MSH Emergency Department

EMS Triage RN

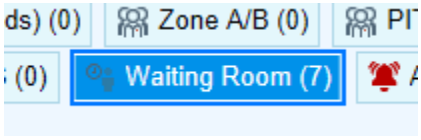
Last Reviewed: 3/11/2022

Description of Process:

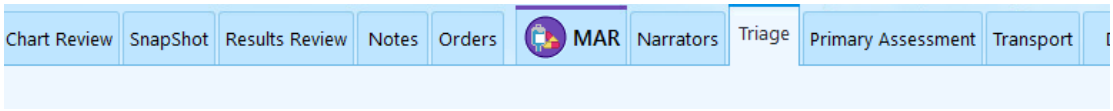
The goal of the Triage RN at the EMS entrance is to obtain sufficient information to rapidly triage patients, appropriately identify high acuity patients, and activate clinical protocols when necessary.

Triage Instructions:

1. Greet Patient and obtain chief complaint.
2. Open patient's "Triage A" Documentation.
    a. Click on patient's name in waiting room.

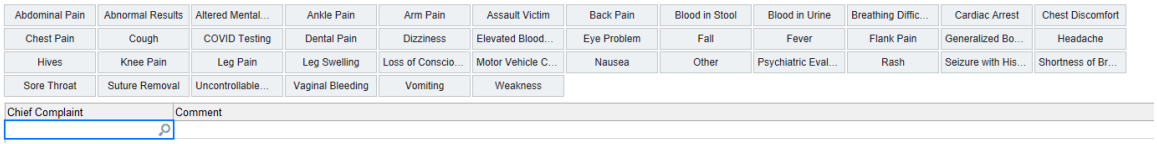


    b. Click Triage Tab (if not already selected. Select "Triage A" if not already selected.



3. Complete the sections under "Triage A"

    a. **Chief Complaint**- select from list or use the magnifying glass to search



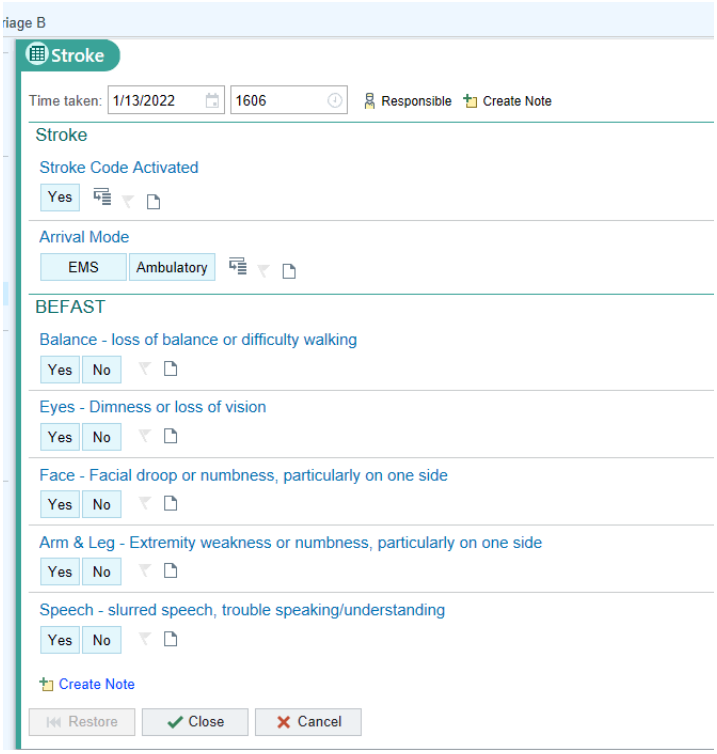
    b. **Language**- Click ✚ New Reading and search for patient's preferred language in the box. Language will autofill based on what you type.

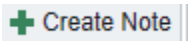
    c. **Mental Status**- Click ✚ New Reading and determine level of consciousness, orientation level, and cognition level.

    d. **ED Surveillance**-Click ✚ New Reading Complete section to identify infectious disease risk.

    e. **Prehospital Treatment**- Click ✚ New Reading to enter any prehospital treatment that was provided (ex. Sling, medications, etc.)

f. **Stroke**- Complete BE-FAST assessment for patients presenting with stroke like complaints. See Escalation protocols for positive screen instructions.



