

eCTAS Train-the-Trainer – Part 2

Application Basic and Complex

Training Team



**Ontario
Health**

Session Logistics



Intended Audience

Integration(s): Basic, Complex

Resources responsible for training and supporting triage nurses on use of the eCTAS application



This session is being recorded



Press  to mute. Press  to unmute.

Agenda

Learning Objectives:

1. Generating Clinically Appropriate CTAS Scores (e.g., Modifiers)
2. TOA Queue & Printing Triage Summary
3. Special Features
4. Troubleshooting, Downtime & Errors
5. Resources
6. Next Steps



Important: This training is on the use of the eCTAS application only, all triage Nurses must complete the [CTAS Participant Course](#) prior to using eCTAS to triage real patients.

Generating Clinically Appropriate CTAS Scores

- Clinical Judgement & eCTAS (e.g., Modifiers)
- Alerts
- Case Scenarios & Low Scores
- CEDIS-Specific Modifiers

CEDIS Complaints & Modifiers List

CEDIS: Canadian Emergency Department Information System

CEDIS Complaint List (169 complaints) have corresponding:

Base Scores

CTAS 1 Resuscitation – constant reassessment

CTAS 2 Emergent – reassess q 15 minutes

CTAS 3 Urgent – reassess q 30 mins

CTAS 4 Less-Urgent – reassess q 60 mins

CTAS 5 Non-urgent – reassess q 120 mins

+

Modifiers

Signs, symptoms and medical issues - displayed in order of CTAS acuity

Selected or **deselected** to modify the base score and dynamically generate the best possible/most appropriate CTAS score

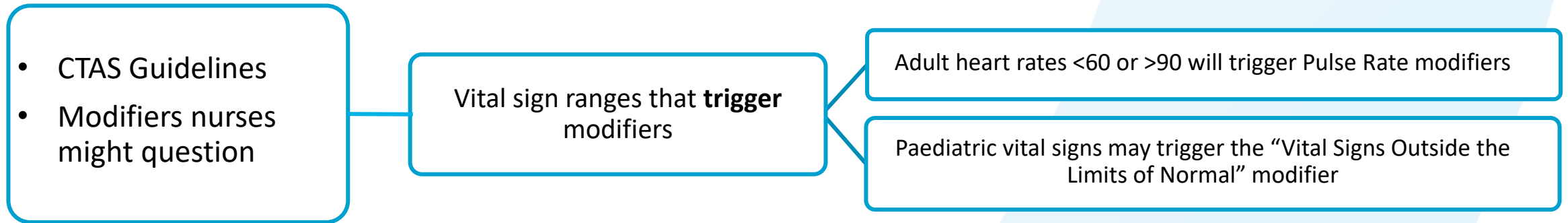
eCTAS is a Clinical Decision-Support Tool

The Nurse's clinical judgement/assessment skills are used WITH eCTAS to reflect the patient's condition AND to generate the best CTAS score

Nurses:

1. Choose most appropriate CEDIS Complaint (or change it)	e.g., Chest Pain (Non-Cardiac Features) = CTAS 5 vs. Chest Pain (Cardiac Features) = CTAS 2
2. Enter applicable Vital Signs →	<ul style="list-style-type: none"> • Trigger modifiers to appear, be highlighted and/or be auto-selected by the system • Potentially increase the CTAS score
3. Select/Deselect Modifiers, if clinically appropriate →	<ul style="list-style-type: none"> • Increase/decrease the CTAS score
*ONLY use CTAS Override as a last resort →	<ul style="list-style-type: none"> • Generate a higher CTAS score when higher scoring modifiers don't appear or correspond to patient's condition

eCTAS is designed around CTAS Guidelines



Note: Posting updated **Paediatric Vital Sign charts** can be helpful for Nurses at Triage

Alerts: Adult Heart Rate

If...

1. Adult HR <40 bpm,
2. CTAS 3, 4, 5 and
3. Nurse attempts to save the record (i.e., hits I'm Done Triage button)



The screenshot shows a software alert interface. At the top left, there is a red triangle icon followed by the word "ALERT". Below this, the text reads "Low pulse rate detected". A yellow callout box with a black border points to the text "HR <40 bpm" within the alert message. Below the main alert text, there is a warning: "Warning: You have recorded... e, Abbie. A higher acuity score may be... Consider selecting the Hemodynamic Compromise or Shock modifier." At the bottom of the alert, it says "Press I'm Done Triage to save your triage or Modify Triage to make adjustments." In the bottom right corner, there are two buttons: "I'm Done Triage" (grey) and "Modify Triage" (orange). A yellow callout box labeled "Options" has lines pointing to both of these buttons.

Vital Signs & Adult Alerts

DEMO



At Triage

The patient presents with a weakness and a pulse rate below the limits of normal. The patient is lethargic and confused with a GCS of 14.



In eCTAS

	Nurse Input	CTAS Score
Patient Stated Complaint	Weakness	
Chief CEDIS Complaint	General weakness	4
Vital Signs	T 37.5, Pulse Rate: 39, R 16, BP 90/56, GCS 14	3
Modifiers	Pulse Rate / Pressure Abnormal (Hemodynamically Stable) is auto-selected	3
	Shock and Hemodynamic Compromise are highlighted in yellow	3
Demonstration of Adult Low HR Alert	Attempt to Save record → MODIFY, Manually select Hemodynamic Compromise	2

Vital Signs

DEMO



At Triage

The patient presents with a fever and a pulse rate above the upper limits of normal. Patient states they have a history of uncontrolled atrial fibrillation, and it is normal for him to have a high heart rate.



