Illness and Injury Triage
A Sample Policy for the
Care of Children in the Emergency Department

Date: June, 2020

Introduction

The process of triage is one of the most critical processes in the Emergency Department. It is essential that nurses who are assigned to complete this process are experienced ED nurses who are experts in recognizing sick patients and have solid critical reasoning skills. To have a successful triage system that accurately and expeditiously identifies a critically ill or injured child, several key points must be considered.

Outline of Priorities

- The ED will establish triage guidelines based on severity of illness and injury, physiologic state, and the risk for critical illness and will provide clinical examples of typical patient clinical presentations to enhance the sorting of patients presenting to the ED.

Triage: Sorting based on symptoms, signs and pertinent medical history to assist in the identification of patients with high risk but treatable conditions, so that they may receive the most timely and efficient care.

Purpose:

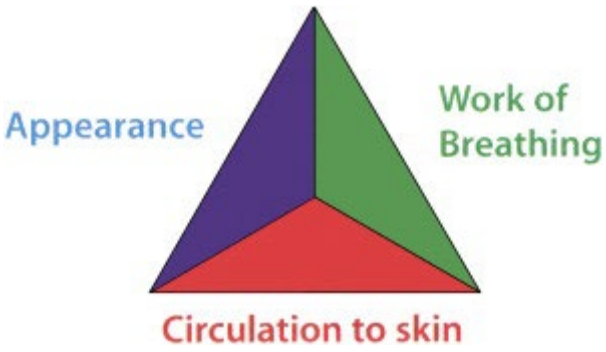
- To facilitate and appropriately prioritize the care of all pediatric patients in the ED, triage levels will be defined to assist the identification of high-risk patients, using a system that is reliable and valid. The Emergency Nurses Association/American College of Emergency Physicians joint position statement Triage Scale Standardization (2017) recommends use of a scientifically validated triage scale such as the Emergency Severity Index (ESI).
- To consider which types of pediatric complaints would be considered high risk.
- To implement a comprehensive triage orientation including the use of the pediatric assessment triangle and recognition of high-risk pediatric complaints should be completed prior to assignment of the nurse to the triage process.
- To integrate a system to measure triage accuracy and efficiency.

Target Group: Emergency departments providing care to pediatric patients.

Procedure/Action:

The Pediatric Assessment Triangle:

The ability to utilize the pediatric assessment triangle (PAT) to rapidly identify ill and injured pediatric patients is paramount in the triage process. The PAT, developed by the American Academy of Pediatrics, is a simple tool that clinicians can use to rapidly identify critically ill or injured pediatric patents regardless of their presenting complaint. The tool is utilized in ENPC, PEPP, PALS, and APLS as an essential component to observational pediatric assessment.



Vital Signs:
Vital signs are measurements of physiological parameters (See Pediatric Vital Signs Poster for details and age appropriate pediatric vital signs). Heart rate, respiratory rate, oxygen saturation, blood pressure and pain assessment are the traditional measures obtained from patients in the ED setting. However, evidence suggests:

- Initial vital signs are not a mandatory component of the Triage Acuity Level-1 or 2 patient, however:
- The clinical presentation of the child can and should be, at a minimum, accurately determined by the assessment of all pediatric patients using the Pediatric Assessment Triangle (PAT). The PAT consists of the observation, documentation and reporting of the child's Appearance, Work of Breathing and Circulation/skin signs (see reference chart).
- When triaging a stable patient, it is never wrong to obtain a set of vital signs. All Level 3 patients shall have a full set of vital signs to include: heart rate, respiratory rate, oxygen saturation, blood pressure (for patients over age 3), and pain assessment.
- Trauma patients should be assessed for: PAT, Neurological status using an appropriate GCS scale, pain assessment and determination if Trauma System Activation is necessary.

For additional information about the ESI 5-level triage acuity scale, please see Emergency Severity Index (ESI): A Triage Tool for Emergency Department Care, Implementation Handbook.

Because of the inability of many children to report signs and symptoms directly, the waiting area of an ED can be one of great vulnerability. Vital signs are variable and dynamic indicators of physiological status thus there is a need to re-assess children who are waiting for care. As changes in physiological status may be exhibited by subtle changes in very young children, heart rate, respiratory rate, oxygen saturation and temperature are required points of initial vital signs measurement in all children under age 3.

Reassessment can be performed and documented by the use of the PAT at regular intervals prior to the Medical Screening Exam (MSE). Once the MSE is complete, reassessment should be performed according to facility policy.

Outline quality indicators

I. Time for triage of patients – mean time in minutes (goal <5 minutes), 90 percentile time to triage complete (goal <15 minutes)

II. Rate of admissions for non-urgent patients (goal <1%)

Special Considerations (as appropriate)

Children with Special Healthcare Needs

Children with special healthcare needs (CSHCN) are those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally. These children could be at

greater risk of rapid and subtle deterioration. As listed above, the emergent (high-risk) category, consider triaging children with special needs and any physiologic abnormality to the emergent (high-risk) category. Consider triaging all others at the urgent level.

