applied to the emergency nurses who agreed to participate in the study. In the second, data on the signs and symptoms of emergency patient presentations brought in private vehicles were identified. This stage was based on information collected by the researcher through directly observing the emergency nurses' performance at the emergency entrance during the rapid triage. At the end of each assessment, the researcher asked these emergency nurses about the signs and symptoms he/she observed during the process and which room the patient was referred to. The researcher filled out form 2 based on the emergency nurses' answers. Finally, in the third step, the researchers retrieved data related to care and outcomes from the patient's hospital record for completing form 3.

2.5 | Ethical considerations

The study received approval from the institution's Research Ethics Committee (opinion No. 1,969,864) and the Free and Informed Consent Form was obtained from nurses and patients (or legal representatives, if the patient was unable to understand and/or sign the form) who participated in the research.

2.6 | Data analysis

The variables were stored in Microsoft Office Excel® 2016 spreadsheets and the Statistical Package for the Social Sciences (SPSS) version 20 software programme was used to analyse the study data. Descriptive statistics were performed to characterize the sample, including: relative and absolute frequencies, mean and standard deviation (SD). Multiple logistic regression (stepwise backward method) (Agresti, 2002) was applied to identify the signs and symptoms associated with the classification of critically ill patients (high priority) by the rapid triage performed by nurses. The predictive capacity of the model was assessed by the Receiver Operating Characteristics Curve (ROC Curve) and a significance level of 5% was applied in all analyses.

3 | RESULTS

3.1 | Characterization of nurses

A total of 13 emergency nurses (100% female) participated in the study with an average age of 39.6 (SD = 10.5) years. Regarding

training, these professionals had at least one specialist graduate certificate (average of 1.8 per nurse) and five (38.5%) had Master's degrees. Respondents had an average of 11.5 ($SD = 6.9$) years of emergency nursing experience.

Regarding the signs and symptoms considered important in evaluating critically ill patients at the emergency entrance according to the professionals' perception, it was identified that altered state of consciousness, the presence of dyspnea and alterations in pulse rate/rhythm were mentioned by more than 70% of emergency nurses. Chest pain (69.2%), skin alterations (61.5%) such as sweating, skin pallor, low temperature and edema, new neurological deficit (61.5%), decreased peripheral perfusion (61.5%) and altered capillary blood glucose (53.8%) were also highlighted.

3.2 | Characterization of patients

A total of 173 patients presenting for emergency care were evaluated by emergency nurses at the adult emergency entrance. There were nine patients evaluated at two different times during the study period featuring two different evaluations, therefore totalling 182 visits (evaluations) with an average of 14 ($SD = 9.87$) evaluations per nurse.

Females prevailed (52.0%) among triaged patients, and the average age was 60.4 ($SD = 21.2$) years. The main co-morbidities presented by the patients were systemic arterial hypertension (44.5%), diabetes mellitus (25.4%), and heart failure and acute myocardial infarction (13.3% each). Patients had an average of 1.8 ($SD = 1.6$) co-morbidities.

The medical clinic received the majority of cases (72.0%) for the first medical care, followed by the surgical clinic (24.7%). Patients stayed for more than 24 h in the institution in 32.4% of the visits, there was admission to the emergency observation unit in 56.0%, admission to the ward in 11.0%, and admission to the Intensive Care Unit (ICU) in 5.0%.

There was a prevalence of survivors regarding the clinical outcome of patients (86.8%). A total of 10 patients returned to the ED within 7 days after discharge from hospital due to persistence, worsening or the appearance of new symptoms, and one of these patients died at the institution.

3.3 | Signs and symptoms identified during rapid triage

The signs and symptoms observed by the emergency nurse at the time of patient assessment in each service are shown in Table 1. It is noticeable that altered state of consciousness (35.2%), altered skin perfusion (25.3%), the presence of tachypnea (13.7%) and low oxygen saturation (13.2%) were the signs and symptoms most frequently identified by emergency nurses during the rapid triage of patients.

