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| **XYZ Medical Center** | **Department: Emergency Department** | | | |
| Policy No. EDD-PC-105 | Effective Date: October 2019 | Review Date: October 2021 | Page  1 of 6 (with addendum) |
| **Title: Triage Process in the Emergency Department** | | | | |

**I. PURPOSE:**

To define the Triage Process for patients presenting at XYZ Medical Center’s

Emergency Department (ED).

**II. DEFINITIONS:**

A. Emergency Severity Index (ESI) – A five level ED triage algorithm that provides from 1 (most urgent) to 5 (least urgent) based on acuity and resource needs.

B. Medical Screening Exam – Examination by an Advanced Practice Provider or physician to determine the existence of an emergency medical condition.

C. Triage – The sorting and classification of patients according to the type and urgency of their conditions and number of resources required.

D. High Risk Situations – Take into account chief complaint, symptoms, history, age, and current medications to form a clinical picture.

**III. POLICY STATEMENT:**

It is the policy of XYZ that all patients presenting at the ED will be triaged to determine the type and urgency of their condition. Triage will be performed using the ESI version 4 (IV). ESI IV and a triage category of 1 through 5 will be

assigned to each patient as a triage acuity score. A patient triage record will be maintained as a part of the medical record.

**IV. EQUIPMENT:**

A. All equipment and supplies necessary to perform the functions of triage including, but not limited to:

1. Blood pressure apparatus

2. Thermometer

3. Stethoscope

4. EKG machine

5. Pulse oximetry

6. Weighing scale

7. Glucometer

**V. PROCEDURE:**

A. Triage Acuity Process

1. Registered Nurses (RN) and Advanced Practice Providers or physicians, as necessary, will be assigned on all shifts to manage the intake area.

a) A Quick Look Nurse (QLN) will greet each person upon enterting the intake area. At which time, the QLN will determine if the person is seeking medical care. Once determined that the person is seeking medical care, the QLN will evaluate the patient to determine the location where the patient will be directed, depending on if a life threatening condition or injury exists.

1) Patients determined to have a life threatening condition or injury will be taken to a patient care area designated by the ED Charge Nurse and bedside registration will be completed.

2) Patients determined not to have a life threatening condition or injury:

(a) The QLN will complete a Quick ID form. (b) A quick registration will be completed.

(c) Patient will be placed in the next available treatment area for triage and medical screening exam.

b) The Triage Nurse assigned to the ED waiting room is responsible for the initial evaluation including chief complaint, a brief history and vital signs to determine the nature and severity of the patient’s condition. The Triage Nurse assigns a triage acuity level to each patient based on presentation and resources required.

1) Triage is performed as promptly as possible to assure adequate evaluation of presenting patients.

c) An Advance Practice Provider or physician will evaluate patients that present to the intake area and complete a medical screening exam.

1) Patients requiring resources that are not available in the intake area are escorted to the Intermediate Care Center (ICC) for further treatment.

2) Patients requiring no orders or limited resources may be discharged from the intake area after the medical screening examination.

B. Status

1. A patient will be assigned a triage category using the ESI IV. The highest level of triage is assigned based on his/her complaint or condition and number of resources required, taking into account the mechanism of injury for trauma patients.

2. The Triage acuity levels are assigned, as follows: (examples of, but not limited to)

a) **Level One – Resuscitative (time to be seen <1 minute)**

1) Unresponsive

2) Intubated

3) Apnea

4) Pulseless

5) Decompensated shock

When a Level 1 condition is identified, the triage process stops, the patient is taken directly to a treatment area and immediate physician intervention is requested.

b) **Level Two – Emergent (time to be seen <10 minutes)**

1) High risk situations

2) New onset confusion, lethargy and/or disorientation

3) Severe pain/distress

4) Unstable vital signs

5) Patients requiring two or more resources with unstable HR, RR or O2 saturation in danger zone. (For danger zone vitals, see Addendum A.)

