1. **Which health facilities should have a triage area?**
   Every health facility that has a dedicated area to receive the unscheduled, undifferentiated acutely ill and injured should have a triage area.

2. **What materials should be in the triage area?**
   Triage using the Integrated Interagency Triage Tool (IITT) can be performed with minimal equipment. Some clinical criteria in the IITT (e.g., hypoglycaemia, fever, hypothermia, ECG with ischaemia, and elevated blood pressure in pregnancy) are included for patients referred from facilities with diagnostic capacity. Please reference the [Triage Area Equipment Checklist](#) for further guidance.

3. **Which health care personnel should perform triage?**
   All health workers trained in the use of the triage tool may perform triage, even junior clinical staff. In most facilities, initial triage is conducted by trained nursing staff. Senior clinical providers (nurses or doctors) may advise on specific patient or process concerns or perform triage as the need arises. Non-health workers such as security guards should not be used to perform triage.

4. **Do we really need this type of process in the emergency unit?**
   Yes, triage has been shown to improve early recognition of the critically ill, decrease mortality and decrease length of stay.

5. **How long does it take to triage a patient with the IITT?**
   A trained provider familiar with the IITT can properly triage a patient rapidly, ranging from a few seconds to under 2 minutes.

6. **Do I need to document the triage category?**
   Yes. The triage category should be documented for communication and clinical governance reasons. This will depend on the context and may be done electronically or on the patients’ clinical notes or on a triage sheet.

7. **When should the patient be triaged: before or after registration?**
   Patients should be triaged prior to registration. The requirement for registration or payment of user fees prior to being triaged can have life and death consequences for those who are acutely ill or injured. Triage before registration and payment also avoids the issue of paying for emergency care and then being redirected.

8. **Our patient arrivals vary depending on the time of day. Do we have to use triage if the patient is going to be immediately placed on a bed?**
   The purpose of triage is to have a reliable way to sort patients by acuity, particularly if the patient has to wait to be seen. In locations where there is no waiting time to get a bed in the EU, triage should still be performed. Even when patients are assigned a bed, they often still need to wait to see a provider. Assigning the patient to a triage category allows common understanding amongst the staff for the urgency of critical interventions.

9. **What are we supposed to do if we identify patients who meet criteria for red or highest acuity?**
   Patients triaged as “red” or highest priority should be immediately transferred to the resuscitation area, for prompt clinical management under the guidance of a senior clinician. See [Resuscitation Area Designation Tool](#) for further guidance.
10. Why should we use the IITT?
The IITT was developed through consensus amongst global leaders in triage. It is a tool produced by the World Health Organization, International Committee of the Red Cross and Médecins Sans Frontières. The goal of this tool is to create common criteria for each triage category that can be adapted to local context.

The benefits of implementing triage into an emergency unit are many: improved patient safety, efficient use of finite resources, expediting delivery of time-critical treatment, and improving patient flow. Triage serves as a common language between different health care professionals - for example, nurses, doctors and pre-hospital staff all understand what a “red” patient means.

11. What if we already are using a form of triage?
If a standardized, validated triage tool is already being used, your facility may not need to change. However, many locations have changed to the IITT as it is easy to learn, represents consensus-based integration of multiple validated tools, and only has three levels of patient category that makes utilization easy.

12. In our facility, senior doctors perform triage. They have a lot of experience. Do they really need to use a tool?
Studies have shown that validated triage tools perform better than clinician judgement. A triage tool also has the benefit of overcoming unconscious bias to ensure that the patient receives the level and quality of care appropriate to clinical need. This also means that in resource constrained settings senior doctors are able to focus on the clinical management of patients.

13. What are the recommended times that each triage colour should be seen by?
Time to care for each triage colour is for facilities to determine, based on local context, however in all contexts the aim should be that red patients are seen immediately. For the other colours as an example, targets could include: Yellow patients should be seen within 2 hours; Green patients can wait up to 4 – 6 hours.

14. Am I supposed to give the patient a diagnosis when the patient is triaged?
A triage category is not a diagnosis. Triage category alone should not be used as a substitute for admission or referral criteria. Patient assessment by a provider, and establishing a provisional diagnosis and treatment plan, should happen after triage.

15. What do we do if our facility is often overwhelmed, and patients wait for many hours to be seen?
Triaging patients occurs at a single point in time, whereas the patient’s medical condition is often dynamic. It is critical to reassess patients who have been triaged to identify those whose condition has deteriorated while waiting. Health facilities should have protocols for reassessment if patients often wait for long periods of time after being given their initial triage colour.

16. When do we use mass casualty triage?
Mass casualty incidents occur where patient needs exceed facility or system resources. Mass casualty triage is one of several processes that are activated during a mass casualty response. The decision to switch from routine triage to mass casualty triage should be taken when the mass casualty plan is activated. Staff receiving patients should be able to activate the plan as they are often the first to recognize that a mass casualty incident has occurred due to a surge of patients.

17. Can we adapt the IITT?
The language in the tool has been through a broad consensus process and should not be changed. Processes around the tool may be tailored to fit local needs and resources.
18. I run a health post, every morning there are 100 patients waiting to be seen and some small number may be very sick. Should I implement routine triage in this context?
While many factors may influence your decision, using routine IITT for screening for critically ill patients is not generally recommended in this context. When the majority of patients are clinically stable and there are a small number that must be identified quickly for stabilization and referral, a simple screening tool is a more appropriate approach. The use of screening tools, such as “quick look” for children in Emergency Triage Assessment and Triage (ETAT), is more appropriate to outpatient settings.