There were 154 (84.6%) of the total 182 evaluations performed classified as critically ill, meaning that high care priority was referred

TABLE 1 Signs and symptoms observed by nurses during rapid triage (182 evaluations) of emergency patient presentations in the emergency department

Signs and symptoms observed	n	%
Ventilation		
Tachypnea	25	13.7
Dyspnea	22	12.1
Low oxygen saturation	24	13.2
Pulse		
Altered pulse rate/rhythm	21	11.5
Cardiac arrest	5	2.7
Neurological dysfunction		
Altered state of consciousness	64	35.2
Convulsive crisis	11	6.0
Focal deficit	12	6.6
Perfusion		
Decreased peripheral perfusion	11	6.0
Altered skin perfusion	46	25.3
Pain		
Chest pain	15	8.2
Mild/moderate/chronic pain	12	6.6
Severe pain	19	10.4
Haemorrhages, injuries and deformities		
Haemorrhages, injuries and serious deformities	13	7.1
Others ^a	16	8.8

^aDecreased mobility ($n = 8$), signs of dehydration ($n = 3$), old age ($n = 4$), anasarca ($n = 1$).

by the emergency nurse, and 23 of these patients died. Nine (39.2%) died during the first care provision in the emergency room. The remaining deaths ($n = 14$) occurred in the observation of the emergency unit (34.8%), in the ward (13.0%) and in the ICU (13.0%). A patient classified as low priority by the nurse in the rapid triage later died in the ICU.

3.4 | Signs and symptoms and priority

It is observed (Figure 2) that an alteration in consciousness level was present in 63 patients classified as high priority by the emergency nurses (34.6% of the evaluations), and only one patient who presented this alteration was classified as low priority. Alterations of skin perfusion (pale skin, sweating, cold and sticky skin) were observed in 46 high priority cases (25.3% of evaluations). No patient classified as low priority presented this sign/symptom. Other symptoms (anasarca, decreased mobility and old age) were the most frequent among all those classified as low priority (2.2% of evaluations).

The signs and symptoms associated with the classification of high-priority patients according to rapid triage were altered in