In eCTAS

	Nurse Input	CTAS Score
Patient Stated Complaint	Fever	
Chief CEDIS Complaint	Fever	4
Vital Signs	T 37.9, Pulse Rate: 110, R 20, BP 110/84	3
Modifiers	Pulse Rate / Pressure Abnormal (Hemodynamically Stable) is auto-selected	3
	Shock and Hemodynamic Compromise are highlighted in yellow	3
	Manually deselect Pulse Rate / Pressure Abnormal (Hemodynamically Stable)	4

Pain Modifiers

DEMO



At Triage

The patient presents with back pain. The patient gives a pain rating of 9/10; however, you observe the patient appears well with normal vital signs. The patient is walking and speaking with no obvious signs of discomfort, drinking coffee and playing with child.



In eCTAS

	Nurse Input	CTAS Score
Patient Stated Complaint	Back Pain	
Chief CEDIS Complaint	Back Pain	5
Vital Signs	Pain: 9/10	2
Modifiers	Acute Central Severe Pain (8-10) is auto-selected	2
	Deselect Acute Central Severe Pain (8-10) → Acute Central Moderate Pain (4-7) next lower Pain Modifier is auto-selected	3

Changing the Chief CEDIS Complaint

DEMO



At Triage

The patient comes in stating pain in their eye after cleaning their oven today.



In eCTAS

	Nurse Input	CTAS Score
Patient Stated Complaint	Right Eye pain	
Chief CEDIS Complaint	Eye Pain Change Complaint to Chemical Exposure, Eye	5 2
Vital Signs	Temp 37.2, Pulse 90, RR 20 (Normal) Pain 7/10 Peripheral Acute (CTAS 4)	2
Modifiers	Acute Peripheral Moderate Pain (4-7) is auto-selected (CTAS 4, no change to score)	2

Patient Condition Changing & Modifiers



At Triage

The patient is intoxicated, and only rouses to verbal stimuli.



In eCTAS

	Nurse Input	CTAS Score
Nurse Assessed Complaint	Intoxicated	
Chief CEDIS Complaint	Substance Misuse/Intoxication	4
Vital Signs	Pulse Rate: 110 GCS: 11	3 2
Modifiers	Pulse Rate / Pressure Abnormal (Hemodynamically Stable) is auto-selected	3
	Hemodynamic Compromise and Shock are suggested in yellow	3
	Altered Level of Consciousness (GCS 10-13) is auto-selected	2
	Manually select Unconscious	1

CEDIS-Specific Age-based Modifiers for Paeds

DEMO



At Triage

Parents present with a 2-week-old infant with a concern about worsening jaundice. Baby is sleeping, however responds to touch, but opening eyes and crying. Parents state the child is drinking and having wet diapers as expected.



