MSH Emergency Department

Welcome Desk Triage RN 2

Last Reviewed: 4/22/2022

Description of Process:

The goals of the Triage RN 2 at the Welcome Desk are to:

1. Carry out escalation tasks for patients requiring immediate care. Triage RN 2 must always prioritize the completion of escalations (ex. Stroke, STEMI, etc.)
2. Work closely with BA 2 to complete initial triage and register patients when number of patients waiting to be triaged exceeds **4**.
3. Complete additional documentation for patients waiting to be roomed in Zone A.

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
    - Assess for Maternal Hypertension:
        - BP >140/90 with symptoms or >160/110 without symptoms, within 6 weeks of delivery
    - Triage patient to RESUS

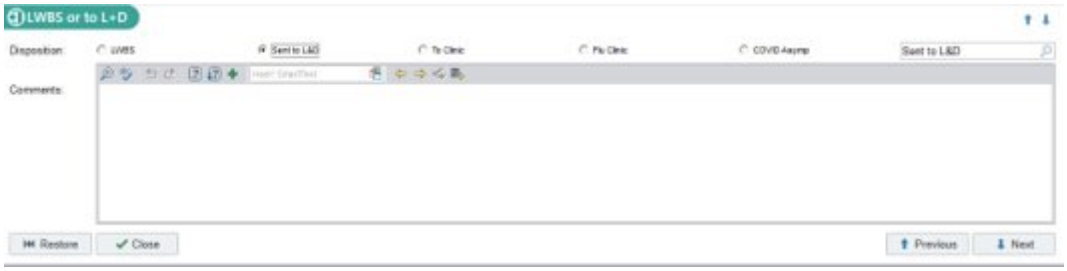
2. Assess if patient meets criteria for triage to L&D
    - Criteria**:** 20 weeks and above **stable** condition
    - Pt must have OB complaint
    - No concern for infectious/contagious disease
    - If traumatic injury, see RESUS trauma criteria

3. **Call L&D at x45501** to provide handoff
    - **S-** Patient name, chief complaint, gestational age
    - **B-** What number baby (parity)?, where does the patient get her care? (they want to know if she is registered or unregistered to us)
    - **A-**Pain/CTX? Vaginal bleeding? Leakage of fluid? V/S-(if taken)?
    - **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 2**

- 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. Receive handoff from Triage RN 1

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

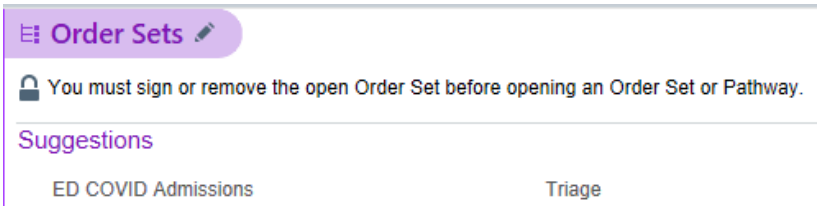
3. If patient is 13 years old and above with psychiatric chief complaint
   - Obtain VS
   - May need medical clearance dependent on medical history, VS or if patient has medical complaint
4. If patient does not quality for direct to west/not medically cleared:
   - Notify security to remove patient belongings (x46068)
   - ERT stays with patient until 1:1 assigned
   - Notify Charge RN
   - Follow handoff procedure to primary RN

5. If patient qualifies for Psychiatric Emergency Department, Call x47147 to provide handoff. Provide
   - Chief Complaint
   - Vital Signs
   - PMH/Past Psychiatric Hx
   - SI/HI/AH/VH
     -
6. Call Security at x46068 for search and escort. ALL belongings must be searched by security. Complete security form

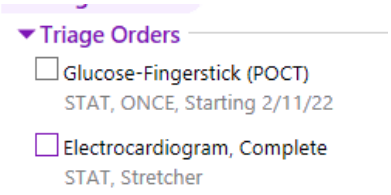
7. Direct ERT 1 to accompany to psychiatry with security

