EMERGENCY DEPARTMENT POLICIES

SUBJECT: Triage and Retriage of AER and PER Patients

Original Date of Issue: 1/1/89

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Policy:

Triage is the process of determining priority of care based on each patient’s initial assessment, vital signs, and chief complaint. This process promotes:

1. Immediate and appropriate intervention to all patients in the Emergency Department.
2. Timely and orderly flow of patients through the Emergency Department.
3. Appropriate utilization of ED resources
4. Patient safety and well-being while they are waiting to be seen by a physician

Triage information will be entered using the triage template of the ED chart. When computer is not functioning paper triage forms will be utilized (see downtime policy).

Implementation:

All patients presenting to the Emergency Department will be seen by a registered nurse functioning in a triage capacity. A brief triage will be conducted by the nurse, who will determine the priority of care necessary and the appropriate area for further evaluation and treatment.

Patients will not be triaged out of the Emergency Department to any other area of the hospital for care except for pregnant women. Pregnant women stable for immediate transport to the labor floor do not need to be registered or triaged. They will be brought directly to KP2 by hospital personnel on stretcher or wheelchair, with the paperwork from EMS. If there is no pregnancy-related complaint, if the patient is unstable, or if the triage RN is unsure of appropriateness of transport to KP2, a greet and quick triage will be completed and the north attending will clear the patient for transport or full triage and registration in the ED. Direct admissions do not need to be triaged unless medical care or stabilization is requested by the patient or the transporting personnel.
Patients who are triaged but leave before being placed in the ED must have documentation in the triage section of the ED record that they were called three times over at least one hour. The final diagnosis, disposition and condition will be recorded as “left without Treatment” and the chart will be removed from the system.

When the appropriate priority level for a patient is unclear, the higher priority is to be assigned.

All patients categorized ESI 1 & 2 are escorted to the treatment area and assigned a primary nurse upon triage. They will be reassessed according to the criteria outlined in the Vital Sign Policy (#38).

Certain studies may be obtained without a physician’s order: (See RN initiated orders Policy #40)

The nurse in charge of the AER/PER is responsible for reviewing charts of patients in the waiting room at least every 2 hours to identify those in need of re-triage.

All patients in the waiting room for 3 hours or more must be re-assessed by triage nurse or designee. Reassessment includes a vital signs, status related to patient’s chief complaint; The reassessment is entered into the triage section of the ED record. The nurse reassessing the patient must take appropriate action if there is a change in patient condition.

The Mount Sinai Hospital Emergency Department utilizes a 5 level Emergency Severity Index (ESI) Triage Classification System:

**ESI Level 1, ESI Level 2, ESI Level 3, ESI Level 4, and ESI Level 5**

**ESI Level 1** – Those patients who are intubated, apneic, pulseless or unresponsive. These patients are placed directly into an Emergency Department bed. This priority #1 in the computerized data base.

**ESI Level 2** - Those patients who are high risk, confused, lethargic, or disoriented, or in severe pain or distress (Physical or psychological) or present with unstable VS, including psychiatric complaints that require 1:1 observation. These patients are placed directly into an Emergency Department bed. This is priority #2 in the computerized database.

**ESI Level 3** - Those patients who are stable, present with normal VS and require utilization of at least 2 or more resources during the evaluation process. This is priority #3 in the computerized database.
**ESI Level 4** – Those patients who are stable, present with minor or chronic problems and require one resource during the evaluation process. This is priority #4 in the computerized database.

**ESI Level 5** - Those patients who are stable with minor problems and will not utilize any resource during the evaluation process. This is priority #5 in the computerized database.

**Resources and Algorithm for the ESI Triage System**

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<thead>
<tr>
<th>Resources</th>
<th>Not Resources</th>
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<tr>
<td>Labs (blood &amp; urine), EKG, Radiology</td>
<td>H &amp; P (including pelvic, bedside U/S)</td>
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<tr>
<td>IV Fluids (hydration)</td>
<td>Saline or heplock</td>
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<tr>
<td>IV or IM medications</td>
<td>PO Medications</td>
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<tr>
<td>Specialty Consultation</td>
<td>Phone call to PCP</td>
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<tr>
<td>Simple Procedures (1) (laceration repair, foley catheterization, NGT)</td>
<td>POCT (point of care test) ([icon, urine, fecal occult, fingerstick])</td>
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<tr>
<td>Complex Procedures (2) (sedation/analgesia)</td>
<td>Simple wound care (dressings, recheck)</td>
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<tr>
<td>Morgan Lens</td>
<td>Crutches, splints, slings</td>
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<tr>
<td>Nebulizers &amp; Peak Flow (1)</td>
<td>Slit lamp/Woods lamp</td>
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<td>Suture removal</td>
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