MSH Emergency Department

Welcome Desk Triage RN 1

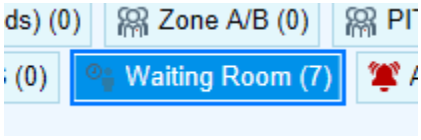
Last Reviewed: 4/22/22

Description of Process:

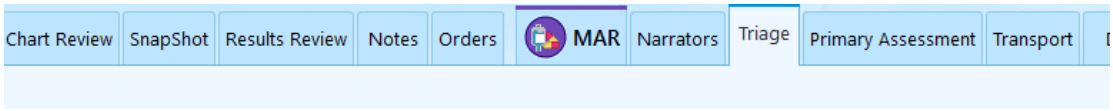
The goal of the Triage RN 1 at the Welcome Desk is to obtain sufficient information to rapidly triage patients, appropriately identify high acuity patients, and activate clinical protocols when necessary.

Triage Instructions:

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

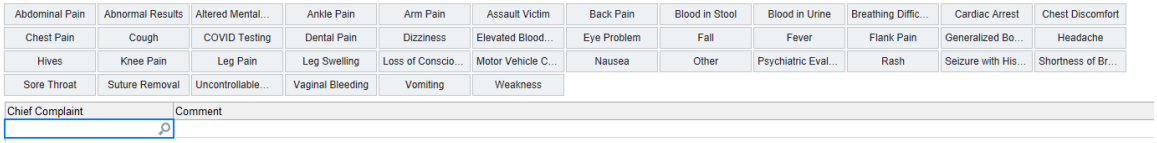


    b. Click Triage Tab (if not already selected. Select "Triage A" if not already selected.



3. Complete the sections under "Triage A".

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



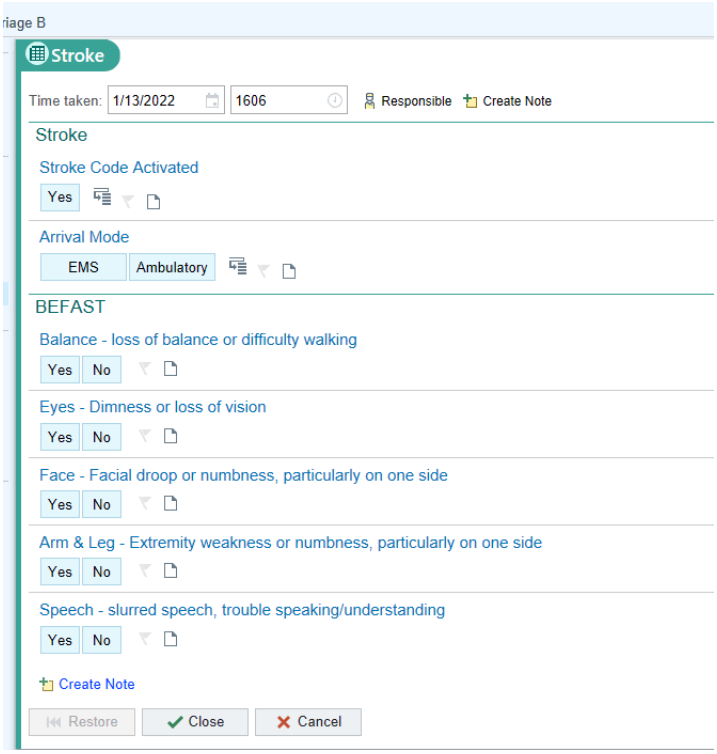
    b. **Language**- Click ✚ New Reading and search for patient's preferred language in the box. Language will autofill based on what you type.

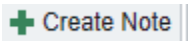
    c. **Mental Status**- Click ✚ New Reading and determine level of consciousness, orientation level, and cognition level.

    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.



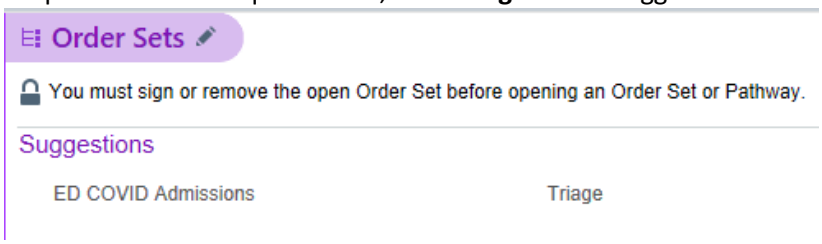
g. **Triage Note**- Click 

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

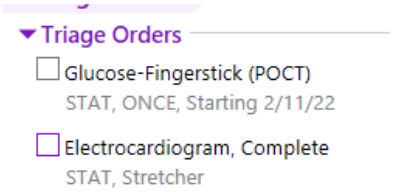
h. **Suicide Risk Assessment**- complete if chief complaint is Suicidal Ideation, see escalation protocols for positive assessment.

