Emergency Department Triage

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Objectives

- What is does triage mean?
- Why is triage important in the emergency department?
- Acuity levels
- Nursing Initiative Protocols
- EMTALA
- Triage Scenarios

Triage

- Triage come from the French word “”trier” which means to sort.
- We use triage in the emergency department to identify those patients that need care first

Triage in the Emergency Department

- The patients that to the emergency department have varying degrees of acuity.
  - Very sick- life threatening illness or injury
  - Moderately sick
  - Minor illness or injury that is not life-threatening.
- Rapid assessment and resuscitation of patients with severe trauma or shock increases survival
- Patient’s who are less sick will not deteriorate significantly over time

Triage- An important position

- The individual in charge of triage is the gatekeeper for the Emergency Department
  - decides who needs to be a seen by a doctor first and where they need to be seen.
  - Must educate families to the process
- Typically a very experienced pediatric nurse

Triage- An important position

- When a patient arrives in the Emergency Department he/she must be quickly assessed and examined to determine appropriate triage catagory
- Typically performed by a very experienced pediatric nurse

Components to Pediatric Triage

1) The Pediatric Triangle
2) The Physical Assessment
3) History Gathering
4) Acuity Level

Pediatric Triage

Triage nurse has be able to assess and understand the special needs of pediatric patients.

- Developmental stage of child
- Illnesses and injuries that are common with different developmental stages
- Risk factors for child maltreatment
- Understand a child's ability to compensate for pain, injury, or shock
- Child's risk for rapid deterioration

Pediatric Assessment Triangle

Rapid assessment from across the room:

- General Appearance
- Work of breathing
- Circulation

General Appearance

- Single most important factor in the assessment of children!
  - SICK vs NOT SICK?
- Need to know the developmental baseline of the child.

Work of Breathing

- Position of comfort?
- Abnormal sounds?
  - stridor
  - Wheezing
  - Grunting
- Increased work of breathing with Normal appearance = respiratory distress
- Increased work of breathing with Abnormal appearance = respiratory failure

Circulation

Primary indicators of overall perfusion:

- Appearance of skin
  - Cyanotic
  - Mottled
  - pale
- Obvious bleeding?
- Diaphoretic?

Physical Assessment

- ABC's always FIRST!!
- Secondary Assessment
- Chief Complaint driven
  - limited pertinent history only
- Remember to keep in mide the history, treatments, and developmental stage

Red Flags

- Choking, drooling
- RR> 60
- HR <60 or >200
- Altered mental status
- Temperature >40C
- Severe Pain
- Caregivers account of events do not make sense

Vital Signs

- Perform the least invasive first
- Crying changes increases HR, RR, and BP
- Know normal vital signs for age
- Abnormal vital signs may indicate lack of compensatory mechanisms
  - Respiratory failure
  - shock

History

- Chief complaint
- Immunizations
- Allergies
- Medications
- Past medical history
- Parent's impression or concerns
- Events leading to presentation
- Still eating/drinking/urinating normally?
- Pertinent associated symptoms

Acuity

- Based upon findings and triage nurse judgement
- Assigned level 1, 2, 3, 4
- At anytime during triage, if child determined to have an emergent condition, triage should be stopped and treatment initiated
- Nursing protocols may be initiated
- Acuity level may change throughout the patient's stay in the emergency department
  - Re-assessment when patient's in waiting room for >30minutes post-triage

LEVEL 1 (RED)

- Any life of limb threatening illness or injury for which immediate treatment is necessary
- Need to be seen immediately
- Examples:
  - Active seizures
  - Respiratory or circulatory failure
  - Compromised airway
  - Arterial bleeding
  - Testicular torsion
  - Severe pain

LEVEL 1 (RED)

- Sickle cell patient with fever or pain
- Oncology patient with fever or pain
- Decreased level of consciousness
- Polytrauma
- Any injury with neurovascular compromise
- DKA
- Impending delivery
- Opthalmologic injuries
- Dental injuries with avulsion of secondary teeth

Level 2 (yellow)

- Any illness or injury for which treatment should be instituted within 30 minutes
- Examples:
  - Respiratory distress
  - Significant dehydration (altered mental status, shock, evidence of decreased perfusion, tachycardia…)
  - Abdominal pain with peritoneal signs or obstruction
  - Ingestions

Level 2 (yellow)

- Corneal abrasions
- Head trauma with persistent vomiting or LOC
- Toxic- appearing (shock)
- Extremity injuries with obvious deformity
- Non-accidental trauma
- Burns <10% BSA
- Fever
  - infants <3 months
  - Any toxic-appearing child

Level 3 (green)

- Any non-emergent illness/ injury for which minor delay in treatment will not alter outcome
- Can wait >30 minutes
- Examples:
  - Gastroenteritis without dehydration
  - Sprained ankle
  - Minor lacerations without active bleeding
  - Foreign body in the ear or nose
  - First degree burns

Level 4 (blue)

- Any non-emergent condition that can be treated very quickly or requires no treatment
- Can wait >30 minutes
- Could potentially be treated by someone other than a physician
- Examples:
  - Ear infections
  - Viral exanthems
  - Strep pharyngitis
  - Worried well

Reassessment

- Patient's may change in acuity at any time
- Reassessment is essential!

Nursing Protocols

- Oncology patients with fever
  - IV Access, Obtain CBC, blood culture, UA
- Sickle cel pain crisis

  Pulse ox, oxygen, Start IV and obtain CBC and retic
- Sickle cell with fever
  - Same + blood culture
- Dysuria
  - UA
- Minor trauma
  - Xray

Nursing protocols cont…

- Asthma
  - Pulse ox, call respiratory therapist
- DKA
  - IV, VBG, glucometer
- Fever in neonate (<1mo)
  - Cath UA and culture, IV, CBC, Blood culture

EMTALA

- Emergency Medical Treatment and Active Labor Act
- All emergency departments require to provide screening exam to determine if emergency medical condition exists to ANY patient who comes in.
- Patient must be stabilized prior to transfer

Customer Service

- Triage friendliness is important
- Acknowledge and validate family's concerns
- Keep families informed
  - Process
  - Wait times
  - What they are waiting for
- Triage is an important and difficult job
- Support your triage nurses!


Case #1