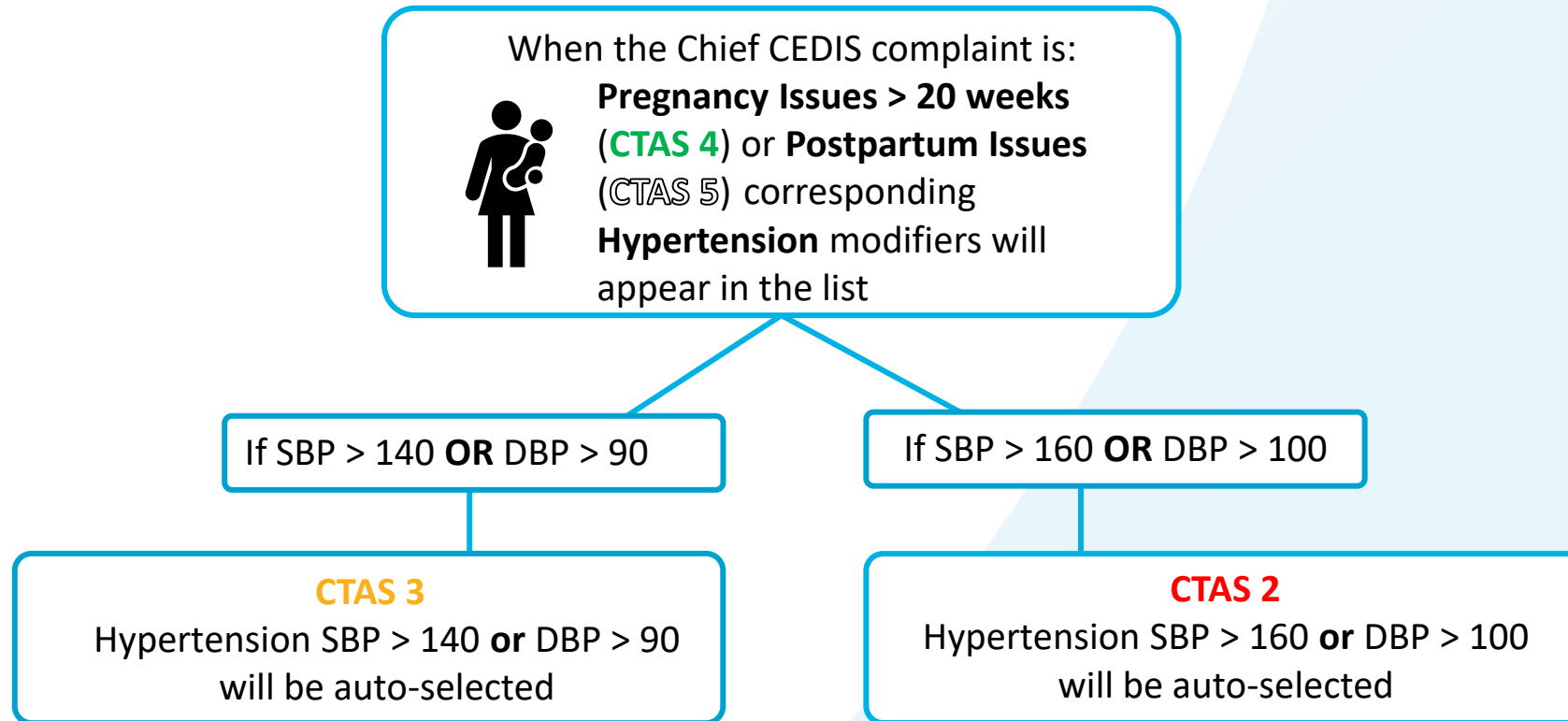
In eCTAS

	Nurse Input	CTAS Score
Patient Stated Complaint	Jaundice	
Chief CEDIS Complaint	Neonatal Jaundice	3
Vital Signs	Normal (Temp 37.2, HR 132, RR 42) – no change	3
Modifiers	Entering (or Updating) a DOB will auto-select Infant <= 30 Days of Age modifier	2



Important: Always attempt to enter an **actual Date of Birth for children** (instead of choosing Paeds cohort and an Estimated Age).

CEDIS-Specific Hypertension Modifiers



CEDIS-Specific & Hypertension Modifiers

DEMO



At Triage

29-year-old female presents 8 hours post delivery of a full-term following a normal pregnancy with no issues during delivery. After arriving home 2 hours ago, the patient describes headache and upper abdominal pain. Normal sensation and movement in limbs, no facial droop noted.



In eCTAS

	Nurse Input	CTAS Score
Patient Stated Complaint	8 hours Post-partum, headache, abdo pain	
Chief CEDIS Complaint	Postpartum issues	5
Vital Signs	Pain 3/10 Central, Acute T 37.8, Pulse 86, BP 156/88	4 3
Modifiers	Acute Central Mild Pain (<4) is auto-selected	3
	Hypertension SBP>140 or DBP > 90 is auto-selected	3
	Headache+/-Edema+/- Epigastric Pain +/- Visual Disturbance +/- Extremity Weakness is manually selected	2

Selecting the Best Modifiers

to reflect the patient's condition and generate the best CTAS score

DEMO



At Triage

Patient arrives with family member who explains the patient tried to cut their wrist. Patient has minor cuts on their wrist. Family member tells the Nurse that the patient has clinical depression but has recently expressed suicidal intent through social media.



In eCTAS

	Nurse Input	CTAS Score
Nurse Assessed Complaint	Self Harm	
Chief CEDIS Complaint	Depression / Suicidal / Deliberate Self Harm	4
Vital Signs	Normal	4
Modifiers	Manually select Active Suicidal Intent	2

CEDIS Complaints with Base CTAS Score of 4 or 5

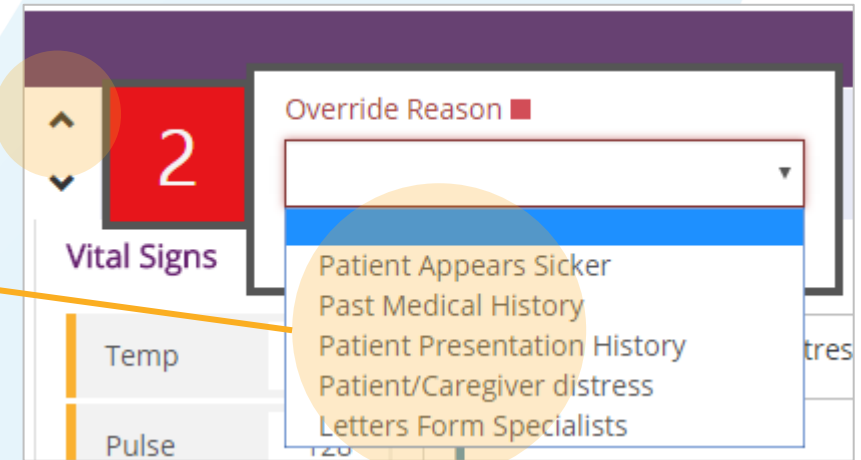
- Laceration/Puncture *...do they have a bleeding disorder or active bleeding?*
- Lumps Bumps *...is there a more appropriate Chief CEDIS Complaint?*
- Prescription requests *...is the patient reporting significant pain?*
- UTI *...is the patient becoming septic?*

Generate the most appropriate CTAS score

DEMO

1. Enter Vitals Signs,
2. Use modifiers as clinically appropriate to reflect the patient's condition,
3. Change the CEDIS Complaint, if appropriate
4. Last resort: Override

- If clinically appropriate, use arrows to override CTAS score
- Select **Override Reason**



Generating Clinically Appropriate CTAS Scores

- ✓ Clinical Judgement & eCTAS (e.g., Modifiers)
- ✓ Alerts
- ✓ Case Scenarios & Low Scores
- ✓ CEDIS-Specific Modifiers

Break:



TOA Queue & Printing Triage Record

Transfer of Accountability



eCTAS CONFORMANCE Krush, Stephanie @ ISMA Training Team Site [Sign Out](#)

[New Patient](#) [Pretriaged Patients 1](#) [Triaged Patients 4](#) Total Patients: 5

Patient	CTAS	LoS	!	Reassess	Care
Unknown, Male Adult, Male Routine Practices Multisystem Trauma - Blunt	1	29:36			
Daniel, Test Adult, Male Droplet/Contact Precautions Fever	3	29:39		-29:09	
Clara, Test Adult, Female Routine Practices Sting	4	29:38		-28:38	
Alice, Test Adult, Female Routine Practices Headache	5	29:40		-27:40	M...