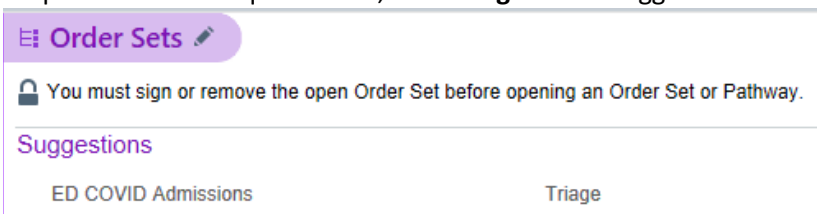
g. **Triage Note**- Click 

and document any pertinent history, abnormal findings, recent procedures, arrival method, wheelchair/ambulatory status, and isolation status if applicable

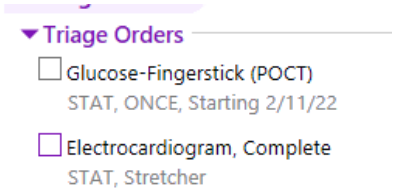
h. **Suicide Risk Assessment**- complete if chief complaint is Suicidal Ideation, see escalation protocols for positive assessment

i. **Order Sets**- used to enter orders for Rapid EKG or Glucose Finger stick.

   i. If patient meets requirements, click **Triage** under Suggestions.



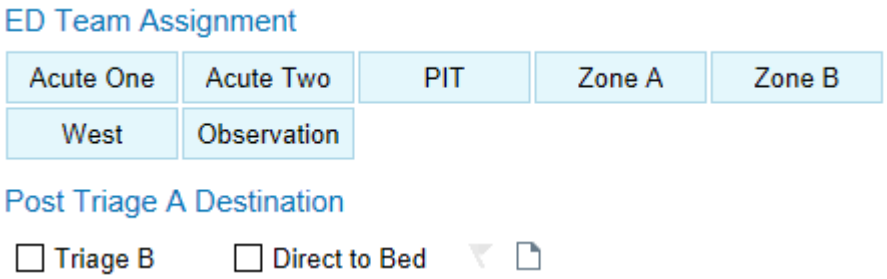
ii. Select appropriate order under Triage Orders.



iii. Click Sign Orders. Enter name of Zone A Attending in **Authorizing Provider**. Click **Accept**.

j. **ESI and Assignment**- Determine patient's ESI and click corresponding number. See below for Team assignment and Post Triage A Destination instructions.

4. Determine patient destination



a. **Resuscitation- (see Resus Triage Criteria)**
   i. Under **ED Team Assignment** Select "Acute One" or "Acute Two", and under **Post Triage A Destination** select "Direct to Bed.
   ii. Overhead page by pressing *697. Press "00" when prompted
      1. Say "Clinical Upgrade to Resus from Welcome Desk" or "Clinical Upgrade to Resus from EMS"
   iii. Under Clinical Upgrade, click "Yes"

   iv. **Provide verbal bedside handoff to care team in Resus**

b. **Acute 1 and 2-**
   i. Under **ED Team Assignment,** select "Acute One" or "Acute Two", and under **Post Triage A Destination** select "Direct to Bed.
   ii. Obtain bed assignment and instruct ERT to escort patient to Zone
   iii. Provide Handoff to Care Team
      1. ESI 2- Vocera Acute Captain
      2. ESI 3, 4, 5- Triage note will be used for handoff. (If ESI 4 or 5, send to Zone A/Express Care during operating hours (M-F 9a-5p))

c. **Pediatrics (Zone G) –**
   i. Under **ED Team Assignment** Select Zone G, and under **Post Triage A Destination** select "Direct to Bed".
   ii. Direct ERT to escort patient to Zone G
   iii. Provide Handoff to Care Team
      1. ESI 1- Overhead for Pediatric Resuscitation and provide bedside handoff
         a. Overhead page by pressing *697. Press "00" when prompted.
         b. **Say "Pediatric Resuscitation from EMS"**
      2. ESI 2- Vocera Zone Captain for handoff
      3. ESI 3, 4, 5- Triage note will be used for handoff

d. **Zone A-**

Exclusions*: Patients < 21 years of age, ESI 1 and 2, Patients who **must** be in a stretcher, patients who require 1:1 observation, patients presenting with Altered mental status, acute agitation or intoxication w/ gait instability.

*Exclusion criteria may be changed based on circumstances impacting the department. Changes will be communicated by department leadership as needed.

   i. Determine if Zone A has direct to bed capacity by contacting Zone A Captain via Vocera or Epic Secure Chat.
   ii. If Zone A has direct to bed capacity, under **ED Team Assignment** Select "PIT", and under **Post Triage A Destination** select "Direct to Bed"
      1. Direct ERT to escort patient to Zone A
      2. Ensure Triage Note has been completed for handoff
   iii. If Zone A does not have direct to bed capacity: Under **ED Team Assignment** Select PIT, and under **Post Triage A Destination** select "Triage B" (by Triage RN 2).
      1. Direct ERT to escort patient to welcome desk
      2. Provide Handoff to Triage 2 RN via Vocera.

e. **Pregnant and Post-Partum Patients**
   i. See Escalation Protocols.

f. **Patients with psychiatric complaints**
   i. See Escalation Protocols.

