Department of Emergency Medicine
UP College of Medicine Learning Unit VI

ED TRIAGE

"TRIAGE is not an endpoint but the beginning of the medical screening examination process."

- Journal of Emergency Nursing, Feb 2006

Who needs immediate treatment?

ED triage is the process of quickly sorting patients to determine priority for further evaluation of care at the time of patient arrival in the ED and assign the right patient to the right resources in the right place at the right time.

Triage and Overcrowding

In the era of ED overcrowding, the demand of emergency medical care has exceeded the limited space and resources of the ED to provide immediate care to patients. To avoid under triage which compromises patient safety and over-triage which exhausts ED resources prematurely, TRIAGE decisions must be as accurate as possible

The "Ideal" Triage Scale

- **Allows for quick sorting of patients and rapid identification of patients in need of immediate care**
- **Clear definitions → accuracy**
- **Acuity level → reflect seriousness of illness or injury and should not be influenced by ED volume**
- **Reliability – ensures accurate communication among users; nurses and physicians should be speaking the same language; applicable to all patient populations and age groups**
- **Validity – provide an objective measure of acuity → allows meaningful comparisons within and between institutions**
- **Relevance – easily adaptable to computer-based documentation and system integration**

TYPES OF ED TRIAGE SYSTEMS

- TRAFFIC DIRECTOR TRIAGE - "Quick LOOK"
- SPOT CHECK TRIAGE – Limited subjective complaint (3-tiered triage)
- COMPREHENSIVE TRIAGE – assessment and prioritization is performed by an experienced RN
- *Triage is about bringing the right patient to the right resources at the right place at the right time*

EMERGENCY SEVERITY INDEX

- Basis: "How urgently patients need to be seen by the physician or healthcare provider"
- For less acute patients, requires the triage nurse to anticipate expected resource needs to move the patient to a final disposition
- *Does not define expected time intervals to physician evaluation*

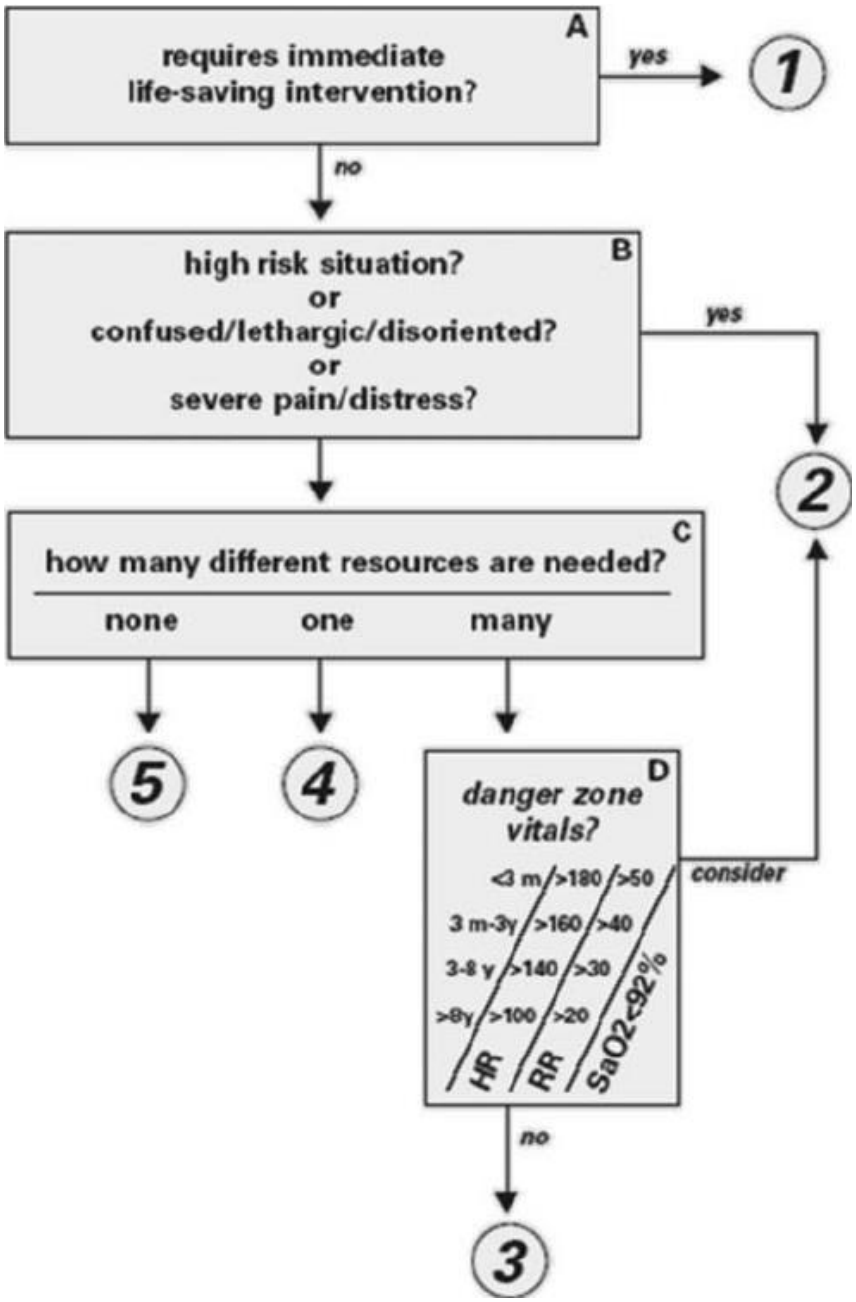

FIGURE 1: The EMERGENCY SEVERITY INDEX TRIAGE SCALE

DEFINITIONS

- **ACUITY** – determined by the stability of vital functions and the potential threat to life, limb or organ
- **RESOURCE NEEDS** – resource (diagnostics, interventions) in order for a disposition decision to be reached