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

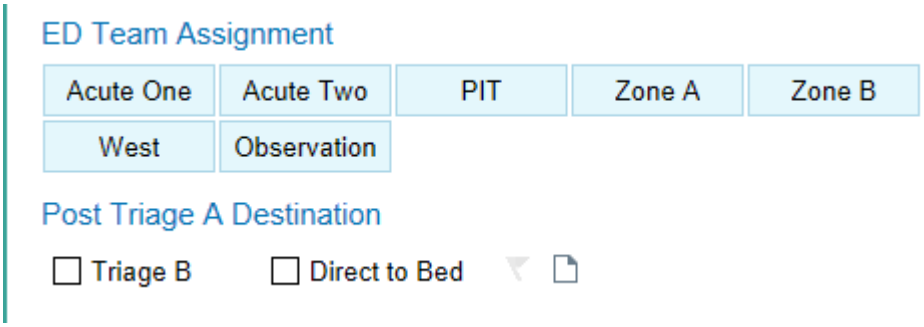
4. Determine if patient can go directly to Zone A**.** Most patients will go to Zone A and go through the PITT process.

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 impacting 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

Escalation Protocols

Contents:

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

Labor and Delivery – For Pregnant or Post-Partum Patients

1. 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

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

3. If patient meets criteria for L&D, Provide handoff to Triage RN 2 for completion of handoff to Labor and Delivery

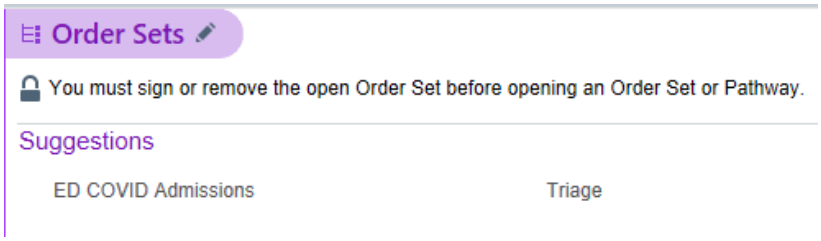
4. If patient does not meet criteria for L&D, determine next care location according to triage protocol

Psychiatric Emergencies

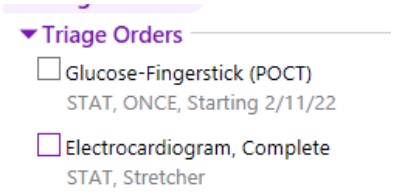
1. If patient **is less than 13 years old**, patient will go to the pediatric emergency room on 1:1 observation.
    a. Under **ED Team Assignment** Select Zone G, and under **Post Triage A Destination** select "Triage B".
    b. Handoff to Triage B for completion of remaining protocol steps
2. If patient **is 13 years old and above** with psychiatric chief complaint, handoff to Triage RN 2 for completion of protocol

Rapid EKG- If patient meets RAPID EKG criteria:

1. Notify EKG 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"



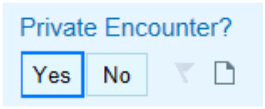
    c. Click Sign Orders. Enter name of Zone A Attending in **Authorizing Provider**. Click **Accept**.

3. Handoff to Triage RN 2 for completion for protocol

4. **If patient is triaged to Resus and meets Rapid EKG criteria, EKG should be conducted at bedside in Resus. Include need for Rapid EKG in handoff to Resus team.**

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

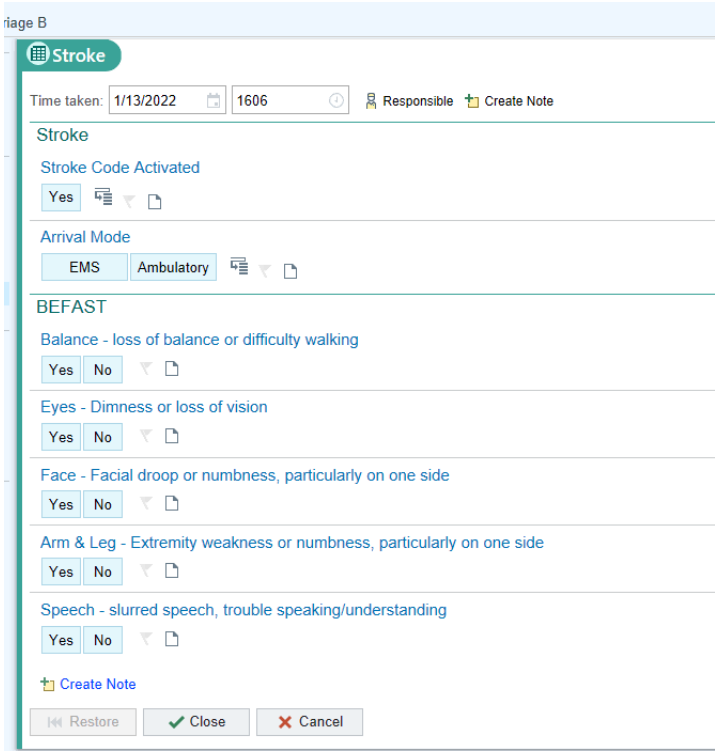
1. Once identified, immediately place patient in private room (Zone A room 112 preferred).
2. In Triage A, under Private Encounter Flag, click "Yes" to hide patient's name from track board.



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



2. Call **33333** to activate stroke team. Provide:
    a. Patient Name
    b. Your Name and Role
    c. Location (ED Welcome Desk)
3. Overhead page by pressing ***697**. Press "**00**" when prompted
    a. Say **" Stroke Code (Location), (Team assignment)"**
    b. For Pediatrics: Stroke code Welcome, pediatrics
4. Send patient to Triage RN 2 with verbal handoff for completion of protocol

Escalations for Patient Arrivals

1. If more than 6 patients are waiting for Triage 1, contact Charge Nurse.