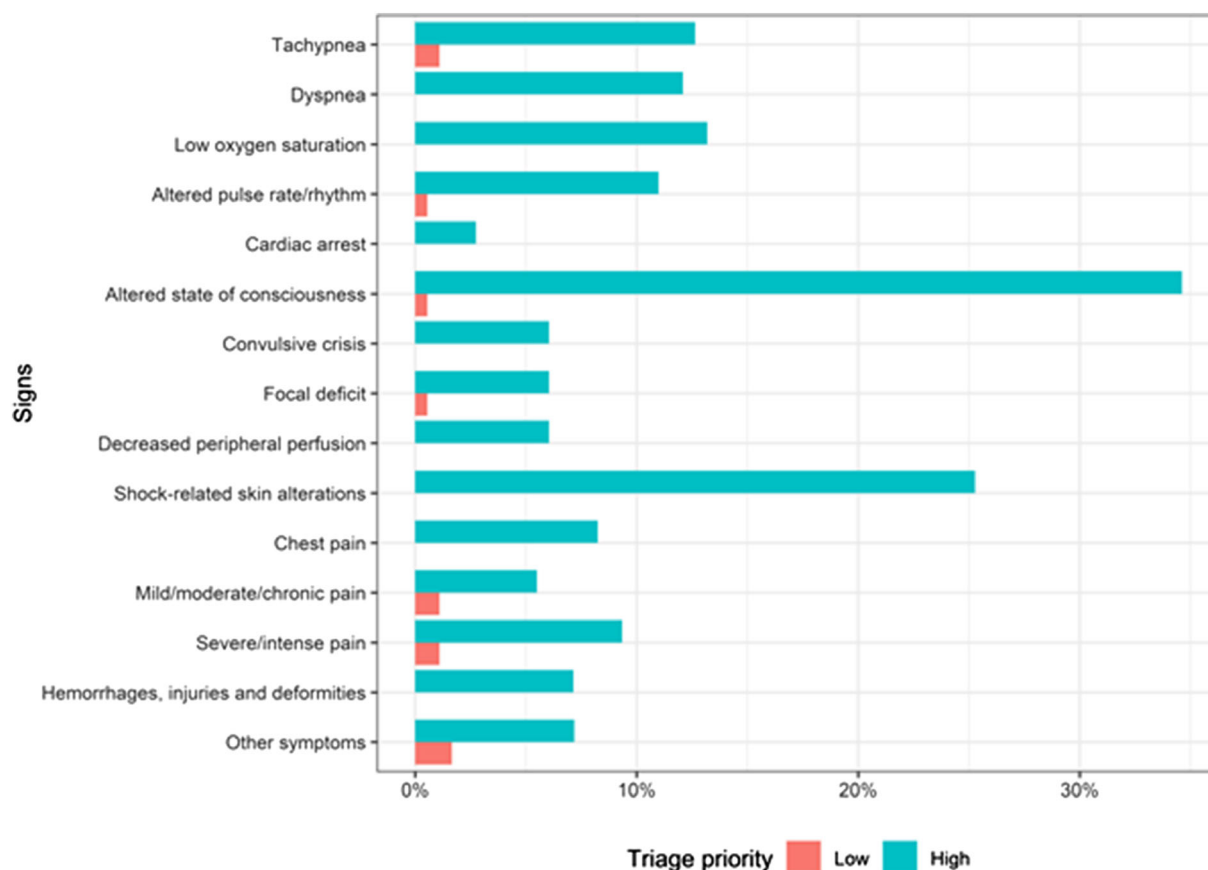


FIGURE 2 Signs and symptoms observed by nurses in rapid triage according to the assigned priority level (high or low priority)

TABLE 2 Signs and symptoms associated with the classification of high-priority patients according to rapid triage

Categories of signs and symptoms	OR ^a	95% CI ^b	p value
Ventilation	6.09	1.21–30.60	0.028
Pulse	4.26	0.45–40.38	0.207
Neurological dysfunction	44.96	5.67–356.68	<0.001
Perfusion	4.40	0.90–21.58	0.068
Pain	5.80	1.73–19.48	0.004
Others	1.84	0.49–6.84	0.364

^aOdds ratio.

^b95% Confidence interval.

ventilation ($p = 0.028$), neurological dysfunction ($p < 0.001$) and the presence of pain ($p = 0.004$) (Table 2). Patients who had problems with respiration, neurological dysfunction or pain were respectively 6.09, 44.96 and 5.80 times more likely to be classified as a high priority in the rapid triage performed by emergency nurses than those who did not have such changes.

The ROC Curve shown in Figure 3 shows satisfactory predictive capacity (area under ROC curve = 0.866) of the model which identified the signs and symptoms associated with the classification of high priority patients according to the rapid triage performed by emergency nurses.

4 | DISCUSSION

This study analysed the rapid triage performed by emergency nurses of emergency patients self-reporting severe complaints in the ED, as well as signs and symptoms associated with high care priority.

The signs and symptoms identified by emergency nurses in the triaged patients were similar to those pointed out as important when answering the question applied in the first phase of the study. Alterations in the state of consciousness, respiratory and altered skin perfusion stood out. A Swiss study (Steirner et al., 2016) showed that neurological (22.6%) and respiratory symptoms (11.1%) are frequent

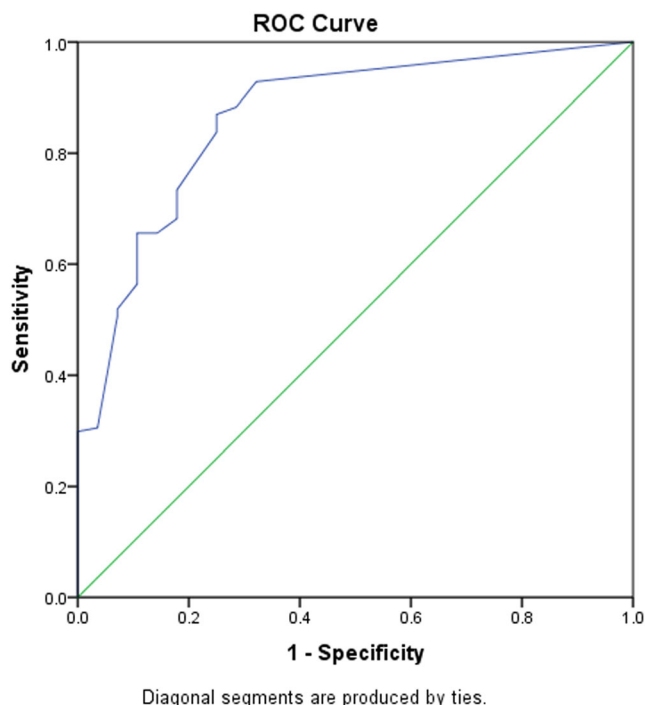


FIGURE 3 Predictive capacity of the logistic regression model related to the signs and symptoms associated with the classification of high-priority patients according to rapid triage

reasons for seeking emergency care. A study carried out in Nepal (Basnet et al., 2012) found that the main problems identified in patients classified as level 2 (imminent risk of life) of the Australian Triage Scale (ATS) were shock (23.1%), altered level of consciousness (21.3%) and breathing difficulties (16.9%).