Unknown, Male CTAS
1

Triaged time: 12:31 Nurse: Stephanie Krush

Queue Priority: Priority Notes

[SUMMARY](#) [REASSESS](#) [CARE](#) [TOA](#)

Nurse Assessed Complaint
MVC

TOA Queue

Click arrow and select option to **Show** or **Hide** TOA Queue

The screenshot displays the eCTAS CONFORMANCE interface. At the top, the user is logged in as 'Krush, Stephanie @ ISMA Training Team Site'. The interface features a navigation bar with 'New Patient', 'Pretriaged Patients 1', and 'Triaged Patients 4'. A 'Total Patients: 5' indicator is also present. A dropdown menu is open under the 'New Patient' button, with the 'Show ToA Queue' option highlighted by a blue hand cursor. The main area contains a table of patients with columns for Patient, CTAS, LoS, Reassess, and Care. The right-hand panel shows a detailed view for a patient named 'Unknown, Male' with 'Multisystem Trauma - Blunt' and a CTAS level of 1. The patient's triaged time is 12:31, and the nurse is Stephanie Krush. The interface includes tabs for 'SUMMARY', 'REASSESS', 'CARE', and 'TOA', with 'SUMMARY' currently selected. The 'Nurse Assessed Complaint' is listed as 'MVC'.

Patient	CTAS	LoS	Reassess	Care
Unk Adult Multi	1	29:15		
Dan Adult, Male Droplet/Contact Precautions Fever	3	29:18	-28:48	
Clara, Test Adult, Female Routine Practices Sting	4	29:17	-28:17	
Alice, Test Adult, Female Routine Practices Headache	5	29:19	-27:19	M...

TOA Queue



eCTAS CONFORMANCE

Refresh | New Patient | Pretriaged Patients 1 | Triaged Patients 4 | ToA 1 | Total Patients: 5 | Sign Out

Patient	CTAS	ToA	Left?	Care
Simone, Test Adult Female Routine Practices Fever	2	17:46		Main ED

Patients will remain in TOA Queue for 6 hours

Return Patient will move patient back to Pretriaged or Triaged Patients Queue. Any notes from the original TOA will be deleted.

Print | Mark as Triaged in Error | Return Patient to Triage Queue

Simone, Test
Fever
Triaged Time: 12:35 TOA initiated by: Stephanie Krush
CTAS 2

SUMMARY CARE

Patient Stated Complaint
General weakness

Subjective Assessment
Patient states usually well. Not eating much - no appetite. Denies vomiting, diarrhea. Complains of a slight headache today and feeling chills overnight.

Objective Assessment
Patient appears pale at triage with very cool hands and feet. Speaks with eyes closed however opens same upon request. No history of recent infections, usually self-sufficient and "busy". Grips equal but weak, PERL. No facial droop noted. No slurred speech. Lips cracked and dry with exudate, mucous membranes dry. States not eating or drinking much.

Vital Signs
Temp 39.7°C; Pulse 96; Resp. 26; BP 89 / 52; SPO2 94 % Room Air; Pain 4 Central, Chronic; GCS 14; Cap Ref < 2sec; CBGM 5; Weight 51

EMS Notes
Picked up at home. Patient weak for 3 days. Not eating much. Fever started this morning.

TOA time and notes

Transfer of Accountability
17:46 - to floor

Printing Summary/Patient Triage Record

DEMO

Selected Modifiers affecting final CTAS score will appear

N

Note: Wait until the Patient Triage Record is fully loaded in the print preview window before clicking the **Print** button. This will ensure the full record is printed.

Care Location will appear in the printed record; Priority in Queue and Care Instruction details **do not**.

View/Print Assessment Record

eCTAS Patient Triage Record

PATIENT INFORMATION (ECTAS ID: 85813) CTAS 2

Patient: Bill, Bill

Birthdate: 01-Jan-97 Age: 28 yr Gender: Male

CEDIS: Abdominal Pain

Override Reason:

Triage Time: 14:17 Triage by: Laura Lee Consent Revoked: No Arrival Mode: Walk-in

PLACE PATIENT LABEL HERE

SELECTED MODIFIERS (HIGHEST ACUITY)

Acute Central Severe Pain (8-10)

VITAL SIGNS		High MOI:	Resp.	BP	SPO2	Pain	GCS	Cap. Ref	Weight:	POC CBGM*	Initials
Time	Temp										
14:15 (T)	37.4°C	88	20	150 / 92		10/10 Central Acute					LL
14:19 (R)						8/10 Central Acute					LL

* Please refer to hospital/laboratory reference ranges for POC Glucose

ASSESSMENT

Nurse Assessed Complaint: Patient Stated Complaint: abd pain

Allergies: ASA (Aspirin) Medications:

Medical History: No Significant Medical History Treatment/Interventions:

SUBJECTIVE/OBJECTIVE ASSESSMENT

Subjective: C/o increasing abd pain since last evening worse today stabbing pain on left side

Objective:

REASSESSMENT TOA

14:19 (Laura Lee) wrote: Pain better while lying down

Unable to complete screening due to patient condition

Pretriage by: Laura Lee Pretriage Time 07-Sep-23 14:14 Triage by: Laura Lee Triage Time 07-Sep-23 14:17