When a Level 2 condition is identified, the triage process stops, the patient is taken directly to a treatment area for immediate intervention. Physician intervention will take place as quickly as possible.

c) **Level Three – Urgent (time to be seen <30 minutes)**

1) Patients requiring two or more resources with stable vital signs. (See Addendum A for a list of vital sign parameters.)

d) **Level Four – Less Urgent (time to be seen <60 minutes)**

1) Patients requiring one resource only.

e) **Level Five – Non-Urgent (time to be seen <120 minutes)**

1) Patients requiring no resources.

3. The following resources will be taken into consideration when assigning triage acuity level:

a) Respiratory treatments b) EKGs

c) X-rays

d) CT/MRI/ultrasound/angiography e) IV fluids

f) IV/IM medications g) Simple procedures

h) Laceration repairs, foley catheters – 1 resource

i) Complex procedures, i.e. conscious sedation – 2 resources j) Labs

k) Procedures

1) The following are not considered to be resources and are **not**

considered when determining triage category: (a) History and physical

(b) Pelvic exam

(c) Saline lock

(d) PO medications

(e) Tetanus

(f) Medication refill requests

(g) Phone calls to Primary Care Provider

(h) Wound care

(i) Slings, splints, crutches

(j) Point of Care testing (WAIVE testing) C. OB Patients – 20 Weeks of Gestation or Greater

1. OB patients who are 20 weeks of gestation that present for evaluation of labor or other obstetrical problems will be escorted to Labor and Delivery (L&D) for triage, unless immediate intervention is indicated. In the case that the patient will stay in the ED for treatment, L&D and Neonatal Intensive Care Unit (NICU) will be notified.

D. Usual Placement by Designated Category

1. Level One - Resuscitative and Level Two - Emergent

a) Trauma Resuscitative Rooms – Bedside registration b) Emergency Department – Bedside registration

2. Level Three - Urgent

a) Emergency Department – Bedside registration

b) Intermediate Care Center – Registration at the registration desk

3. Level Four - Less Urgent

a) Intermediate Care Center – Registration at the registration desk

4. Level Five – Non-Urgent

a) Intake – Registration at the registration desk

b) Intermediate Care Center – Registration at the registration desk

E. Refusal of Service

1. Patients who request to leave prior to being seen by the provider are asked to complete and sign a Refusal of Service form, indicating the reason for leaving and the time/date of departure from the ED. In compliance with COBRA/EMTALA regulations, a copy of the signed Refusal of Service form will be given to the patient. The original becomes a part of the patient’s medical record.

**VI. SPECIAL CONSIDERATIONS: N/A VII. EDUCATION:**

A. XYZ Staff:

1. All staff will receive education regarding the triage process and the COBRA/EMTALA rules and regulations governing the triage for patients requesting emergency services. (Refer to policy, PCS-PC-609, COBRA/EMTALA Compliance.)

2. Will receive education pertaining to this policy at time of unit orientation and as changes occur in legislation, quality or regulatory requirements. Staff’s knowledge, skills and abilities will be validated during unit specific orientation.

3. All RNs who perform triage will meet the necessary qualifications and competencies of the ED Triage Competency and applicable Standardized Procedures.

4. The following are the qualifications for Triage Nurse assignment:

a) Registered Nurse;

b) Two years’ experience as an RN;

c) Ability to make decisions under pressure of workload or crisis;

d) Demonstrates competency in ED Standardized Procedures, as outlined in policy, NRS-PC-1265, Standardized Procedures, Unit Specific, Emergency Department;

e) Demonstrates good communication skills;

f) Approved by the Clinical Director and Clinical Supervisor.

**VIII. DOCUMENTATION:**

A. Completion of the Quick ID form. B. Registration of the patient.

C. Completion of the Rapid Triage in the medical record. D. Documentation of triage acuity level.

E. Vital signs and documentation of patient’s condition/status during re- assessment.

F. Completion of the Refusal for Services form, if applicable.

**IX. ADDENDUMS:**

A. Danger Zone Vitals/ESI Triage Algorithm (See figure 5.1)

**X. REFERENCES:**

A. COBRA/EMTALA Patient Anti-Dumping Laws

B. Emergency Nurses Association (2020),Emergency Severity Index, Implementation Handbook Version 4

**XI. KEY WORDS: Triage, Emergency Severity Index**

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**Addendum A**

**Figure 5-1. ESI Triage Algorithm, v. 4**