There was great heterogeneity of the groups (high and low priority) regarding the signs and symptoms identified according to the assigned priority level. This was because no signs or symptoms were identified for patients classified as low priority which attracted attention from the emergency nurse. Thus, the category of other symptoms (signs of dehydration, anasarca, decreased mobility and advanced age) was the most prominent in the group classified as low priority. Tachypnea and a change in pulse rate/rhythm present in the low priority group can be explained by the hyperventilation and tachycardia caused by anxiety or pain. A patient who had a change in their consciousness level and focal deficit was classified by the emergency nurses as low priority in the rapid triage and referred to the routine triage sector, as the time between the onset of signs and symptoms and the evaluation time exceeded what is recommended to be a candidate for thrombolytic therapy.

In the high priority group, the high frequency of changes in the consciousness level, changes in the skin perfusion, changes in the respiratory system (tachypnea, dyspnea and low oxygen saturation), changes in pulse rate/rhythm, pain and chest pain are remarkable, as in the Nepalese study (Basnet et al., 2012) which described the conditions observed and the initial resuscitation performed of patients who visited the ED.

Thus, the factors associated with classifying high priority patients by rapid triage were altered in ventilation, neurological dysfunction and the presence of pain. These findings corroborate the signs and symptoms which are considered important in evaluating patients at the emergency entrance from the perception of emergency nurses (first phase of this study).

A Swedish study (Ljunggren et al., 2016) found a relationship between changes in the patient's consciousness level and an increased chance of mortality on the first day of hospitalization. Thus, patients who only responded to verbal or painful stimuli or who did not respond to any stimulus respectively presented 4.9 (95% CI 3.3–7.1), 5.4 (95% CI 2.8–10.5) and 31.0 (95% CI 16.9–56.8) times more probability to die on the first day of hospitalization compared to patients without altered level of consciousness. The chances of 30-day mortality and ICU admission also increased for nonalert patients compared to alert patients. In addition, patients who had peripheral oxygen saturation below 90%, even receiving supplemental oxygen, were 5.2 (95% CI 3.1–9.0) times more likely to die early (in the first 24 h) than those with saturation parameters above 95% (Ljunggren et al., 2016).

In analysing the signs and symptoms which are considered important in the assessment of patients according to the emergency nurses' perception, chest pain (69.2%) was more frequently mentioned in relation to general pain (30.8%). It is important to note that acute pain affects most patients who seek ED and the triage nurse must also decipher the meaning and clinical importance of each patient's pain when they assess pain levels (Vuille et al., 2018).

It is important to highlight that when corroborating the findings of this study with the available literature, studies refer to all ED visits, while our sample refers only to those patients who self-reported severe complaints upon arrival at the ED. Hospitalization, ICU admission and mortality rates in the analysed sample were substantially higher than those found in other Brazilian studies (Marconato & Monteiro, 2017; Raita et al., 2019), once again supporting the clinical severity of patients that comprised the sample.

Some further data regarding the outcome of the triaged patients also stand out: the fact that nine patients died during the first care provided in the emergency room draws attention to the clinical severity of these cases, meaning that these patients had an unfavourable outcome even with immediate care first from the emergency nurse during the rapid triage and then by the entire health team upon arrival at the hospital.

The occurrence of a death among those who were classified as a low priority due to rapid triage must be also emphasized. This patient was referred to the routine triage sector where he/she was classified as orange (very urgent) according to the MTS and died 18 days after hospitalization. Thus, potentially avoidable deaths like this should be evaluated for possible causes which led to death to identify whether or not there was a failure in the rapid triage process and/or treatment.

Another point is the expertise of the emergency nurses in the sample. The long emergency experience and excellence in

professional training stood out in relation to the findings of other investigations which had analysed triage aspects in an ED in Brazil (Silva et al., 2017; Souza et al., 2018). Reay et al. (2020) described that nurses consider triage assessment subjective, often based on years of experience, which appears to be a key component of a nurse's expertise to make triage decisions and to know when patients were at greatest risk, when immediate intervention is needed or when there is a mismatch between the assessment finding and the information provided by the patient. Thus, triage nurses use experience to complement the triage process (Reay et al., 2020).

4.1 | Study Limitations

Some limitations of this study must be considered: it was carried out in a single emergency centre, and the data were collected by one researcher. Furthermore, the final sample of the evaluations showed great heterogeneity between the groups (high and low priority) since it was mostly composed of patients classified by the rapid triage of emergency nurses as a high care priority. It is suggested that further research based on the method of this study should be developed in different emergency centres, making it possible to expand the findings for future elaboration of a decision tree for the rapid triage of emergency patient presentations which may better contribute to organizing management flows/care, optimizing the use of resources and safety in classifying these patients in the ED.