Print Close

If checked off, Unable to complete screening due to patient condition will appear

- Date, Time
- Name of the **person** who completed Pretriage (Patient Presentation)
- Name of the **clinician** who completed the Triage assessment

End of Section

- ✓ Transfer of Accountability
- ✓ TOA Queue
- ✓ Printing Triage Record

Special Features

- Triage In Progress
- Copy Assessments & Notes
- Recommended Assessments

Triage in Progress Indicators/Alerts

The screenshot displays the eCTAS CONFORMANCE interface. At the top, the user is logged in as 'Krush, Stephanie @ IMDA Training Team Site'. The interface includes a navigation bar with 'New Patient', 'Pretriaged Patients 2', and 'Triaged Patients 10'. A notification bell icon is present, with a red box indicating 'Click the bell icon above for details'. The main patient list shows two patients: Henry, Henry (Adult, 51 yr Male, Routine Practices, 'headache', LoS 04:51) and Maggie, Maggie (Adult, 93 yr Female, Routine Practices, 'General Weakness', LoS 00:00). A detailed view of Henry, Henry is shown on the right, with a red 'Triage in Progress' warning and a red 'Continue to Triage' button. A yellow callout box points to the red warning icon in the patient list, containing the text: 'A Triage Assessment is already in Progress: Am I selecting the correct patient to Triage? Is it okay to bypass these red warnings?'.

A Triage Assessment is already in Progress:

- Am I selecting the **correct** patient to Triage?
- Is it okay to bypass these red warnings?

Two Nurses open the same patient record

Warning for the First Nurse already triaging the patient

▲ ALERT

Another nurse has begun triaging this patient

Warning: The record for Samantha, Samantha was just opened by Laura Lee for triage. Two patients are likely being triaged under the same name at the same time. You should STOP your triage, CONFIRM you have the right patient and NOTIFY the other nurse of the situation. Click OK to return to your triage in progress.

OK

Warning for the Second Nurse who selected the same patient

▲ ALERT

Another nurse is already triaging this patient

Warning: The record for Samantha, Samantha is already opened by Joy McCarron for triage. Proceeding to triage may result in two patients being triaged under the same name at the same time. You should STOP and before proceeding to triage, CONFIRM you have the right patient and NOTIFY the other nurse of the situation.

Click Cancel to return to the queue. Click Proceed only if you have confirmed Joy McCarron is not currently documenting a triage on this patient.

Cancel Proceed

The name of the **patient** and the name of the **other nurse** will appear in each alert.

- **STOP**
- **CONFIRM** correct patient and
- **NOTIFY** the other Nurse

Patient Visits in Past 2 Years

Copy Medical History, Medications, Allergies

DEMO

Number of previous entries from past triage records indicated in red box (maximum of 20)

Notes

Indicate 'Suspected COVID' in Subjective Notes as appropriate. ⓘ

EMS	Subj	Obj	Tmt/Int	Med Hist	Meds	Allergies
				2	2	6

Nancy, Nancy

Previously Documented Allergies

- Penicillin (PCN)
- Erythromycin
- Peanut
- Bees
- Latex
- Amoxicillin (Amoxil)

Dismiss, Add All, or Add Selected ...

Dismiss Add All Add Selected

Notes

Indicate 'Suspected COVID' in Subjective Notes as appropriate. ⓘ

EMS	Subj	Obj	Tmt/Int	Med Hist	Meds	Allergies
				2	2	

Penicillin (PCN) x

Sort x

Bees x

Latex x

Amoxicillin (Amoxil) x

...into current visit

Add new items here

Delete



Important: Red indicators will only appear if the patient's Last Name, First Name, Health Card Number, Gender and Birthdate match past visits within the past 2 years and the **Patient Does Not Consent** checkbox had **not** been checked off during previous visits.

Copy Assessments

DEMO

from Past 10 Days/Previous Visits Flag

Click on **Previous Visits** to view details

Enter additional notes related to **current** visit above copied assessments

EMS	Subj	Obj	Tmt/Int	Med Hist	Meds	Allergies
	'Pain is much worse today, lying down is the only way it will go away'					

Copied notes appear in the **Subj** Notes

Add (copy) to Notes if appropriate, relevant



Important: **Previous Visit** flag will only appear if the patient's First Name, Last Name, Health Card Number, Gender and Birthdate match past visits. Also, the **Patient Does Not Consent** checkbox must **not** have been checked off during previous visits.

Special Feature: Recommended Assessments

The screenshot displays a clinical assessment interface with three main sections: **Presenting complaint**, **Vital Signs**, and **Modifiers**.

- Presenting complaint:** Includes fields for 'Patient's Stated Complaint' (vaginal bleeding), 'Nurse Assessed Complaint', and 'Chief CEDIS Complaint' (Pregnancy Issues > 20 wks). An orange callout box highlights the Chief CEDIS Complaint, with an arrow pointing to a 'Recommended Assessment' popup.
- Vital Signs:** Includes fields for Temperature, Pulse Rate, Respiratory Rate, Blood Pressure, and SpO2.
- Modifiers:** Includes checkboxes for Severe Respiratory Distress, Shock, Unconscious (GCS 3-9), Presenting Fetal Parts or Prolapsed Cord, and No Fetal Movement.

