Many A&E departments in the UK have now adopted the Manchester Triage System, a system which selects patients with the highest priority first and works without making assumptions about diagnosis. This selection process is deliberate, and recognises that emergency departments are influenced by the patient’s presenting signs and symptoms (Manchester Triage Group 1997).

Manchester Triage is a ‘physical’ tool based on a series of 52 flow charts covering various presenting complaints to A&E. Patients are allocated to one of the five national triage categories and then assigned to a particular category based on the presence of general or specific discriminators (clinical signs or symptoms that differentiate degrees of urgency for intervention). General discriminators are applicable to all algorithms. Specific discriminators apply to one or a small number of algorithms.

Although this system works well for prioritisation purposes, it does not encourage the nurse to question why and how the patient came to present to A&E in the first place. This is particularly important in relation to children due to the possibility of nonaccidental injury (NAI) and the fact that the Children Act 1989 requires that all paediatric accidents be investigated by health visitors and school nurses after discharge.

Traditionally, A&E documentation provides little information surrounding these accidents. CWILTED is a system which encourages triage nurses to explore more fully the factors leading to the child’s attendance to the department. The Manchester Triage System and CWILTED may be successfully used together to gain important information often not recorded.

This article describes why improved documentation surrounding paediatric accidents was needed and how to obtain this information in order to target accident prevention and highlight possible child protection issues.

At the time of implementing CWILTED, Manchester Triage was not in use in our department, however, the author had worked with it previously.

**Background**
In line with current figures available, about one quarter of all A&E attendances are children (Audit Commission 1996). Observation of practice in our own department had
shown that these presentations were poorly documented by the triage nurse, and that health visitors were often ignorant as to the cause of these attendances.

The quality of the information provided by the triage nurse in A&E needed to be improved so that school nurses could prioritise those forms which needed further follow up. Through these observations and discussions with the multidisciplinary team, it became obvious that a system was needed that would not take up more of the triage nurse’s time than the present system, and which would be ‘user friendly’ to acute and community staff. Finally, it could not involve any extra cost in stationary or training.

**The need for follow up**

Why do health visitors and school nurses spend so much time following up paediatric A&E attendances? The document *Working Together* highlights the need for interagency co-operation. This document states that ‘staff in hospitals see children in the course of their normal duties’;

Abused children may attend A&E as a consequence of injuries inflicted upon them, and understand the mechanism which caused the accident.

The Health of the Nation: A Strategy for Health in England (1992) sets ambitious targets for accident prevention:
1. Reduce accidents among children and elderly people by at least one third by 2005
2. Reduce accidental deaths among 15-24 year olds by at least one quarter
3. Reduce the National suicide rate by 15 per cent.
These ambitious targets cannot be attempted without effective strategies to prevent recurrence of common accidents, and causes for deliberate self-harm. Causes for local accidents can only be identified by accurate documentation recorded in A&E soon after the event has occurred.

An example of a typical A&E documentation could be as follows: ‘Head injury...child fell out of buggy’. This particular documentation poses more questions than it answers:

1. Was the child harnessed in the buggy?
2. Did the buggy fall over of it’s own accord or was the child tipped out of the buggy?
3. Who was in charge of the buggy at the time? Was it a mother overburdened with shopping and other children?
4. Or, was it an older sibling taking the child for a joy ride?
5. Was this a child who had just learnt to climb out of the buggy and demonstrate new-found independence?
6. Has somebody failed to put on the brakes when the buggy was at rest?
7. Had the buggy run into the road unattended, and the baby fell out?

Using Manchester triage, this attendee would most likely be triaged as ‘green’ for recent problem unless of course there were signs of severe head injury, in which case a higher priority category

<table>
<thead>
<tr>
<th>Table 1. CWILTED mnemonic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CONDITION</strong></td>
</tr>
<tr>
<td><strong>WITNESS</strong></td>
</tr>
<tr>
<td><strong>INCIDENT</strong></td>
</tr>
<tr>
<td><strong>LOCATION</strong></td>
</tr>
<tr>
<td><strong>TIME</strong></td>
</tr>
<tr>
<td><strong>ESCORT</strong></td>
</tr>
<tr>
<td><strong>DISABILITY</strong></td>
</tr>
</tbody>
</table>

*We have since reverted to ‘description’ again to mean what the child looks like, behaving like etc, as disability did not always work with a medical presentation
would be used. Manchester triage would not prompt the triage nurse to find out the answers to the above questions and therefore an important Child Safety or Protection issue could be missed.