Cultural Sensitivity Issues

Assess the need for the triage policy to be available in multiple languages when it is posted. All those who request ED service should be sorted without regard to cultural background or language.

_____ _____

Signature Date

Attachments & Addendums

1. Isolation
2. Patient Flow from Initial Triage

Relevant TJC Standards

1. EC 1.4 Emergency Management
2. Pain Assessment standard

Reference List

1. Cain R, Waldrop RD, Jones J. Improved pediatric patient flow in a general emergency department by altering triage criteria. *Acad Emerg Med*. 1996;3(1):65-71.
2. Dowd MD, McAneney C, Lacher M, et al. Maximizing the sensitivity and specificity of pediatric trauma team activation criteria. *Acad Emerg Med*. 2000;7(10):1119-25.
3. Gorelick MH, Lee C, CronanK, et al. Pediatric emergency assessment tool (PEAT): a risk-adjustment measure for pediatric emergency patients. *Acad Emerg Med*. 2001;8(2):156-62.
4. Kennedy K, Aghababian RV, Gans L, et al. Triage: techniques and applications in decision making. *Ann Emerg Med.* 1996;28(2)136-44. Review.
5. Kuensting LL. "Triaging out" children with minor illnesses from an emergency department by a triage nurse: where do they go? *J Emerg Nurs.* 1995;21(2):102-8.
6. Mower WR, Sachs C, Nicklin EL, et al. Pulse oximetry as a fifth vital sign. *Pediatrics*. 1997;99(5):681-6.
7. Nuss KE, Dietrich AM, Smith GA. Effectiveness of a pediatric trauma team protocol. *Pediatr Emerg Care.* 2001;17(2):96-100.
8. Salk ED, Schriger DL, Hubbell KA, et al. Effect of visual cues, vital signs, and protocols on Triage: A prospective randomized crossover trial. *Ann Emerg Med.* 1998;32(6):655-64.
9. Sola JE, Scherer LR, Haller JA Jr, et al. Criteria for safe cost-effective pediatric trauma triage: prehospital evaluation and distribution of injured children. *J Pediatr Surg*. 1994;29(6):738-41.
10. Waldrop RD, Harper DE, Mandry C. Prospective assessment of triage in an urban emergency department. *South Med J*. 1997;90(12):1208-12.
11. Wiebe RA, Rosen LM. Triage in the emergency department. *Emerg Med Clin North Am.* 1991;9(3)491-505.
12. Wuerz R, Fernandez CM, Alarcon J. Inconsistency of emergency department triage. Emergency Department Operations Research Working Group. *Ann Emerg Med.* 1998;32(4):431-5
13. Wuerz RC, Travers D, Gilboy N, etal. Implementation and refinement of the emergency severity index. *Acad Emerg Med*. 2001;8(2):170-6.

Contributors:
We gratefully acknowledge the contributions of the following individuals:

Robert W. Ready RN, MN, CEN
Director of Emergency Services
Caritas Norwood Hospital
Norwood, Mass.

Richard M. Ruddy, MD
Director, Division of Emergency Medicine
Cincinnati Children's Hospital Medical Center
Professor of Clinical Pediatrics
University of Cincinnati College of Medicine

Deena Brecher, MSN, RN
Clinical Nurse Specialist
Nemours/Alfred I. duPont Hospital
Emergency Nurses Association

Susan Fuchs, MD
Professor in Pediatrics-Emergency Medicine
Lurie Children's Hospital of Chicago
Northwestern University Feinberg School of Medicine

Addendum 1

Isolation

All children with potentially contagious illnesses should be placed where they are at minimal risk to others; (they should be placed in an isolation room for evaluation and treatment based on your hospital requirements). An appropriate isolation tag should be placed on the door in which the patient is placed. If capacity constraints prevent placing such in an isolation room, the patient should be placed in an area that minimizes the exposure risk to other patients. Examples of potentially highly contagious illnesses include:

I. Varicella
II. Measles
III. Whooping cough
IV. Coughing with possible exposure to tuberculosis or suspected active pulmonary TB
V. Patient colonized with Methicillin Resistant *Staphylococcus Aureus* (MRSA)

Addendum 2

Patient Flow from Initial Triage

Patients triaged as critical will be sent to a highly visible place to be observed. Patients triaged as emergent (high risk) will be sent to a highly visible place to be observed *or in certain cases to a visible exam room where staff may immediately be able to initiate the assessment effectively*. Any time in which census requires staff to place a walk back patient in another area the charge nurse and emergency physician should be notified immediately to assign resources as appropriate.

All hospital/ED transfer and EMS squad patients should be triaged to the emergent (high risk) category when new or continued therapy is required for the patient's condition. Triage all patients presenting as a result of a hospital-based emergencies (ie, children visiting a sibling), including in-hospital office or clinic patients sent over for emergency treatment.