LIVE-SAVING INTERVENTIONS

- BVM ventilation, Intubation, surgical airway, emergency CPAP/Bipap
- Electrical Therapy – defibrillation, emergent cardioversion, external pacing
- Procedures – needle decompression, pericardiocentesis, open thoracotomy
- Circulation – significant IV fluid resuscitation, control of major bleeding, blood
- Medications – D50, dopamine, atropine, adenosine, naloxone

NON LIFE-SAVING INTERVENTIONS

- **A/B** – oxygen supplementation
- **Electrical Therapy** – Cardiac Monitor
- **Procedures** – ECG, Labs, UTZ, FAST
- **Circulation** – IV access, heplock for meds
- **Medications** – ASA, IV nitroglycerin, heparin, antibiotics, beta-agonists

Is the patient in a high-risk situation?

- Condition could easily deteriorate
- Does not require detailed physical assessment or full set of vital signs
- "sixth sense" – clinical experience
- Patient must not be in waiting room for any length of time
- Alert bedside nurse
- Initiate treatment protocols without physician orders (i.e. initiate IV access, administer supplemental oxygen, hook to cardiac monitor, do ECG)

Is the patient confused, lethargic or disoriented?

- Alert
- Responds to verbal stimuli
- Responds to pain
- Unresponsive

Is the patient in sever pain or distress?

- VAS score
- Distressed facial expression, grimace, cry
- Diaphoresis
- Body posture
- Changes in vital signs
- May triage to level-2 but is not required to assign to level-2
- May do initial nursing interventions to comfort patient
- *"Would I give my last open to this patient?"*

RESOURCES

- Labs (blood, urine)
- Imaging (ECG, xray, CT)
- IV fluids; IV, IM nebulized meds
- Specialty referral

NON-RESOURCES

- History and PE
- Point-of-care testing
- Heparin lock or Oral medications/prescription
- Dressing or simple wound care
- Crutches, splints, slings

FAST-TRACK AREA

- Stable can wait for a provider
- BUT these patients are better served in a fast-track or urgent care area
- Rapid disposition → discharge

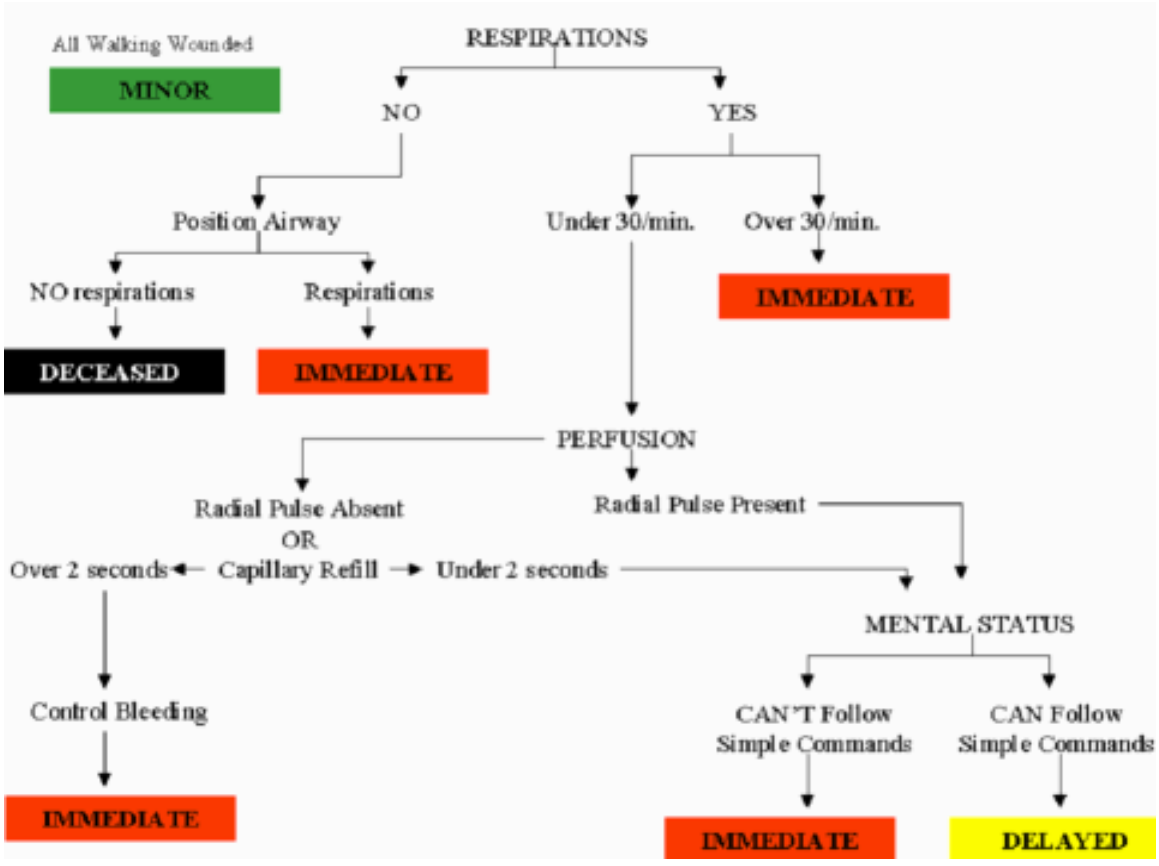

FIGURE 2: The START triage for MASS CASUALTY INCIDENT