Many A&E nurses are unaware of the effort expended by community nurses following up accidents with appropriate prevention advice.

A system of questions, which were more specific than who, what, where and why so that triage nurses would be stimulated to think – Does this cause and effect make sense? – was needed.

Following discussion with our liaison paediatric A&E health visitor, a mnemonic, which was phonetically recognisable (Brown 1991) was devised to assist in clinical assessment. CWILTED is the mnemonic, though missing the familiar ‘qu’, the sound is still that of warmth and security. There is a positive underlying semantic, that once children have been CWILTED, they are cocooned from further damage! The use of the mnemonic was piloted with some of the 300 A&E forms which the liaison health visitor collected from A&E each week (See Chart 1).

Implementation
The original concept of CWILTED was for use in paediatric accidents but could be used for paediatric assessment. During piloting it emerged that many presenting medical problems originate from a worrying incident or accident. Using CWILTED for all paediatric presentations avoided wasting the triage nurse’s time deciding whether to use CWILTED or not (See Chart 2).

Several teaching sessions were arranged in A&E to explain the idea and mnemonic to groups of four or five nurses at a time. Staffing levels dictated that teaching sessions could only be delivered at lunchtimes. This perceived intrusion into the lunch break might have affected staff motivation to participate in the implementation of CWILTED.

Two large versions of Chart 1 and 2 were stuck up in the triage room. The letters were written vertically down the lower half of the second page of the A&E form therefore allowing nurses to write as much or as little as necessary under each title.

All local health visitors and school nurses were sent an information sheet about the system. Initially the scheme was to be used for a three-month trial, to see how acute and community staff found the results. A ‘key’, for the paediatric ward notice board which explained the letters, was prepared.

In July 1998, a questionnaire was prepared to evaluate the project. This was done in two parts. One question-
naire for nurses working in A&E and another for health visitors and school nurses to ascertain whether CWILTED had achieved its aim to provide more information surrounding childhood accidents.

Evaluation and discussion
Seventy questionnaires were distributed in total to the above-specified groups; 67 per cent replied. From early January 1998, most children were being CWILTED with very pleasing results. So pleasing, that documentation which was not CWILTED became frustrating in its lack of information.

Feedback was encouraging: staff enjoyed using the mnemonic. Most of them found it quick and easy and user friendly. They soon noticed that they were obtaining a more detailed description of why parents attend A&E.

The inclusion of ‘witness’ in the titles has proved most valuable. Many children cannot describe events accurately, particularly if communication is not based on the individual’s level of understanding (RCN Children in A&E Special Interest Group 1998). Only a witness to an accident can say exactly what they saw. In many cases unwitnessed accidents are those which cause greatest concern. It inevitably poses the question ‘who was responsible for the child at the time?’ Did the accident occur as a result of poor adult supervision? So often neglect is difficult to prove. Accidents that result from lack of supervision provide concrete evidence of non-specific neglect.

In many cases, the child’s escort to A&E did not witness the incident. His or her details may not be accurate, or may even be prefabricated to disguise what really happened. This is often revealed when a potential child protection incident is investigated by a health professional such as a paediatrician, admitting nurse and social services. A prefabricated story is often modified each time it is recounted, thereby causing doubt on the accuracy of details given by the escort. The escort is also useful to identify what responsibility the adult has for the child, and whether they may authorise treatment. They may not know of any pre-existing conditions or allergies of the child.

