Olive View-UCLA
MEDICAL CENTER

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES

Policy Title:	**EMERGENCY DEPARTMENT TRIAGE - NURSING**		
Category:	1 - Provision of Care	**Policy No.:**	143
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Distribution:	**Hospital-Wide** ☒	**If not Hospital-Wide, Other:**	

PURPOSE:

To assess a patient's condition upon arrival to the Department of Emergency Medicine and to determine the order in which patients are referred for a medical screening examination to determine whether an emergency medical condition exists.

DEFINITION(S):

Emergency Severity Index is a five-level DEM triage algorithm that provides clinically relevant stratification of patients into five groups from 1 (most urgent) to 5 (least urgent) on the basis of acuity and 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 a patient is expected to consume in order for a disposition decision to be reached.

Initial Contact Nurse (ICN) is the first point of contact with a registered nurse, who receives the patient's chief complaint and quickly observes and decides whether the patient can or cannot wait for triage.

Electronic Record Terminology for ICN prioritization:

- Straight-to-back (STB): Patients in need of life-saving resuscitative measures.
- Priority Red/P1: Patients presenting with a chief compliant (CC) indicative of a cardiac/Acute Coronary Symptoms (ACS) event.
- Priority Green/P2: Patients presenting with a CC indicative of an acute or hyper-acute process.
- Priority Neutral/P3: All CC that are non-acute, chronic, and routine presentations.

ESI Acuity Levels: ESI Acuity Levels are used to clinically stratify patients into five groups from 1 (most urgent) to 5 (least resource intensive) on the basis of acuity and resource needs. The ESI Acuity Levels are:

Level I: Patient requiring immediate life-saving intervention
Level II: High-risk situation, confused/lethargic/disoriented, or severe pain/distress
Level III: Requires two (2) or more resources
Level IV: Requires one (1) resource

Level V: No resources required

Rapid Medical Examination (RME) is the initiation of the Medical Screening Exam (MSE) and is performed by a designated provider following triage.

MSE is the process required to reach, within reasonable clinical confidence, the point at which it can be determined whether or not an emergency medical condition exists or a woman is in labor. The scope of a MSE must be tailored to the presenting complaint and the medical history of the patient.

All persons seeking emergency care at Olive View-UCLA Medical Center will receive an appropriate MSE to determine whether an emergency medical condition exists, without regard to the person's ethnicity, religion, national origin, citizenship, age, gender, sexual orientation, pre-existing medical condition(s), physical or mental disability, insurance status, economic status, or ability to pay for medical services. (See Olive View-UCLA Medical Center Policy, "EMTALA".)

POLICY:

All patients presenting to the Olive View-UCLA Medical Center's Department of Emergency Medicine (DEM) will be triaged and assigned an Emergency Severity Index (ESI) Acuity Level by a Registered Nurse, based on presenting complaints, use of assessment criteria, information gathered during patient assessment and the ESI algorithm.

PROCEDURE:

A. **The Initial Contact Nurse (ICN) responsibilities are to:**

1. Greet patient at the point of entry.
2. Record arrival time and date on Electronic Medical Record.
3. Solicit the patient's chief complaint and document in the appropriate section of the Electronic Medical Record.
4. Escort and/or facilitate the immediate transport of all straight-to-back (STB) patients and relinquishes further triage duties to the Charge Nurse, Charge Nurse designee, or a Registered Nurse in the main Emergency Room who receives the patients.
5. Facilitate and redirect all non-STB patients to the ESI Triage Nurse.
6. The duties and responsibilities of the ICN shall be fulfilled by the Charge Nurse or designee for those patients who arrive by any means other than the front entry point of the DEM (e.g., paramedic/EMT, ambulance, clinics, DEM transfer in, etc.)

B. **SUICIDAL/HOMICIDAL ASSESSMENT**

1. Does the patient present to triage with a chief complaint or primary diagnosis of an emotional or behavioral disorder or is experiencing suicidal thoughts?
2. If "YES" –
   Assess the *Suicide Risk Factors* and *Factors that may Decrease Suicide*

3. Ask patient “Do you feel like hurting yourself?” if “Yes” then ask “Do you have a plan?” if “Yes”, then ask “Do you have the means to carry out the plan?
4. Patient is labeled an ESI 2 and brought straight back to the treatment area.
5. Notify charge nurse or designee, assign a 1:1 sitter for patient and initialize suicide precaution checklist/duties.

C. <u>12-Lead ECG Station:</u>

1. Receives the patient for ECG according to the priority level set in the Electronic Medical Record by the ICN.
2. Performs a rapid 12-lead ECG on all patients designated P1/Red in the Electronic Medical Record waiting queue and presents the results to the Triage Nurse.
3. Enters all pertinent data into the Electronic Medical Record.

