COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Triage using the Emergency Severity Index		**EMD-006**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Emergency Department		
DEPARTMENT	REFERENCE	
Emergency Department		

SCOPE

This policy applies to Mangum Regional Medical Center for the assessment and prioritization of patients based on level of acuity and resources using an evidence based five-level triage assessment tool for those patients presenting to the Emergency Department (ED).

PURPOSE

The Hospital has adopted the Emergency Severity Index (ESI) for triaging patients arriving in the ED to improve the quality and safety of patient care. The ESI is an evidence based five level triage scale that facilitates the prioritization of patients based on the urgency of treatment for the patients' condition. The triage nurse initially performs a brief focused assessment to assign a triage acuity level, which determines how long a patient can safely wait to be seen by a physician/mid-level provider and receive a medical screening examination (MSE) and treatment. In 2010 the American College of Emergency Physicians (ACEP) and the Emergency Nurses Association (ENA) revised their original statement regarding the use of triage scales as follows: "*the ACEP and ENA believe that the quality of patient care benefits from implementing a standardized emergency department (ED) triage scale and acuity categorization process. Based on expert consensus of currently available evidence, ACEP and ENA support the adoption of a reliable, valid five level triage scale such as the Emergency Severity Index (ESI).*" In 2010 the Centers for Disease Control and Prevention National Center for Health Statistics provided a report that categorized acuity on arrival as a five-level based on how urgently the patient needed to be seen by the physician or healthcare provider and included the following categories:

Acuity Level	Time Seen
Level 1 - Immediate	Immediately
Level 2 - Emergent	10-20 minutes
Level 3 - Urgent	15-60 minutes
Level 4 – Semi-Urgent	1-2 hours
Level 5 – Non-Urgent	2-24 hours

Finally, the triage nurse is responsible for determining resources necessary to move the patient to a final disposition (admission, discharge, or transfer) for those patients who do not meet a high acuity level. This process ensures patients are placed in the right location at the right time to receive the appropriate level of care and facilitates the allocation of the appropriate resources to meet the patient's medical needs.

DEFINITIONS

A. **Acuity:** refers to the severity of the illness or injury, as well as the potential for complications. Acuity is determined by the stability of the patient's vital functions and the potential for the threat to life, limb or organ.
B. **Emergency Severity Index (ESI):** an evidence-based five-level triage scale developed as a triage tool to help facilitate the prioritization of patients arriving in the ED based on the urgency of the patients' condition.
C. **Disposition:** means where the patient is being discharged to such as admitted to the hospital, discharged to home or transferred to another facility.
D. **High-Risk Situation:** refers to a patient with a condition that could easily deteriorate or presents with symptoms suggestive of a condition requiring time-sensitive treatment. This patient presents with a potential for a threat to life, limb or organ. Examples include but not limited to active chest pain, signs of stroke, suicidal or homicidal patient.
E. **Medical Screening Examination (MSE):** means an examination performed by a licensed physician or Qualified Medical Person (QMP) including any ancillary services to determine with reasonable clinical confidence whether an emergency medical condition (EMC) does or does not exist.
F. **Resources:** refers to the number of resources a patient is expected to consume for a disposition decision to be reached. Resources would include but not limited to hospital services, tests, procedures, consults or interventions that are above and beyond the history and physical, or simple interventions such as applying a bandage.
G. **Triage:** entails the clinical assessment of the patient's presenting signs and symptoms at the time of arrival at the hospital, in order to prioritize when the patient will be seen by the physician or other QMP.