The **Recommended Assessment** popup contains the following fields:

- Gravida/Para, Weeks Pregnant or Due Date, Hx of Pregnancy Issues
- Cramping, Contractions (frequency), Vag discharge (colour, consistency, amount, date/time began)
- Pain (location), Headache, Visual symptoms, Irritability/feels jittery (pre-seizure symptom), N&V, Bleeding issues/disorders, Bruising, Petechiae
- Diabetes, Renal disease, Chronic HTN, Other

Buttons at the bottom of the popup are 'Cancel' and 'Add To Subjective Notes'.



Note: All Special Features can be found within the Clinical End User section of the Online Help, including a full list of [CEDIS Complaints with Recommended Assessments](#)

Recommended Assessments



At Triage

Patient arrives with badly cut finger.



In eCTAS

	Nurse Input	CTAS Score
Nurse Assessed Complaint	Lacerated Fingers	
Chief CEDIS Complaint	Laceration/Puncture	5
Vital Signs	Normal	5
Modifiers	Manually select Sutures Required	4
	Manually select Active Bleeding	3
Add/Insert Recommended Assessments	Recommended Assessments saved to Subj Notes tab	3

Special Features

- ✓ Triage In Progress
- ✓ Copy Assessments & Notes
- ✓ Recommended Assessments


Troubleshooting, Downtime & Errors

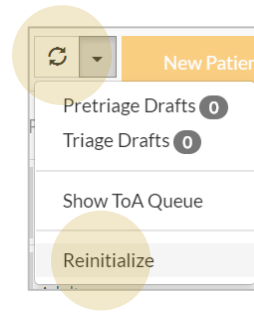
- Self-Help
- 'Sync Error' Messages
- Downtime Contingency
- Clinical Documentation Errors
- Mark a Record as Triaged in Error

eCTAS Screens not updating as expected

Queues not syncing between different computers?

Options:

- Click on the **Refresh**  button
- Press **Ctrl + F5** on keyboard
- If necessary, select **Reinitialize**



I **Important:** Reinitializing will delete Drafts on the computer being used.

- Check the [Status Page](#) for communication about unexpected downtimes

T **Tip:** Review the Troubleshooting and Support Contacts sections of the [Online Help](#).

N **Note:** If you have issues when **logging in to eCTAS**, it may be related to cookies. Try clearing your browser cache by pressing **Ctrl + Shift + Del** on your keyboard.

What to do if Sync Errors Alert Appears

Sync Error means the record is not saving to Ontario Health

Patient	CTAS	LoS	!	Reassess	Care
Davids, David A Adult, 34 yr Male Routine Practices Abdominal Pain	5	17:31		-15:31 G	
Payne, Abbie Adult, Female Routine Practices Abdominal Pain	5	00:00		01:59 G	

A visual indicator will appear on the queue where a patient's Pretriage, Triage Assessment, Reassessment, or TOA, **fails to save**

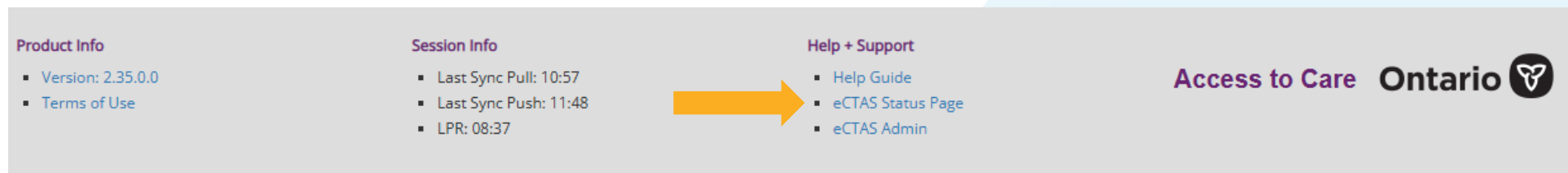
Patient	CTAS	LoS	!	Reassess	Care
Davids, David A Adult, 34 yr Male Routine Practices Abdominal Pain	5	17:32		-15:32 G	
Payne, Abbie Adult, Female Routine Practices Abdominal Pain	5		!	Error Sending Assessment Click here to retry If error persists, contact your help desk	

Try to save again by clicking on the error message.

N **Note:** If the issue persists, your hospital eCTAS may be offline. Offline means eCTAS information is only being saved on your computer; it is not being synced to Ontario Health or your HIS – i.e., other computers will not display your entries. **Contact your Help Desk.**


Downtime Contingency

- If your Hospital Help Desk confirms eCTAS or your HIS is down, start your downtime protocols
- Downtime protocols will vary based on each facility's unique workflow and configuration
- Switch to paper triage if it is part of your downtime protocol **or** stay logged in and continue to use eCTAS
- If you stay logged in, data that you entered will sync and update patient queues when connectivity is restored
- Check **eCTAS Status Page** for downtime recovery:



The screenshot shows a navigation bar with three main sections: Product Info, Session Info, and Help + Support. An orange arrow points from the Session Info section to the eCTAS Status Page link in the Help + Support section. The Access to Care Ontario logo is visible on the right.