5. Complete Remaining Documentation

a. **Mass Casualty or Disaster**- only use when instructed to do so by ANM, Charge RN, or other leadership.

b. **Treatment in Triage A-** Select if patient was given a mask and/or if patient was placed in isolation based on ED Surveillance screening

c. **ID Band On-** Confirm patient ID band has been placed on patient

Escalation Protocols

Contents:

- Labor and Delivery – For Pregnant or Post-Partum Patients
- Psychiatric Emergencies
- SAFE Protocol- Chief complaint of sexual assault
- Rapid EKG/STEMI Protocol
- Stroke Protocol

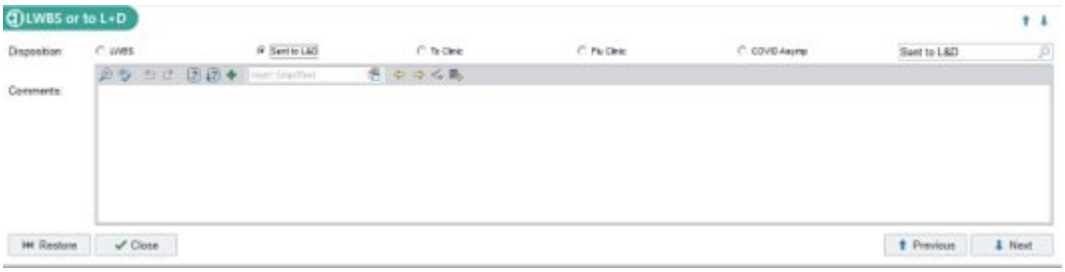
Labor and Delivery – For Pregnant or Post-Partum Patients

1. Obtain VS
    a. Assess for Maternal Hypertension:
    b. BP >140/90 with symptoms or >160/110 without symptoms, pregnant or within 6 weeks of delivery
    c. Triage patient to RESUS

2. Assess if patient meets criteria for triage to L&D
    a. Criteria: 20 weeks and above stable condition
    b. Pt must have OB complaint
    c. No concern for infectious/contagious disease
    d. If traumatic injury, see RESUS trauma criteria

3. Call L&D at x45501 to provide SBAR handoff
    a. S- Patient name, chief complaint, gestational age
    b. B- What number baby (parity)?, where does the patient get her care? (they want to know if she is registered or unregistered to us)
    c. A-Pain/CTX? Vaginal bleeding? Leakage of fluid? V/S-(if taken)?
    d. R-Patient disposition-(Based on the clinical situation and policy, should the patient be transferred to L&D or should our team consult the patient in the ED).

4. **All patients must be escorted to L&D by ERT**
    a. If patient is having contractions every 3-5 minutes, patient must accompanied by resident.
5. Under “LWBS or to L+D”, document disposition as “Sent to L&D” and discharge off board



Psychiatric Emergencies

1. If patient is less than 13 years old, patient will go to the pediatric emergency room on 1:1 observation.
    a. Call Security at x46068 for search and escort. ALL belongings to be searched by security.
    b. Accompanied to Pediatrics by ERT 2 with Security.
    c. Notify Zone Captain & Attending:
        i. Provide Chief Complaint, History, 1:1 status

2. If patient is 13 years old and above with psychiatric chief complaint:
    a. Obtain VS
    b. May need medical clearance dependent on medical history, VS or if patient has medical complaint

3. If patient does not quality for direct to west/not medically cleared:
    a. Notify security to remove patient belongings (x46068)
    b. ERT stays with patient until 1:1 assigned
    c. Notify Charge RN
    d. Follow handoff procedure to primary RN

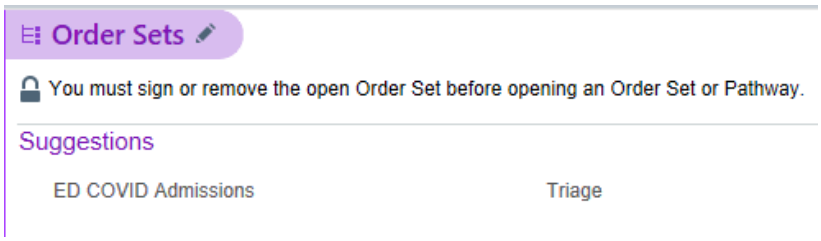
4. If patient qualifies for Psychiatric Emergency Department, Call x47147 to provide handoff. Provide:
    a. Chief Complaint
    b. Vital Signs
    c. PMH/Past Psychiatric Hx
    d. SI/HI/AH/VH

5. Call Security at x46068 for search and escort. ALL belongings to be searched by security. Complete security form.

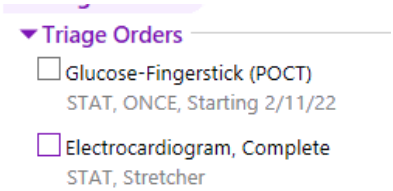
6. Direct ERT to accompany to psychiatry with security.