POLICY

Triage is a process that will be initiated upon the patient's arrival to rapidly assess the severity of the patient's injury or illness and assign priorities of care to be provided. This process ensures patients are placed in the right location at the right time to receive the appropriate level of care and facilitates the allocation of the appropriate resources to meet the patient's medical needs. Goals of triage include:

- Rapid identification of life-threatening illnesses or injuries
- Prioritizing care for patients with emergent needs
- Facilitate the flow of patients through the ED
- Refer patients to the appropriate level of care in the ED

The ED triage assessment of the patient will include the rapid systematic collection of subjective and objective data that is relevant to each patient. The triage nurse will then assign an acuity

level using the ESI Triage Algorithm (see EMD-006A) based on the needs of the patient and determine how long the patient can safely wait before receiving an MSE and treatment by a physician/mid-level provider. If the triage nurse determines the patient is not a high acuity patient, then the triage nurse will then determine the number of resources the patient is going to consume for the patient to reach a disposition decision. The triage nurse will estimate the number of resources based on the patient's brief subjective/objective assessment, past medical history, allergies, medications, age/gender and ED standards of practice. The triage nurse will review the patient's vital signs and if outside accepted parameters the nurse will consider upgrading the patient to a Level 2 based on the ESI Triage Algorithm. If all ED beds are full and the patient is stable enough to wait in the ED waiting room, reassessment will be performed at defined intervals. Any significant symptoms will be reassessed, and acuity level will be increased if necessary. The triage nurse will use ESI criteria to determine to triage level and assign ED room assignment regardless of method of arrival.

PROCEDURE

A. All patients presenting to the ED will initially be triaged using the ESI Triage Algorithm in order to identify life-threatening conditions and prioritize patients according to acuity.
B. The triage nurse will determine if the patient requires immediate life-saving intervention. If the patient requires life-saving intervention, then the triage process is complete, and the patient will be triaged as a Level 1 and taken directly to an ED room and seen by a physician/mid-level provider immediately.
    1. When determining if the patient requires immediate life-saving intervention, the triage nurse must also assess the patient's level of consciousness using the AVPU (alert, verbal, pain, unresponsive) scale.

AVPU	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 a painful stimulus, such as a squeeze to the hand or sternal rub. A noxious stimulus is needed to elicit such a response.
U	Unresponsive. The patient is nonverbal and does not respond even when a painful stimulus is applied.
Emergency Nurse Association, 2000	

    2. Once Level 1 criteria has been met and the patient has been taken to an ED room a full set of vital signs should be obtained which should include the following:
        a. Blood pressure
        b. Heart Rate (HR)
        c. Respiratory Rate (RR)
        d. Temperature

e. Oxygen Saturation (SpO2)

3. Examples of ESI Level 1 patients include but are not limited to:
    - Cardiac arrest
    - Respiratory arrest
    - Severe respiratory distress
    - SpO2 < 90%
    - Critically injured unresponsive trauma patient
    - Overdose patient with respiratory rate of 6 or less
    - Severe respiratory distress with agonal or gasping type respirations
    - Severe bradycardia or tachycardia with signs of hypoperfusion
    - Trauma patient who requires immediate crystalloid and colloid resuscitation
    - Chest pain, pale, diaphoretic, blood pressure 70/palpation
    - Weak and dizzy, heart rate 30
    - Anaphylactic shock
    - Unresponsive patient with strong odor of alcohol
    - Hypoglycemia with change in mental status
    - Intubated head bleed with unequal pupils

C. If the triage nurse determines the patient does not meet ESI Level 1 criteria, and does not need immediate life-saving treatment, the triage nurse will determine if the patient can safely wait to be seen by a physician/mid-level provider. The nurse will then consider three (3) questions and obtain pertinent subjective and objective information through a brief focused assessment to determine if the patient meets Level 2 criteria:
    - Is this a high-risk situation?
    - Is the patient confused, lethargic or disoriented?
    - Is the patient in severe pain or distress?

    1. A high-risk patient will be determined based on a brief interview and observation by the triage nurse. In most cases a high-risk patient will not require a detailed physical assessment or vital signs. Examples of high-risk situations include but are not limited to:
        - Active chest pain that does not require immediate life-saving interventions (stable)
        - Signs of stroke that does not meet Level 1 criteria
        - Suicidal/Homicidal patient
    2. To determine Level 2 criteria the triage nurse will assess for an acute change in level of consciousness. Patients with a baseline mental status of confusion would not meet Level 2 criteria.
    3. The triage nurse will assess patients presenting with signs and symptoms of pain with a validated evidence-based pain scale such as the Numeric Pain Scale (See EMD Form B) or the Wong-Baker Faces Scale (See EMD Form C) and clinical observation (i.e. distressed facial expression, diaphoresis, body posture, vital sign changes).
        a. Clinical observation and pain rating should be used to determine Level 2 criteria. For example: severe abdominal pain, diaphoretic, elevated heart rate and blood pressure would meet Level 2 criteria.