Product Info	Session Info	Help + Support
<ul style="list-style-type: none">Version: 2.35.0.0Terms of Use	<ul style="list-style-type: none">Last Sync Pull: 10:57Last Sync Push: 11:48LPR: 08:37	<ul style="list-style-type: none">Help GuideeCTAS Status PageeCTAS Admin

Access to Care Ontario 



Note: Hospitals eCTAS Leads may leverage and **post** [Quick Reference Poster](#) located on the [ATC Information Site](#).

eCTAS Backup Triage Assessment Form

Patient Triage Record

MODE OF ARRIVAL <input type="checkbox"/> Walk-in <input type="checkbox"/> EMS <input type="checkbox"/> Police		PATIENT LABEL HERE Last Name _____ DOB _____					
PATIENT INFORMATION <input type="checkbox"/> Patient Stated Complaint <input type="checkbox"/> Provider Assessed Complaint							
CEDIS Complaint _____							
Triage Date/Time _____	CTAS Score 1 2 3 4 5						
ALLERGIES _____ _____							
HEALTH HISTORY _____ _____							
MEDICATIONS (i.e., Name, Route, Frequency, Purpose) _____ _____							
VITAL SIGNS High MOI? _____ Immunocompromised? _____							
Time	Temp	Pulse	Resp	BP Left	BP Right	SPO2	PaO2
SUBJECTIVE NOTES (Patient's Narrative) _____ _____							
OBJECTIVE NOTES (Triage Provider's Observations) _____ _____							
TRIAGE PROVIDER SIGNATURE: _____							
REASSESSMENT							
Time	Initials	Temp	Pulse	Resp	BP	SPO2	

INFECTION CONTROL <input type="checkbox"/> Unable to complete screening due to patient condition	
a. Travel Risk 1. Have you travelled outside of Canada/USA in the last 3 weeks? YES / NO <i>If yes, list appropriate countries</i>	
2. Have you had contact with a sick person who has travelled outside of Canada/USA in the last 3 weeks? YES / NO <i>If yes, list appropriate countries</i>	
b. Symptoms 1. Do you have a new/worse cough or shortness of breath? YES / NO 2. Are you feeling feverish or have had shakes or chills in the last 24 hours? YES / NO 3. Do you have a new onset of Vomiting/Diarrhea in the last 24 hours? YES / NO 4. Do you have a new Rash? YES / NO	
c. Precautions 1. Have you ever been isolated/required isolation for an infectious disease when receiving care in a healthcare setting? YES / NO <input type="checkbox"/> ESBL (extended-spectrum beta-lactamase-producing organisms) <input type="checkbox"/> MRSA (methicillin-resistant Staphylococcus aureus) <input type="checkbox"/> VRE (vancomycin-resistant enterococci) <input type="checkbox"/> CPE (carbapenemase-producing Enterobacteriaceae) <input type="checkbox"/> Unknown	
2. Have you received Health Care in another country in the last 2 years? YES / NO	
3. What precautions have been/will be initiated for this patient? YES / NO <input type="checkbox"/> Routine Precautions <input type="checkbox"/> Droplet/Contact <input type="checkbox"/> Contact <input type="checkbox"/> Airborne <input type="checkbox"/> Airborne/Droplet/Contact	

- During eCTAS downtimes, Ontario Health recommends using the 2-page paper eCTAS Backup Triage Assessment Form
- Available in the eCTAS Online Help
- No special access required
- Hospitals have the option to use their own form

Clinical Documentation Errors

- Hospitals must establish clear processes for correcting clinical documentation errors that occur within the correct patient record.
- Guidance on handling [Clinical Documentation Errors](#) can be found in the Online Help
 - For example: If you receive patients in an HIS (e.g., Meditech/Expanse), clinical documentation errors (allergies, meds, med history, notes, vital signs) must be corrected in your HIS
- If your clinical documentation error involves a potential privacy breach, or a patient triaged under incorrect identifiers, refer to the processes for [reporting privacy breaches](#), and [reporting a visit triaged under incorrect patient](#)

Mark Record as Triaged in Error

Nurses should mark a patient record as triaged in error when:

- A Triage Nurse submits a triage assessment under an incorrect patient name (i.e. the Triage Nurse entered triage information for Patient A under Patient B)
- A Triage Nurse accidentally logs into the incorrect site and begins triaging patients



Note: a Nurse can only mark their own triage as triaged in error



Important: If the error constitutes a privacy breach (e.g. a Triage Nurse working at more than one site accidentally logs into the incorrect site and begins triaging patients) notify your Privacy Officer and eCTAS Coordinator immediately and follow the process for reporting [privacy breaches](#).

Mark Record as Triaged in Error

- Nurses can mark episodes as triaged in error from the [TOA queue](#) within the Clinical Application

1. Click on the **Mark as Triaged in Error** button

2. A pop-up will appear where the Nurse can:

- Cancel
- Mark as Error and Print
- Mark as Error

Note: If information documented in the record needs to be transcribed into a new triage the Nurse may choose to print the record

ToA 3 Total Patients: 2

Mark as Triaged in Error Return Patient to Triage Queue

Mayes, May CTAS 3
Allergic Reaction
Triaged Time: 12:37 TOA initiated by: Stephanie Krush

SUMMARY CARE

Patient Stated Complaint
Allergic reaction

Vital Signs
Temp 38.5°C; Pulse 90; Resp. 14; BP 108 / 56 Right

Transfer of Accountability
12:38 - [No disposition notes]

Mark as Triaged In Error

Mayes, May
Adult | 50 yr Unknown
Routine Practices
Allergic Reaction

Verify the patient information above before making a selection.

Marking this episode as Triaged in Error will remove it from the TOA Queue. If you need a copy of the data to re-enter into a corrected triage, press **Mark as Error and Print** to print a copy or **Mark as Error** if no printout is needed.