Rapid EKG/STEMI Protocol- If patient meets RAPID EKG criteria:

1. Confirm EKG ERT is aware of rapid EKG order
2. Confirm order for EKG was placed. If not, place order.
    a. In the Order Sets section of Triage B documentation, select Triage



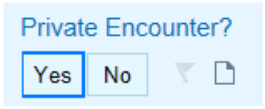
    b. Select "Electrocardiogram, Complete"



    c. Click Sign Orders. Enter name of Zone A Attending in **Authorizing Provider**. Click **Accept**.
3. Review EKG to determine if STEMI or Non STEMI.
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)

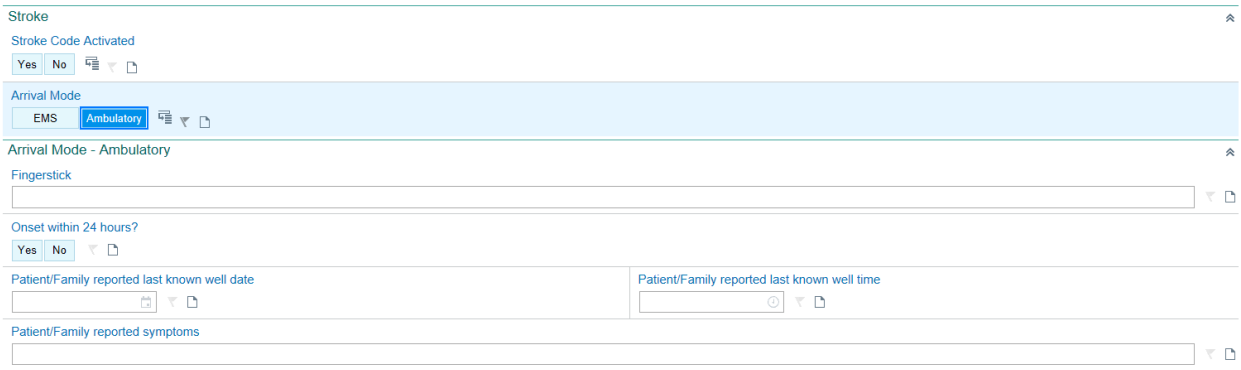
1. Once identified, immediately place patient in private room (Zone A room 112 preferred).
2. In Triage tab, under Private Encounter Flag, click "Yes" to hide patient's name from track board



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. Ensure BE-FAST Assessment was completed
2. If Stroke Team was not activated by Triage RN 1:
    a. Call **33333** to activate stroke team. Provide:
        i. Patient Name
        ii. Your Name and Role
        iii. Location (ED Welcome Desk)
    b. Overhead page by pressing *697. Press "00" when prompted
        i. Say " Stroke Code (Location), (Team assignment)"
            1. Location: Welcome Desk
            2. Team assignment: Acute 1 or Acute 2
3. Obtain finger stick.
4. Obtain vital signs if not already obtained by ERT 1. Vital signs must not be delayed.
5. Complete stroke documentation:
    a. **Stroke Code Activated**- click "Yes"
    b. **Arrival Mode**- click Ambulatory
    c. Finger stick- Enter finger stick value
    d. Onset within 24 hours- Click "Yes" if symptom onset was within 24 hours of arrival to the ED
    e. Patient/Family Last known well date and time- Enter time and date of when patient was last known to be well according to patient or family member
    f. **Patient/Family reported symptoms**- Enter symptoms as reported by patient or family member

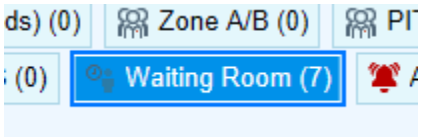


    g. Provide verbal handoff at bedside to stroke resident and nurse

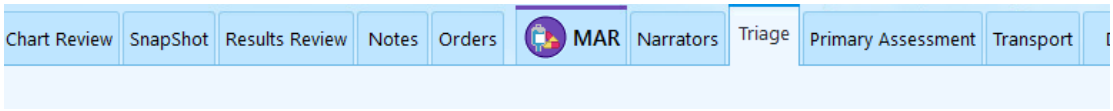
Initial Triage Instructions:

When more than **4** patients are waiting to be triaged:

1. Greet Patient and obtain chief complaint.
2. Once Quick Registration is completed by BA, open patient's "Triage A" Documentation.
    a. Click on patient's name in waiting room.