D. <u>The Triage Nurse:</u>

1. Receives patients according to Electronic Medical Record queue priority assigned by the ICN, NA may obtain vital signs while Triage RN begins patient interview.
2. Confirms the patient’s CC.
3. Performs a focused and pertinent nursing assessment appropriate to the patient’s CC.
4. Assesses the patient’s initial vital signs.
5. Obtains and documents patient’s triage pain score using the triage pain assessment tool.
6. Enters all collected data, which includes but is not limited to weight (if indicated), allergies, immunizations, blood sugar, suicide risk assessment, Fall Risk assessment, and Pain assessment, in the Electronic Medical Record and prints a copy of the entry.
7. Assigns an appropriate ESI acuity level to patients based on acuity and resources required.

NOTE: The Triage Nurse may consult with the Emergency Department provider on any patient, at any time.

<u>For all ESI Level I & II Patients the Triage Nurse:</u>

1. Escorts the patient to a definitive treatment area as a STB patient.
2. Hands off patient’s care to Charge Nurse/Charge Nurse designee/receiving treatment nurse.
3. Enters patient in DEM-Electronic Medical Record track as ESI Level I or II.
4. ICN/RN enters data into the Electronic Medical Record for patients brought by EMS with ESI Acuity Level I & II, completes nursing flow sheet and identifies a treatment area assignment.

<u>For all ESI Level III Patients the Triage Nurse:</u>

1. Documents ESI acuity level III in the Electronic Medical Record.

2. Identifies patient to be assigned to the Rapid Medical Exam (RME) room.
3. Directs patient to the waiting room to be called for a RME.
4. If the RME provider, concludes that an emergency medical condition exists the patient will be sent immediately to the ED 1.
5. If the RME provider concludes that **no** emergency medical condition exists, initial diagnostic tests may be ordered, and the patient will be sent back to the waiting room.
6. When the results from the diagnostic tests are available for review or at the time of patient reassessment, the provider may disposition the patient to the main ED, another treatment area, or discharge home with or without follow-up.

For all ESI Level IV and V Patients the Triage Nurse:

1. Documents ESI acuity level IV and V in the Electronic Medical
2. Identifies patient to be assigned to Urgent Care during hours of operation or the main ED waiting room.
3. Directs/escorts patient to Urgent Care Waiting Room.
   Exception: Patients identified as ESI acuity level IV and V Minor Trauma will be assigned to the main ED.
4. When Urgent Care is not open, all ESI Level IV and V, are seen by the RME provider and the triage process for ESI Level III is followed.

E. Triage of Pregnant Patients:

Pregnant patients that are equal to or greater than 14 weeks estimated gestational age (EGA) would be escorted to OB Triage after ED triage, except for those patients identified by the OB-Triage exclusionary conditions. See DEM Triage of OB patients.

DEM personnel will transport patients to OB Triage.

F. Triage of Pediatric Patients:

1. Documents ESI acuity level I, II, III, IV, or V in the Electronic Medical Record.
2. ESI Level I and II: Follow above procedure.
3. ESI Level III: If deemed suitable for the clinic by the RME provider, or the ED Attending (in collaboration as needed with the Pediatric resident or attending, the patient may be dispositioned to the Pediatric Walk-In clinic, during normal clinic hours. The Pediatric resident or Attending will be notified, if appropriate. Registration process (quick reg) will be initiated in ED before the patient is sent to Pediatric Walk-In clinic.
4. ESI Level IV and V: Follow above procedure but patient will be sent to Pediatric Walk-In Clinic, after completion of the RME. The RME will be completed by the ED provider or assigned Pediatric resident or Attending. Registration process (quick reg) will be initiated in the ED before the patient is sent to the Pediatric Walk-In clinic.
5. Directs or escorts patient to Pediatric Walk-In Clinic.
6. After 1500 on weekdays, weekends and holidays, all Pediatric patients are treated in the DEM.

G. Triage Reassessment:

1. The Triage/Reassessment RN will reassess ESI Acuity Level III patients every four (4) hours.
2. The Triage/Reassessment Nurse will assess ESI Acuity Level IV and V patients every eight (8) hours.
3. Reassessment includes vital signs, pain and any other issues related to the patient's chief complaint.
4. Changes/pertinent findings noted during reassessment shall be reported to the RME physician or (to the Triage/Reassessment RN, if appropriate) and documented.

Attachment: ESI Implementation Handbook, Version 4, Chapter 4, ESI Level 2:Sever Pain/Distress: "The final question to address when determining whether the patient meets level 2 criteria is, "Does the patient have severe pain or distress?" The patient should be assessed for the presence of severe pain or distress. All patients who have a pain rating of 7/10 or greater should be considered for meeting the ESI level 2 criteria. *Considered* is a very important word, 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. In summary, the triage nurse assesses 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. It is important for the triage nurse to understand that the patient's self-reported pain rating is only one piece of the pain assessment. Triage nurses should assign ESI level 2 if the patient reports a pain rating of 7/10 or greater and the triage nurse's subjective and objective assessment confirms that the patient's pain requires interventions that are beyond the scope of triage, inappropriate to wait, and should be brought straight back."

ATTACHMENTS/FORMS:

None

REFERENCE(S)/AUTHORITY:

Emergency Medical Treatment and Active Labor Act ("EMTALA"), Sections 1866 and 1867 of the Social Security Act, 42 U.S.C. Sections 1395(dd) and 4716

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