Cancel Mark as Error and Print Mark as Error

View/Print Assessment Record eCTAS Patient Triage Record

PATIENT INFORMATION CTAS 3
Patient: Mayes, May
Birthdate: Age: Gender: PLACE PATIENT LABEL HERE
CEDIS: Allergic Reaction
Override Reason:
Triage Time: 14:29 Triage by: Stephanie Krush Consent Revoked: NO Arrival Mode: Walk-in

SELECTED MODIFIERS (HIGHEST ACUITY)
Fever (Looks Unwell), < 3 SIRS Criteria

VITAL SIGNS High MOI: Immunosuppressed: Blood Disorder: Weight:
Time Temp Pulse Resp. BP SPO2 Pain GCS Cap. Ref POC CBGM* Initials
14:28 (T) 38.5°C 90 14 108 / 56 Rept SK
* Please refer to hospital laboratory reference ranges for POC Glucose

ASSESSMENT
Nurse Assessed Complaint: Patient Stated Complaint:
Allergic reaction Allergic reaction
Allergies: Medications:
Medical History: Treatment/Interventions:

SUBJECTIVE/OBJECTIVE ASSESSMENT
Subjective:

Print Close



Note: Other designated resources can mark a record as triaged in error through the Administration Console. More information can be found on the System Administrator Section under [Past Record Lookup](#) within Registration View.

Triage Errors Training Video: Self-directed

Trainers and eCTAS users can access the video via:

- Online Help  icon within eCTAS → Training Videos section → 'Triage Errors Training' or...
- [eCTAS Triage Errors Basic and Complex](#)

Troubleshooting, Downtime & Errors

- ✓ Self-Help
- ✓ 'Sync Error' Messages
- ✓ Downtime
- ✓ Clinical Documentation Errors
- ✓ Mark a Record as Triaged in Error

Resources

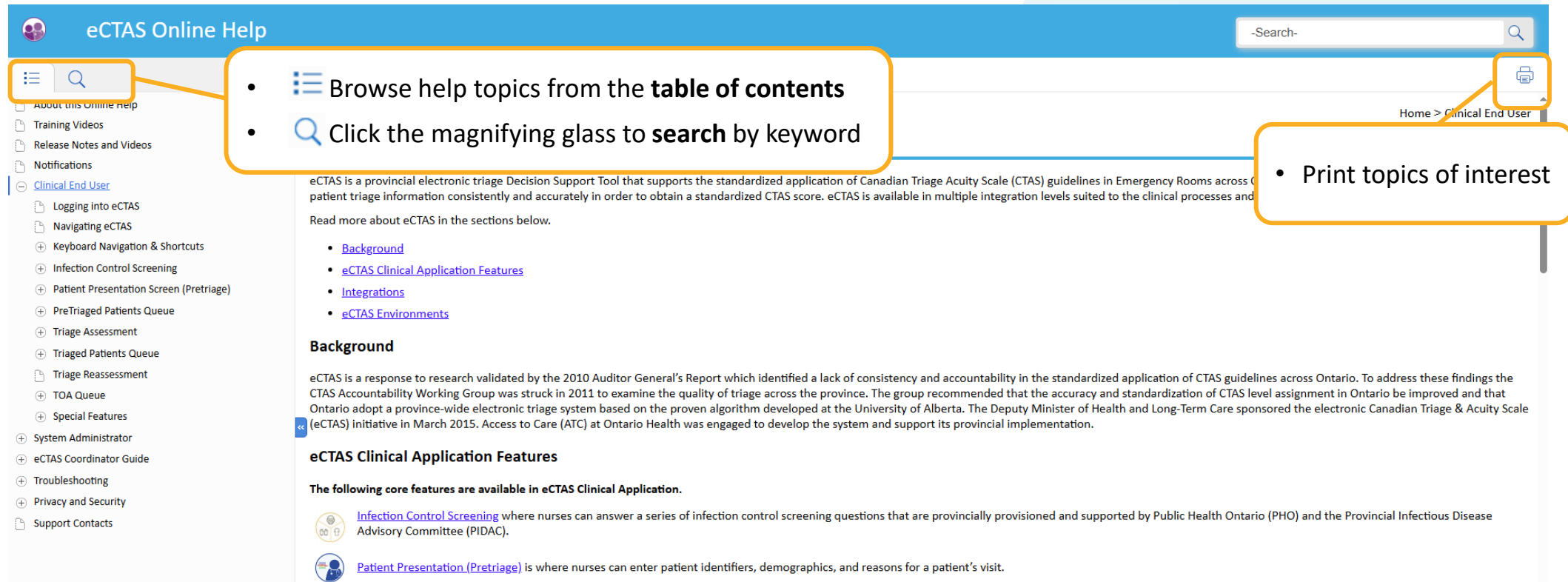


eCTAS Clinical End User Online Help




DEMO

Click on the question mark icon  in the eCTAS Clinical Application

Visit the eCTAS Online Help URL: <https://help.accesstocare.on.ca/helpfiles/eCTASOnlineHelp>



The screenshot shows the eCTAS Online Help interface. The top navigation bar includes a search box and a search icon. The left sidebar contains a table of contents with a magnifying glass icon and a question mark icon. The main content area displays the 'Clinical End User' section, which includes a search box, a question mark icon, and a list of help topics. A callout box points to the magnifying glass icon, stating: 'Click the magnifying glass to search by keyword'. Another callout box points to the question mark icon, stating: 'Browse help topics from the table of contents'. A third callout box points to a print icon in the top right corner, stating: 'Print topics of interest'.

-  Browse help topics from the **table of contents**
-  Click the magnifying glass to **search** by keyword
-  Print topics of interest

Questions



We are happy to answer your questions

Thank You