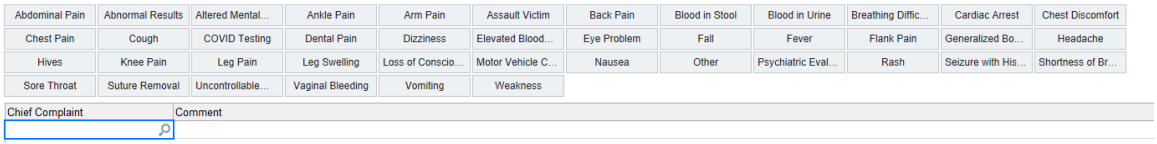


    b. Click Triage Tab (if not already selected. Select "Triage A" if not already selected.



3. Complete the sections under "Triage A".

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



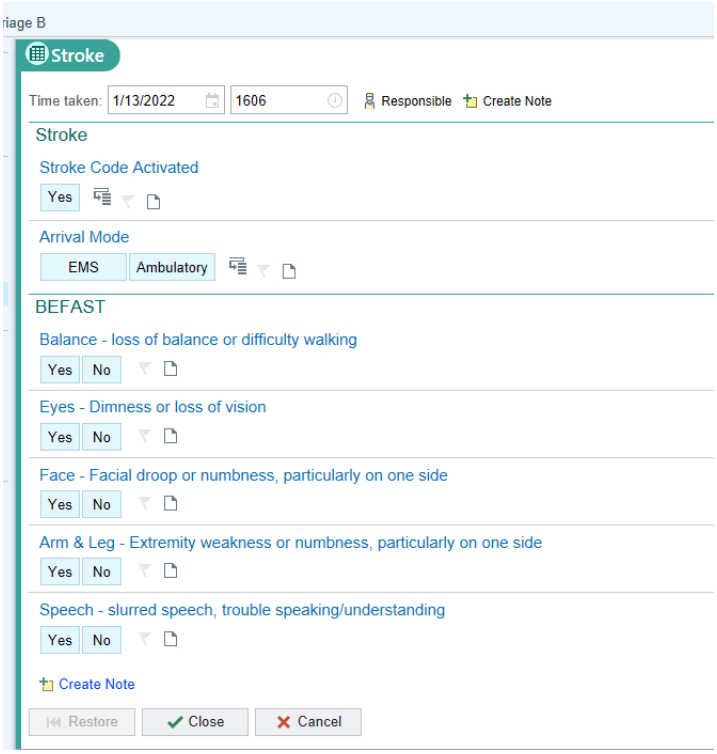
    b. **Language**- Click ✚ New Reading and search for patient's preferred language in the box. Language will autofill based on what you type.

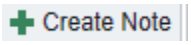
    c. **Mental Status**- Click ✚ New Reading and determine level of consciousness, orientation level, and cognition level.

    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.



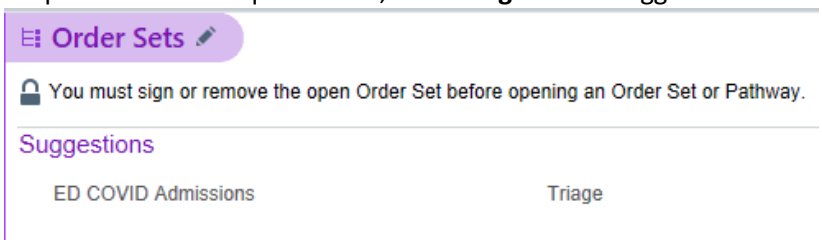
g. **Triage Note**- Click 

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

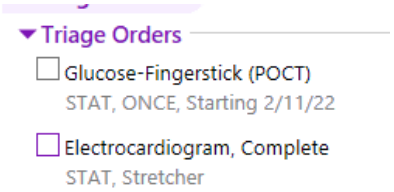
h. **Suicide Risk Assessment**- complete if chief complaint is Suicidal Ideation, see escalation protocols for positive assessment.

