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* **ADDENDUM** *
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HACKETTSTOWN REGIONAL MEDICAL CENTER

Division of Nursing

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TITLE: **TRIAGE POLICY**

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It is the policy of the Hackettstown Regional Medical Center Emergency Departments to triage all patients who present to the Department requesting care according to EMTALA and NJDOH (8:43 G -2.7 A) guidelines.

The purpose of triage is to provide a process in which an RN can rapidly evaluate all patients entering the department and determine the priorities of care. Patients are categorized according to the 5 Level Emergency Severity Index. The objectives of this system include:

- Identification of patients requiring immediate definitive care
- Efficient use of resources and space
- Facilitation of patient flow in the department
- Alleviation of anxiety of patients and their families
- Improve patient satisfaction
- Process of assessment and reassessment of patients

An Emergency Department RN may triage after showing competency through completion of ESI Triage Educational Module".

Triage will be performed twenty-four hours a day. Patients will have prompt initial assessment by a Registered Nurse in order to determine initial intervention, potential severity of illness, and order of priority. All life threatening emergencies will be treated immediately; all other cases will be treated based on priority of care.

PROCEDURE:
An Emergency Department nurse evaluates and determines the priority of care based on presenting complaint, rapid airway breathing and circulation assessment which considers physical developmental, psychosocial needs and patient flow within the department. The Patient Access staff will complete registration for all patients at either the patient bedside or designated registration areas. Patients will be reassessed according to guidelines for assigned triage level.
The triage assessment initiates a Medical Screening Exam which includes but is not limited to:

- Chief complaint
- Level of consciousness
- V/S
- Pain scale
- Allergies
- Medical / Surgical History
- Medication / dose
- LMP Para Gravida
- Visual Acuity
- Height / Weight
- Td Status / Vaccinations
- PMD
- Communicable disease exposure

All medications patient is taking routinely as well as in past 24 hours are documented using appropriate electronic documentation tool in Cerner, with amount and frequency.

The emergency severity index (ESI) is a five level triage instrument that categorizes ED patients by both acuity and expected resource needs.

Acuity is determined by the stability of vital functions and potential for life, limb or organ threat.

Resource needs are defined as the number of resources and interventions a patient is expected to utilize in order for a disposition decision to be reached.

The ESI algorithm is utilized to place patients properly within the ED in order to provide the best possible outcomes and to maximize staffing and resources.

Patients are assigned one of 5 levels.
Level 1 - those who have the most life threatening presentation.
Level 5 - are the most stable and utilize the least amount of resources.

FIVE LEVEL TRIAGE SYSTEM

Level 1: Emergent
Patients requiring immediate life-saving intervention. These patients should be seen immediately. The Triage nurse will stay with the patient until a treatment area is available.

Examples of Level 1 triage:
1. Cardiac arrest
2. Respiratory arrest
3. Critically injured trauma patient that is unresponsive

Refer to appendix 2

Level 2: Urgent
Patients in high-risk situations, patients who are confused/lethargic/disoriented or in severe pain or distress. The Triage nurse will closely observe the patient until the charge nurse assigns a bed.

The triage nurse assess not only the pain intensity rating provided by the patient, but also the chief complaint, past medical history and physiologic appearance of the patient when determining a triage category. All patients who have a pain rating of 7/10 or greater should be ***considered*** for meeting ESI level 2 criteria. It is up to the discretion of the triage nurse to determine whether the clinical condition and pain rating in combination warrant a rating of ESI level 2 (Gilboy, N, Tanabe, P., Travers, D., Rosenau, A., Eitel, D., Emergency Severity Index, Version 4, 2005) .

After determining the patient is stable, not at risk for loss of life or limb, the triage nurse or primary RN should implement appropriate comfort measures at triage including, but not limited to applying ice, elevation/repositioning and analgesics (if standing orders are in place) to reduce pain . (Gilboy, N, Tanabe, P., Travers, D., Rosenau, A., Eitel, D., Emergency Severity Index, Version 4, 2005).

If the triage nurse is unable to provide adequate comfort measures due to obvious deformity, patient is assigned ESI Level 2 so that IV access can be obtained and patient medicated for pain quickly.