5 | CONCLUSION AND IMPLICATIONS

The findings of this study reinforce that nurses should value the neurological and ventilation alterations and pain in emergency patient presentations during rapid triage in the ED, since these signs and symptoms are associated with high care priority.

Patient triage has been widely studied and applied in different parts of the world, especially in places where emergency overcrowding is part of the routine of professionals. In this sense, the nurse's first look at and contact with a serious patient who seeks care in an ED are essential. Therefore, knowing rapid triage aspects and the relevant signs which should be valued by nurses is an important step to direct strategies for improving the early and accurate identification of critically ill patients and to consequently increase the survival of this population.

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CONFLICT OF INTEREST

The authors declare that no competing interests exist.

AUTHORSHIP STATEMENT

BRSM conceived and designed the study, collected the data, interpreted data, and contributed to discussions; GNO and GM collected the data, interpreted data, contributed to discussions, drafted the manuscript, and approved the final version. ASV interpreted data and contributed to discussions; LSN conceived and designed the study, interpreted data, and contributed to discussions. All authors drafted and revised the manuscript and approved the final version for submission.

DATA AVAILABILITY STATEMENT

Data available on request from the authors.

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APPENDIX A: INSTRUMENTS USED FOR DATA COLLECTION

FORM 1. CHARACTERIZATION OF THE EMERGENCY NURSE			
Participant ID: _____	Birth date: _____	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	
Length of professional experience in emergency: _____			
Specialist graduate certificate: <input type="checkbox"/> Yes <input type="checkbox"/> No. Number: _____			
Master degree: <input type="checkbox"/> Yes <input type="checkbox"/> No			
What signs and symptoms do you consider important in evaluating critically ill patients at the emergency room entrance?			

FORM 2. SIGN AND SYMPTOMS ANALYZED BY EMERGENCY NURSE DURING TRIAGE			
Patient Record: _____	Participant ID: _____	Date: ____/____/____	Hour: ____:____h
Rapid triage - Signs and symptoms			
Ventilation			
<input type="checkbox"/> Tachypnea	<input type="checkbox"/> Dyspnea	<input type="checkbox"/> Low oxygen saturation	
Pulse			
<input type="checkbox"/> Altered pulse rate/rhythm		<input type="checkbox"/> Cardiac arrest	
Neurological dysfunction			
<input type="checkbox"/> Altered state of consciousness		<input type="checkbox"/> Convulsive crisis	<input type="checkbox"/> Focal deficit
Perfusion			
<input type="checkbox"/> Decreased peripheral perfusion		<input type="checkbox"/> Altered skin perfusion	
Pain			
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Mild/moderate/chronic pain		<input type="checkbox"/> Severe pain
Hemorrhages, injuries and deformities			
<input type="checkbox"/> Hemorrhages, injuries and serious deformities			
Other signs and symptoms			
Describe other signs and symptoms:			
Classification of patients according to rapid triage			
<input type="checkbox"/> High priority Patients referred to the emergency room		<input type="checkbox"/> Low priority Patients referred to the normal flow of triage – entrance 1	

FORM 3. CHARACTERIZATION OF THE PATIENTS AND CLINICAL EVOLUTION			
Patient Record: _____	Birth date: _____	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	
Comorbidities			
<input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes mellitus <input type="checkbox"/> Heart failure <input type="checkbox"/> Stroke <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Cancer <input type="checkbox"/> Hepatic failure <input type="checkbox"/> Hypothyroidism		<input type="checkbox"/> Acute myocardial infarction <input type="checkbox"/> Epilepsy <input type="checkbox"/> Dyslipidemia <input type="checkbox"/> Chronic kidney disease <input type="checkbox"/> Dementia <input type="checkbox"/> Chronic obstructive pulmonary disease <input type="checkbox"/> Asthma Others: _____	
Clinic responsible for care: _____			
Destination after being attended to in the ED			
<input type="checkbox"/> Admission to the emergency unit		<input type="checkbox"/> Admission to the ward	<input type="checkbox"/> Admission to the ICU
Outcome: <input type="checkbox"/> Surviving <input type="checkbox"/> Not surviving		Date: ____/____/____	Hour: ____:____h
Length of hospital stay: _____			
Returned to the ED within 7 days: <input type="checkbox"/> Yes <input type="checkbox"/> No			