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

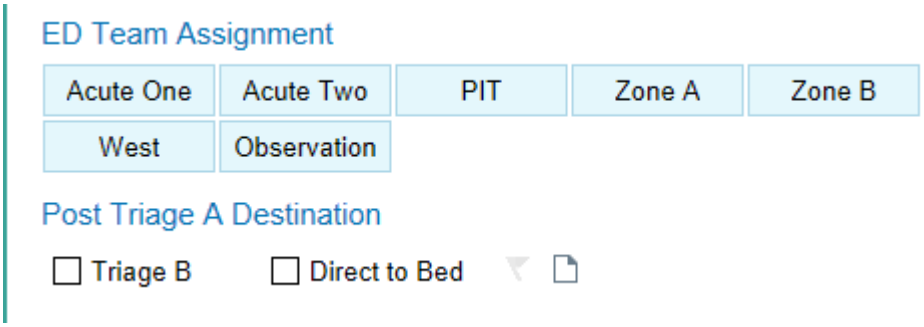
4. Determine if patient can go directly to Zone A**.** Most patients will go to Zone A and go through the PITT process.

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 affecting the department. Changes will be communicated by department leadership as needed.

b. Under **ED Team Assignment** Select "PIT", and under **Post Triage A Destination** select "Direct to Bed"
Direct patient to Zone A.

c. Ensure Triage Note has been completed for handoff



d. 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". Ask patient to remain in the waiting room.

5. Determine alternative ED destination

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

   b. **Acute 1 and 2-**
      - **i.** Under **ED Team Assignment** Select "Acute One" or "Acute Two", and under **Post Triage A Destination** select "Triage B".
      - ii. Refer patient to triage RN 2 for handoff and bed assignment

   c. **Resuscitation- (see Resus Triage Criteria)-**
   ***Patients meeting criteria go directly to Resus. DO NOT send to Triage RN 2

      - 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. Refer patient to Triage RN 2 for verbal bedside handoff to care team in Resus.**

   d. **Pregnant and Post-Partum Patients**
      - i. See Escalation Protocols. Identify patient per criteria and handoff to Triage RN 2 for completion of protocols.

   e. **Patients with psychiatric complaints**
      - i. See Escalation Protocols. Identify patient per criteria and handoff to Triage RN 2 for completion of protocols.

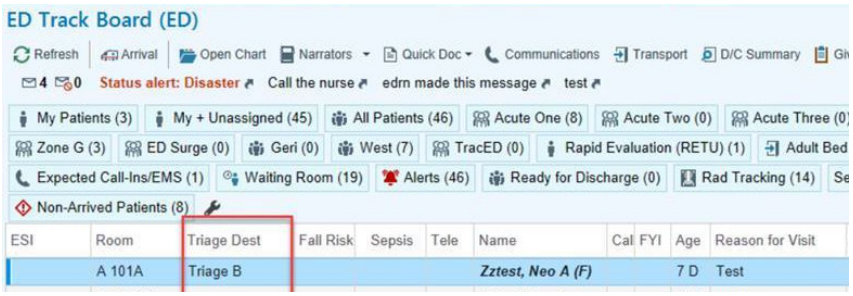
6. Complete Remaining Documentation

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

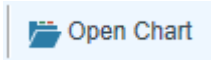
   b. **Treatment in Triage A-** Select if patient was given a mask and/or if patient was placed in isolation based on ED Surveillance screening
   c. **ID Band On-** Confirm patient ID band has been placed on patient

Secondary Triage Instructions for Patients waiting for Zone A:

7. Triage patients based on acuity then length of stay.
    a. Review the "Needs Triage" or "Waiting Room" track board for patients who have "Triage B" listed under triage destination.