Examples of Level 2 triage includes high risk situations such as:

- Chest pain suspicious for M.I.
- Needle stick injury in a health care worker
- Stroke
- R/O ectopic pregnancy,
- A suicidal or homicidal pt.
- A child less than 12 months with temp greater than 100.4
- A CHILD 12-24 MOS w/ fever >102.2
- A patient with danger zone vital signs

Level 3: Non-Urgent
Patients with injuries and illnesses requiring more than one resource. (Vital signs and severe pain will be considered following the ESI algorithm and the patient may be triaged to an ESI Level 2: patients < 3 mos old with HR>180, RR>50; patients 3 mos – 3 yrs with HR>160, RR>40; patients 3-8 yrs with HR>140, RR>30; patients >8 yrs with HR>100, RR>20; any patient with SaO2<92%).

Level 4: Non-Urgent
Patients with injuries and illnesses requiring one resource.

Level 5: Non-Urgent
Patients with injuries and illnesses that do not require a resource.

There are 4 questions that are addressed as a patient presents to the department. Questions the triage nurse must ask him/her self.

1. Is this patient dying?
2. Is this a patient that should not wait?
3. How many resources will this patient need?
4. What are the patient's vital signs?

By applying the answers to those questions to the ESI Algorithm, a triage level is easily determined. Please refer to appendix 1

If the answers to questions l and 2 are no, then the nurse looks at how many different resources will be needed to make a disposition for this particular patient. If no resources are needed the patient is assigned a level 5. If one resource is needed a level 4 is assigned. If 2 or more resources are needed patient is assigned ESI level 3.

Resources	**Not Resources**
Labs (blood, urine) ECG, x-rays CT-MRI Ultrasound angiography	History & physical (including pelvic) Point of Care Testing
IV Fluids (hydration)	Saline or Heplock
IV or IM Medications	PO Medications Tetanus Immunization Prescription refills
Specialty Consultation	Phone call to PCP
Simple procedure = 1 (lac, repair, Foley cath) Complex procedure = 2 (conscious sedation)	Simple wound care (dressings, recheck) Crutches, splints, slings

Vital signs are to be taken on all adult patients brought to Emergency Department. It is not necessary for vital signs to be done in Triage on Level 1 and 2 patients. Vital signs are to be done on all Level 3 patients in triage as well as level 4 and 5 patients as time permits. Otherwise it is acceptable for vital signs to be done after the patient is registered. If danger zones on vital signs are noted, the triage nurse might consider assigning ESI Level 2. Patients are to be kept in the triage area only long enough to make an appropriate triage decision. BP is routinely taken on patients over 6 years of age. BP shall be taken on all patients below 6 years with a chief complaint that indicates a need.

Once a patient is placed in a room:

- Patient will be undressed enough to expose for exam all affected areas and all body parts that will need assessment.
- A gown will be provided as needed as well as sheet and blanket
- All patients will be given a call bell
- Patients who are elderly, exhibit lower level of consciousness, confusion or who may suffer injury should they attempt to walk, should have both siderails up and have close observation

REASSESSMENT GUIDELINES:

Level 1	ongoing
Level 2	every 15 minutes until stable
Level 3	every hour
Level 4 & 5	every 4 hours

X-Ray Orders Initiated AT Triage

The immediate treatment of an acutely ill or injured patient is the primary goal of the department. For this purpose, an emergency physician is on duty 24 hours a day. However, to facilitate the timely treatment of these patients with acute conditions, it is recognized that trained RN's may have occasion to institute standing orders. Implementation of standing orders is contingent on the adequate and appropriate communication between nurse and physician. Standing orders replace neither current standards of nursing practice and assessment nor appropriate medical intervention; rather they are an adjunct to them.

X-rays are indicated when there is historical and physical evidence of injury which is severe enough to result in a fracture or avulsion of bone, or history of foreign body. When appropriate, patients who present with orthopedic injuries will have x-ray orders initiated at triage, prior to seeing the Emergency physician.

Once a history and nursing assessment of the injury has been obtained, the following x-ray films may be ordered by the triage nurse whenever there is a history of trauma, a deformity or point tenderness is present:

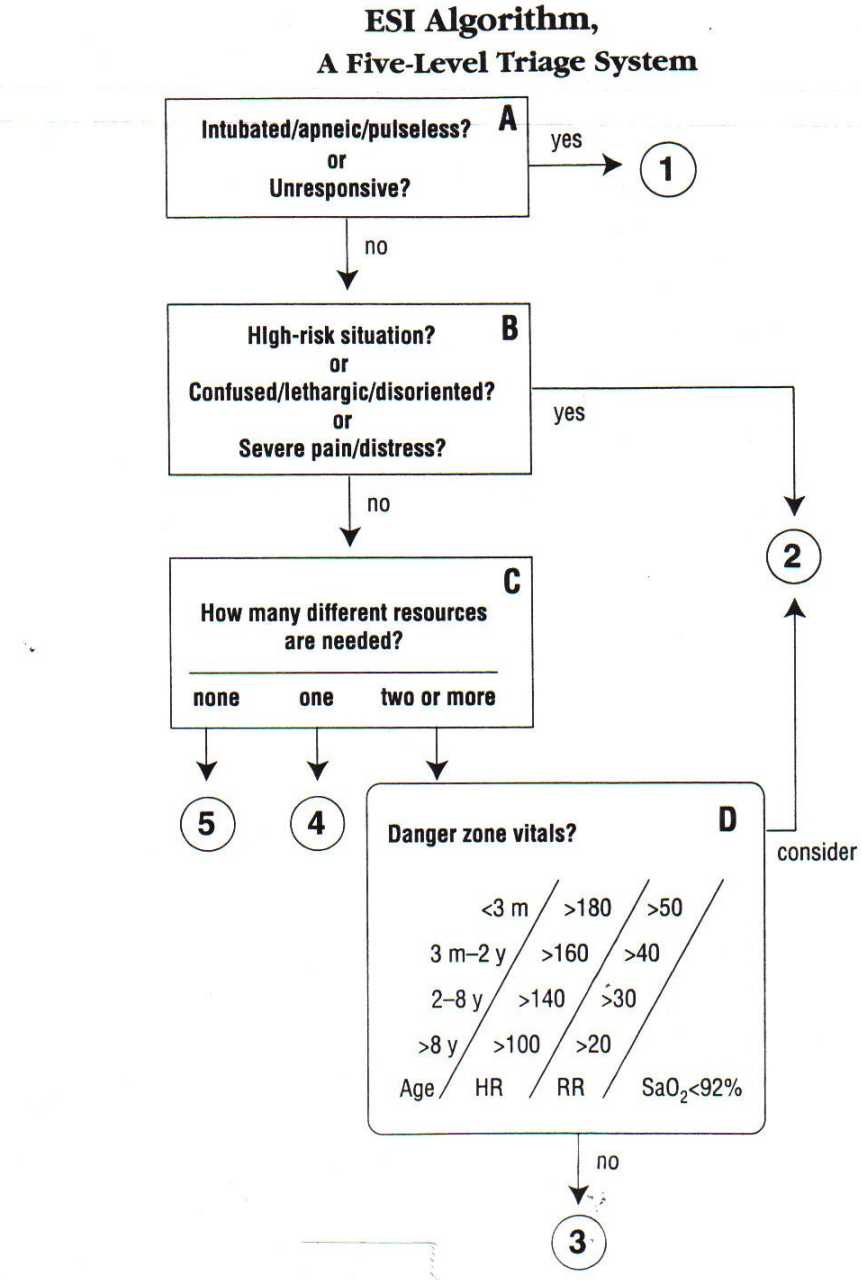
- Clavical
- Hand/ Fingers
- Shoulder
- Knee
- Humerus
- Tib/Fib
- Elbow
- Ankle
- Forearm
- Foot/Toes
- Wrist
- Ribs (if ordering you should order CXR also)
- Foreign bodies - x-rays should be ordered.

References:

Emergency Severity Index Implementation Handbook : A Five Level Triage System; Nicki Gilboy, RN, Paula Tanabe, RN, Debbie Travers, RN, David Eitel MD Richard C. Wuerz MD copyright 2005

Sheehy's Emergency Nursing: Principles and Practices by ENA 2009 Edition Elsevier Health Sciences

Appendix 1



Appendix 2

Four Levels of the AVPU Scale

AVPU Level	Level of Consciousness
A	**Alert:** The patient is alert, awake and responds to voice. The patient is oriented to time, place and person. The triage nurse is able to obtain subjective information.
V	**Verbal:** The patient responds to verbal stimuli by opening their eyes when someone speaks to them. The patient is not fully oriented to time, place or person.
P	**Painful:** The patient does not respond to voice, but does respond to painful stimulus, such as a squeeze to the hand or sternal rub. A noxious stimulus is needed to elicit a response.
U	**Unresponsive:** The patient is non-verbal and does not respond even when a painful stimulus is applied.
Emergency Nurses Association 2000	