Accurate details about location of accidents has highlighted dangerous play areas, poor

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**Chart 2. CWILTED**

<table>
<thead>
<tr>
<th>C</th>
<th>Condition</th>
<th>CPR</th>
<th>Abdominal pain</th>
<th>Short of breath</th>
<th>Vomiting and visual disturbance</th>
<th>Dizziness</th>
</tr>
</thead>
<tbody>
<tr>
<td>W</td>
<td>Witness</td>
<td>Friend</td>
<td>Mother</td>
<td>Father</td>
<td>Girlfriend</td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>Incident</td>
<td>Kicked in stomach</td>
<td>Had a row with mother’s partner</td>
<td>Solvent abuse</td>
<td>Hit by a car from behind</td>
<td></td>
</tr>
<tr>
<td>L</td>
<td>Location</td>
<td>Outside BR station</td>
<td>Home</td>
<td>Party</td>
<td>M25</td>
<td></td>
</tr>
<tr>
<td>T</td>
<td>Time</td>
<td>Incident 9am</td>
<td>Treatment/</td>
<td>Treatment/</td>
<td>Incident: 10am</td>
<td>Incident 2pm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>First aid: 10am</td>
<td>First aid: 4.15pm</td>
<td>First aid: 10.10am</td>
<td>First aid: 2.30pm</td>
<td>First aid: 3.30pm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Seen 10am</td>
<td>Seen 6pm</td>
<td>Seen 10.30am</td>
<td>Seen 3.30pm</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>Escort</td>
<td>Girlfriend</td>
<td>Mother</td>
<td>Father</td>
<td>Girlfriend</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>Description/</td>
<td>Distressed generalised</td>
<td>Asthma/wheezy,</td>
<td>Tachycardia sweating</td>
<td>RTA whiplash</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diagnosis</td>
<td>abdominal pain</td>
<td>following family</td>
<td>nauseous injury</td>
<td>injury</td>
<td></td>
</tr>
</tbody>
</table>
crossings and faulty equipment. It has also identified registered childminders who were not respecting recommended safety standards. Time highlights delays in seeking first aid or medical advice. The triage nurse can investigate such delays. The responses showed that:

- 63 per cent (19) of replies were happy that they had received adequate information and training about the project.
- 50 per cent (15) of A&E staff believed CWILTED used the same amount of time to obtain an accurate history as previously.
- 40 per cent (12) estimated that it used less time to obtain an accurate history; 10 per cent (3) of staff felt that CWILTED increased the time taking a history.

Some triage nurses did not like applying CWILTED to medical conditions as they found it repetitive, while others liked the structured questions so much they used them for all adult and elderly accidents as well.

Perhaps the most valuable observation is that accidents treated as a ‘priority’ such as those which go straight to the resuscitation room and bypass triage. These are often the most serious accidents, such as road traffic accidents and burns. These accidents require investigation by police or social workers. If details are not recorded accurately as soon as possible details may become unclear.

The staff on the paediatric ward did not value CWILTED as highly as other departments, possibly because once the child is admitted to the ward, staff can ascertain as many details as they need during the admission procedure. However, it was felt the improved quality of information gathered in triage had enhanced the hand over of care from A&E to the ward.

Health visitors and school nurses estimated that improved quality of information provided by CWILTED saved them between 1-30 minutes per form. If we average this at 15 minutes per form for 300 forms a week, throughout the Trust, the economy of time could be estimated as an economy of NHS resources. However, further work will be required to validate this.

Improved information has enabled health visitors to target their accident prevention advice to families. Despite criticisms, all respondents would prefer this system to continue.

Conclusion

Following the set up of a community rehabilitation scheme in January 1999, CWILTED was implemented for all adult patients as the nurses found the information gathered invaluable when investigating adult accidents.

On merging of the Trust, the A&E card now has CWILTED preprinted on the inside. This should prevent ‘priority’ accidents missing CWILTED details.

CWILTED has been described as a valuable child protection tool. Perhaps it will also become an adult protection tool which enables all A&E and community staff to feel they are actively working towards the Health of the Nation targets.

Manchester Triage has now been introduced and is documented alongside CWILTED. Triage is now structured and measurable but with the added advantages outlined above. CWILTED was never intended to replace Manchester Triage but it does add another dimension that can only serve as an enhancement to what appears to be a very comprehensive prioritisation tool.

Acknowledgements

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