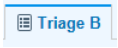


    b. Double click on the patient's name or click "Open Chart"



    c. Call patient to desk. Be mindful of preferred name and pronouns.

8. **Introduce yourself and confirm patient ID and band placement. Ask patient to state their full name and date of birth.**

9. Complete "Update Triage A documentation" section.
    a. Click 

on the triage tab
    b. Confirm Triage A documentation has been completed

10. Complete "Triage B documentation" section

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

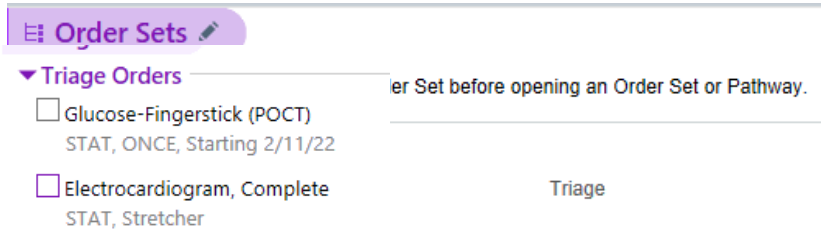
b. **Prehospital Treatment**- Click ✚ New Reading to enter any prehospital treatment that was provided (ex. Sling, medications, etc).

c. **Vitals**- For direct to bed patients, vital signs will be completed in the zone. For patients who go to Triage 2, ERT 1 should obtain vital signs. If ERT 1 is unavailable, Triage RN 2 should obtain vital signs.

d. **Allergies-** If the patient has any known allergies, click ✚ Add to document the appropriate agent. Allergen will autofill based on what you type. If no known allergies, check ☐ No Known Allergies.

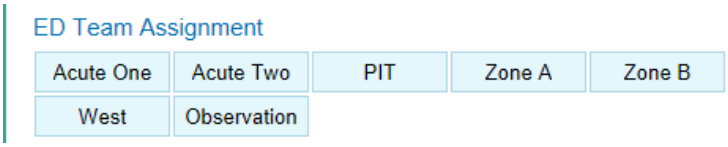
e. **Allergy band-** If patient has a known allergy, apply the allergy band and click "Yes" under Allergy Band applied. If the patient cannot have a band placed, click "No". If the patient does not have known allergies, click "N/A".

f. **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**.

11. Complete “Triage B End” documentation section
    a. **Treatment in Triage-** check off any treatments that were provided in triage
    b. **Update Triage Plan-**
        i. **ESI-** Update ESI if needed
        ii. **ED Team Assignment-** Updated if needed.



    c. **Clinical Upgrade**- Click “Yes” only if patient is direct to Resus
    d. **Mass Casualty or Disaster**- only use when instructed to do so by ANM, Charge RN, or other leadership.
    e. **ID Band On-** Confirm patient ID band has been placed on patient
    f. **Allergy Band Applied-** Confirm patient allergy band has been placed on patient
    g. **End Triage B-** click “End”

12. Handoff to Zone
    a. **Zone A**
        i. Ensure ED Team Assignment is “PITT”
        ii. Direct patient into Zone A. Direct ERT to escort patient if needed.
        iii. Provide Handoff:
            1. **ESI 2- Vocera to Zone A Captain**
            2. ESI 3,4,5, provide handoff to Care Team using Triage note
    b. **Acute 1 and 2**
        i. Ensure ED Team Assignment is “Acute 1” or “Acute 2”
        ii. Provide Handoff
            1. ESI 2- Vocera Zone Captain
            2. ESI 3, 4, 5- Use Triage note for handoff
        iii. Obtain patient Primary RN bay assignment
        iv. Inform ERT 2 of location for transport to zone

13. Escalate when 6 or more patients are waiting for secondary triage