FAQs – Telephone Triage

During the assessment, do I only need to ask the questions on the chart?
No. The MTS is a clinical framework, it is not the complete assessment. The MTS relies on your clinical knowledge and understanding of the discriminators to be able to build your assessment around the discriminators present.

When triaging children, do we assess using the adult MTS charts, as there are only a few charts that are specific for children?
Yes, the MTS is designed to be used in adults and children for most presenting complaints, apart from the few charts that have been specifically designed for use with children.

What if I disagree with a PPM outcome for my patient?
Presentation Priority Matrix (PPM) outcomes are there to support your decision making and your actions should be justified in situations where your outcome is different to the PPM; clinicians should use their own clinical judgement to determine where their patient is best assessed. Senior clinical advice should be sought if there are any questions regarding PPM outcomes. If during the triage, however if there are concerns with a particular PPM outcome or particular service, you should raise this with your MTS lead.

What does “Advice only” relate to in terms of a PPM outcome?
If the patient elicits no discriminators on the chosen MTS chart, they fall into the “Advice only” (blue) category and the clinician could provide relevant self-care advice and/or signpost the patient towards appropriate care where appropriate.

How can we determine if a patient is just “hot” compared with “very hot” over the telephone?
Very hot is classed as a temperature of ≥41°C however it is acknowledged that when performing telephone triage the patient/caller may not have a thermometer to hand. Therefore the clinician should look for other signs associated with this level of pyrexia, aside from hot skin, which include decreased level of consciousness, ataxia, muscle rigidity, confusion and possible absence of sweating (these signs/symptoms are consistent with heat stroke). In the absence of these, the patient may be classed as hot.

If I am unable to get past a discriminator during my assessment, does this mean I have to stop?
If you are able to justify bypassing a discriminator as the history does not suggest that the discriminator would be positive, then you can move past it.
Do I have to ask every discriminator even if it is not relevant?
Some discriminators may not be relevant at all to your assessment, for example when using the foreign body chart for someone who has swallowed a foreign object, it would not be relevant to ask if they had a penetrating injury to their eye, so this may be bypassed during your assessment. However, be careful not to bypass something just because you think it is not relevant, unless you can clinically justify why you haven’t asked it.

If I am talking to my patient, do I still have to ask if they have an airway compromise or an altered level of consciousness?
If the answer to the discriminator is something you cannot determine by listening to the patient then this will need to be asked directly for example if you are talking to a patient who is alert and clearly not short of breath then this does not need to be asked, but if you are not talking with the patient you would have to ask all the questions to determine their level of response and that their breathing was adequate.

If the patient answers yes to a discriminator does this mean I have to stop?
If a patient answers yes to a discriminator, you should explore further using your clinical questioning. If you are able to clinically justify your decision to move past this to the next priority then you can make this decision but you must be able to justify your decision making process.