Rapid EKG- If patient meets RAPID EKG criteria:

1. Notify ERT of rapid EKG order
2. Place order for EKG in the Order Sets section of Triage A
    a. Select Triage



    b. Select "Electrocardiogram, Complete"



    c. Click Sign Orders. Enter name of Zone A Attending in **Authorizing Provider**. Click **Accept**.
3. Acute 1 provider to Review EKG to determine if STEMI or Non STEMI.
    a. If patient is triaged to Resus, Resus provider will review EKG.

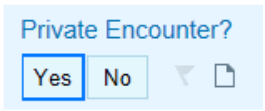
4. **If concern for STEMI, determine Acute 1 or 2 team**

    a. Overhead page by pressing *697. Press "00" when prompted
    b. Say "STEMI ALERT Acute (1 or 2)

5. If no concern for STEMI, direct patient to Zone A for follow up.

SAFE/"Code 11"- Chief complaint of sexual assault (See Sexual Assault and Intimate Partner Violence policy in Epic Documents)

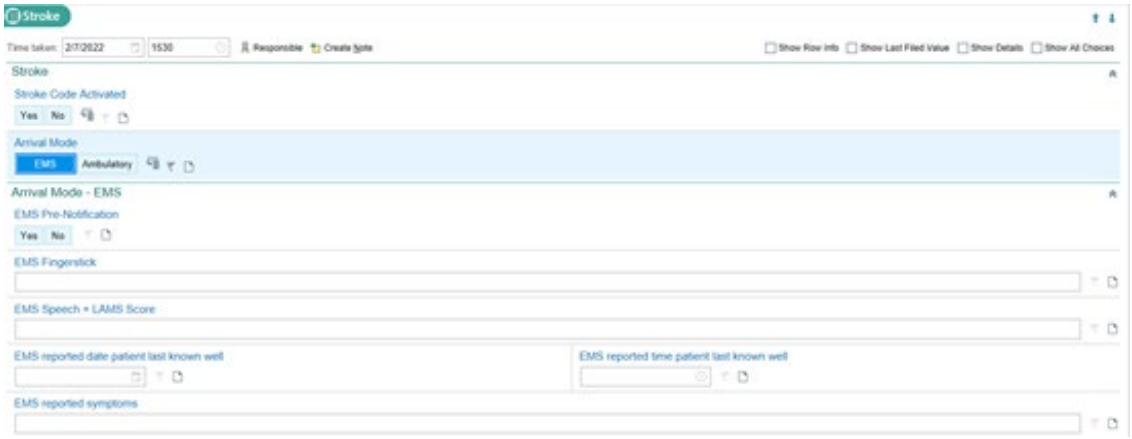
1. Once identified, immediately place patient in private room (Zone A room 112 preferred).
2. In Triage tab, under Private Encounter Flag, click "Yes" to hide patient's name from track board



3. Obtain chief complaint and limit intake of medical history unless medically necessary. This is to reduce patient having to repeat story.
4. Notify Charge RN
5. Notify Attending in Area**. Attending will call AMAC for SAVI/SW.**
6. Do not have the patient change, eat or drink anything.

Stroke: Based on BE-FAST assessment and last known well of up to 24 hours.

1. Complete BE-FAST Assessment
   For positive screens, Call x**33333** to activate stroke team. Provide:
   a. Patient Name
   b. Your Name and Role
   c. Location (ED Welcome Desk or ED EMS)
2. Overhead page by pressing ***697**. Press "**00**" when prompted
   a. Say **"Stroke Code (Location), (Team assignment)"**
3. Obtain Finger stick
4. Obtain vital signs if not already obtained by ERT. Vital signs must not be delayed.
5. Complete stroke documentation:
   a. **Stroke Code Activated**- click "Yes"
   b. **Arrival Mode**- click EMS
   c. EMS Pre-notification- Click "yes" if received pre notification from EMS
   d. EMS Fingerstick- Enter fingerstick value obtained from EMS
   e. EMS Speech + LAMS Score- Enter Speech and LAMS score obtained from EMS
   f. EMS Last known well date and time- Enter time and date of when patient was last known to be well according to EMS
   g. **EMS reported symptoms**- Enter symptoms as reported by EMS



   h. Provide handoff to stroke resident and nurse

Escalations for Patient Arrivals

1. If more than 5 patients are waiting for Triage, escalate to Charge RN