Date Last Revised: 1/3/25 Date Last Reviewed: 7/17/25 Date Next Review:
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Applicability: Pediatric Triage Guidelines

Triage of the pediatric Emergency Department patient

I. SCOPE

To establish the Nursing standards and process for triage of the pediatric patient at ThedaCare Neenah Emergency Department.

II. PURPOSE STATEMENT

Every child and family is assured to receive a defined level of comprehensive, quality care as specified by the core philosophies of patient care and nursing. In the emergency department, triage refers to evaluations that you must perform to gather information quickly to assess patients and determine their priority treatment needs and potential for death. Care, treatment, and services are provided in an interdisciplinary, collaborative manner as appropriate to the needs of the patient. Patient outcomes are prioritized and a mutual plan of care is developed in collaboration with the patient and family.

III. POLICY

Patient care staff performs assessments and completes documentation for all patients who receive care and treatment based on presenting needs within their scope of practice per procedure outlined below.

IV. PROCEDURE

A. Verify demographic Information
    a. Patients full name, including middle initial
    b. Gender
    c. Date of birth
    d. Verify correct armband placement with guardian
B. Triage Information
    a. Across the room assessment to assess for obvious uncontrolled external hemorrhage or unresponsive/apnea and the need to reprioritize to C-ABC (Circulation, Airway, Breathing, Circulation). Assess the three components of the Pediatric Assessment Triangle (PAT). Abnormality in each section will determine if the patient is sick, sicker, or sickest.
        1. Sick is classified if a caregiver determined that something was “not right” and requires provider evaluation.
        2. Sicker is classified as an abnormality in any one of the three components of the PAT, and the child will require evaluation before a “sick” child.
        3. Sickest is classified as an abnormality in two or more of the components of the PAT, and the child often requires rapid treatment.
        4. Pediatric Assessment Triangle (PAT)
            a. Appearance
                i. Abnormal tone, decreased interactiveness, decrease consolability, abnormal look/gaze, abnormal speech/cry

b. Work of breathing
    i. Abnormal sounds, abnormal position, retractions, flaring, apnea/gasping
c. Circulation
    i. Pallor, mottling, cyanosis

b. Visit Information- Chief Complaint– Taken by a RN
c. Mode of Arrival (Walk – Wheelchair – Carry – Police – EMS)
d. Perform hand hygiene and DON PPE
e. Vital Signs:
    1. Temperature / Heart Rate / Respiratory Rate / Pulse Oximetry on all patients.
    2. Rectal temperature performed on ill children under age of 2, unless contraindicated.
    3. Blood pressure (BP) on all patients 4 and over with appropriate size cuff and all ESI 1 and 2.
    4. Weight in Kilograms (without conversion from pounds) on all patients.
        a. Bed scale and standing scales should be zeroed prior to obtaining
        a weight.
        b. Infant scale should be zeroed with a dry diaper prior to obtaining weight. Wet/ dirty diaper should not be on scale when obtaining weight.
        c. Infant should be weighted in dry diaper only.
        d. Be sure the entered weight does not flag for EPIC discrepancy. Re-collect if indicated.
    5. Blood glucose documented on any pediatric patient with a noted mental status change as reported by RN, MD or parent/guardian.
    6. ETC02 for any patient that is presenting in respiratory failure or any other condition that warrants oxygenation monitoring, example: seizures or decrease in mental status.
    7. Face to face notification to physician immediately for critical vitals. Provider will get notified via EPIC for abnormal vitals * see attached document for reference ranges
e. An initial comprehensive pain assessment is conducted as appropriate to the patient's condition, age, and ability to understand.
    1. Pain scale
        a. For patient who are verbal and can self-report utilize the numeric pain 1-10 scale, verbal descriptive scale, or Wong-Baker FACES pain rating scale.
        b. For patient who can't self-reports, such as those who are nonverbal, have cognitive issues, or infants utilize NPASS, FLACC, or NIPS.
        c. Critically ill patient, intubated or non-intubated, utilize Critical-Care pain observation tool

2. The assessment should include a pain score and may include any of the following components based on setting, developmental age of the patient, diagnosis, and severity of the condition:
    a. Pain intensity (Pain Score)
    b. Location
    c. Quality, patterns of radiation, character
    d. Onset, duration, variations and patterns
    e. Alleviating and aggravating factors

f. Allergies
g. Pre-hospital treatment
    1. Document vital signs completed and reported by ems; to include blood glucose, heart rate, respiratory rate, pulse oximetry, temperature, blood pressure.
    2. Interventions
        a. IV start date and location.
        b. IV bolus amount and stop time (arrival to ED)
        c. IV, intranasal, or oral medications provided
    3. Cervical collar, backboard, splints
    4. Documented loss of consciousness
h. Pharmacy of choice
i. Patient's immunization status
j. The ED RN is to assign the triage level based on the Emergency Severity Index (ESI) Algorithm
    1. Level 1: requires immediate life-saving intervention(s); patient is immediately roomed and EDMD notified.
    2. Level 2: patient requires many resources; high-risk conditions; situation could progress to severe without intervention. Patient is roomed ASAP.
    3. Level 3: patient requires (2) or more resources for the physician to reach a disposition. While patient is in the waiting room, rounding will be done on patients using RN discretion, or with changes in condition at a minimum of every 60 minutes.
    4. Level 4: patient requires (1) resource for the physician to reach a disposition. While patient is in the waiting room, rounding will be done on patients using RN discretion, or with changes in condition at a minimum of every 60 minutes.
    5. Level 5: non-urgent condition and the patient does not require any resources. While patient is in the waiting room, rounding will be done on patients using RN discretion, or with changes in condition at a minimum of every 60 minutes.

C. Initiating treatment for pediatric patient using approved nursing protocols.
    a. Behavioral Health
    b. EKG Obtainment
    c. Cervical-Spine Immobilization/Long Board Removal
    d. Extremity Injuries
    e. Fever Algorithm

f. IV Access
g. Lacerations/ Puncture Wounds
h. Sore Throat
i. N/V/D
j. Suspected Viral Respiratory
k. Tetanus Immunization Protocol
l. Signs/Symptoms of Urinary Tract Infection

D. Rooming of patients
a. Patients will be roomed based off of bed availability and ESI. High risk patient should take priority for bed placement. High risk patients would include immunocompromised, seizure, respiratory distress, altered mental status, trauma, recent infant delivery, neonatal fever, or patients requiring isolation or decontamination.
b. Patients may return to the waiting room with frequent rounding.

D. Reassessment of patients in waiting room.
a. Vital to include HR, RR, Sp02 every 60 minutes.
b. Reassessment of pain every 60 minutes.
c. Reassessment of fever 60 minutes after an intervention.

VI. RELATED INFORMATION

Table 2. Vitals signs (PALS)

AGE	HEART RATE	RESP RATE	SYSTOLIC BP	TEMP (C)
Term Neonate (0-28 days)	100-205	30-60	67-84	96.8-100.4
1-12 mo	100-180	30-53	72-104	96.8-101
1 yr – 3 yr	98-140	22-37	86-106	96.8-101
3 yr - 5 yr	80-120	20-28	89-112	96.8-101
5 yr – 12 yr	75-118	18-25	97-120	96.8-101
12 yr- 18 yr	60-100	12-20	110-131	96.8-101

VII. STATEMENTS

VIII. REFERENCES

Pediatric Vital Signs Normal Ranges. Iowa Head and Neck Protocols. 2024. https://medicine.uiowa.edu/iowaprotocols/pediatric-vital-signs-normal-ranges

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