4. Once Level 2 criteria has been met and the patient has been taken to an ED room a full set of vital signs should be obtained which should include the following:
    a. Blood pressure
    b. Heart Rate (HR)
    c. Respiratory Rate (RR)
    d. Temperature
    e. Oxygen Saturation (SpO2)

D. If the triage nurse determines the patient does not meet Level 2 criteria, the nurse will then make an estimation of the number of resources the patient will need to reach a disposition decision based on the patient's brief subjective/objective assessment, past medical history, allergies, medications, age/gender and ED evidence-based standards of practice.
    1. To differentiate between ESI Levels 3, 4 and 5 the nurse will need to estimate if the patient needs one (Level 4), two (Level 3), or no (Level 5) resources reach a disposition decision.
        a. Once the nurse determines the patient needs two or more resources, there is no need to continue to estimate resources.
        b. The triage nurse should not count the number of individual tests when estimating resources. The triage nurse should only estimate the number of resources. Examples:
            i. CBC and electrolyte panel, equals one resources (lab test)
            ii. CBC and chest x-ray equal two resources (lab test, x-ray)
            iii. Cervical spine x-ray and head CT scan equals two resources (x-ray and CT scan)
        c. List of resources include but are not limited to:

Resources	Not Resources
Labs (blood, urine	History & physical (including pelvic)
ECG, x-rays, CT-MRI-ultrasound, angiography	Point of care testing
IV fluids (hydration)	Saline or heplock
IV, IM, or nebulized medications	PO medications, Tetanus immunization, Prescription refills
Specialty consultations	Phone call to PCP
Simple procedure = 1 (lac repair, Foley cath)	Simple wound care (dressing, recheck)
Complex procedure = 2 (conscious sedation)	Crutches, splints, slings

E. The triage nurse will obtain a full set of vital signs prior to determining Level 3 criteria. If the patient's vital signs are outside accepted parameters, the nurse will consider upgrading the triage level to ESI Level 2.
    1. A full set of vital signs will include the following:
        a. Blood pressure

b. Heart Rate (HR)
c. Respiratory Rate (RR)
d. Temperature
e. Oxygen Saturation (SpO2)

2. The triage nurse will document the triage level decision in the patient's medical record. The nurse will include the rationale for the triage decision in the patient's medical record.

F. Five-Level ESI Categories and Reassessment Objectives

1. ESI Level 1 – Immediate
    a. Any condition presenting an immediate threat to the patient's life or limb requiring immediate interventions to save the patient's life or to prevent irreversible damage.
    b. Time to Treatment: Immediate.
    c. Reassessment: Continuous.
    d. Presentation: Includes but not limited to patients that are unresponsive, intubated, apneic, pulseless.
    e. When Level 1 criteria is met the triage process must stop and the patient taken directly to an ED room and seen immediately by a physician/mid-level provider and treatment initiated.
2. ESI Level 2 – Emergent
    a. Any condition that potentially threatens the patient's life or limb and could worsen without intervention.
    b. Time to Treatment: Immediate.
    c. Reassessment: Every 15 to 30 minutes, and PRN (as needed).
    d. Presentation: Includes but not limited to patients that have new onset confusion, lethargy or disorientation, severe pain or distress; patients that require two or more resources; heart rate, respiratory rate or oxygen saturation in the danger zone; or high-risk situations.
    e. When Level 2 criteria is met the triage process must stop and the patient taken directly to an ED room and the patient evaluated by a physician/mid-level provider within 20 minutes or less.
3. ESI Level 3 – Urgent
    a. Any condition that requires evaluation and treatment, is not time-critical, and will not worsen if left untreated for several hours.
    b. Time to Treatment goal: Less than 1 hour.
    c. Reassessment: Every 1 hour, and PRN.
    d. Presentation: Patients requiring two or more resources with vital signs that are not in the danger zone.
4. ESI Level 4 – Semi-Urgent
    a. Any condition that requires evaluation and treatment, is not time-critical, and will not worsen if left untreated for several hours.
    b. Time to Treatment goal: 2 to 4 hours.
    c. Reassessment: Every 2 to 4 hours, and PRN.
    d. Presentation: Patients who only require one (1) resource.
5. ESI Level 5 – Non-Urgent

a. Any condition that requires minimal interventions and will not worsen if treatment is delayed for several hours to days.
b. Time to Treatment goal: 2 to 8 hours.
c. Reassessment: Every 2 to 4 hours, and PRN.
d. Presentation: Patients requiring no resources.

G. If all ED beds are full and the patient's condition is stable enough to wait in the ED waiting room, reassessment should be performed at appropriate intervals. Any significant symptoms should be reassessed for change and the acuity category increased if necessary. Reassessment guidelines are as follows based on the five-level ESI categories:

Acuity Level	Reassessment
Level 1 - Immediate	Continuously
Level 2 - Emergent	Every 15 minutes
Level 3 - Urgent	Every 1 hour, PRN
Level 4 – Semi-Urgent	Every 2 hours, PRN
Level 5 – Non-Urgent	Every 4 hours, PRN

Triage is a dynamic process; a patient's condition may improve or deteriorate at any time during the patient's wait in the ED.

H. If the triage nurse is in doubt regarding a triage category, the triage nurse should choose the higher triage acuity level to avoid under-triaging a patient.
I. The triage nurse will use ESI criteria to determine the triage level and assign ED room assignment regardless of method of arrival.
    a. Arriving by ambulance will not be used a criterion to assign a higher-level acuity and place the patient in an available ED room.
J. Any patient with a cough or fever and/or a rash will be assessed by the triage nurse to determine if isolation is required. If the nurse determines the patient requires isolation a mask will immediately be placed on the patient and the patient will be placed in the isolation ED room. The triage nurse will immediately notify the physician/mid-level provider of the presence of patients requiring isolation.
K. Documentation:
    1. The triage assessment and triage level must be documented in the appropriate area of the nursing note, including the date and time the assessment was completed.
    2. All re-assessments should be documented including date and time completed in the nursing note.
    3. Documentation should be clear, concise and objective.
    4. Documentation should include the time to nurse and time to medical provider in the nursing note.

QUALITY MONITORING

The Quality Manager will review all ED patients presenting to the ED for accurate triage level. The Quality Department will track and monitor the door-to-triage time as it is a key indicator of

a vital emergency department processes. The goal of the ED will be to assign an accurate triage score for immediate, emergent and urgent cases in less than 5 minutes.

Hospital leadership including but not limited to, the Quality Manager and Chief Nursing Officer are responsible for ensuring that all hospital staff adhere to the requirements of this policy, procedures are implemented and followed at the Hospital. All instances of non-compliance with the policy should be reported to the Quality Manager and the Chief Nursing Officer and an incident report completed. All incidents will be reported to following committees: Quality, Medical Staff and Governing Board.

EDUCATION AND TRAINING

All nursing staff (RN and LPNs) are required to have initial orientation and annual education and competency (except as otherwise noted) in the following:

- Emergency Severity Index course
- Emergency Department core competencies

All nursing staff will also be certified in CPR, ACLS, and all RNs will be PALS certified in accordance to the American Heart Association (AHA) standards of training. All clinical staff is required to have CPR certification.

ATTACHMENTS

See Forms:
See EMD Form 006A: ESI Triage Scale
EMD Form B: Numeric Pain Scale
EMD Form C: Wong-Baker Pain Scale

IV. REFERENCES

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REVISIONS/UPDATES

Date	Brief Description of Revision/Change