POLICY ON HOSPITAL OPERATIONAL TRIAGE SYSTEM (H.O.T.S)

POLICY NO: ER-009

DIVISION: NURSING SERVICE DIVISION

SECTION: E.R TRIAGE

POLICY REVIEW DATE: July 12, 2016

Reviewed by:		
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OBJECTIVES: This policy shall aim to:

a. Provide an effective and accurate distinction between those patients who have immediate medical and nursing needs from those who can safely wait without compromising their health;
b. Make speedy clinical assessment of each patient based on accepted levels of evaluation to reduce emergency room waiting time;
c. Determine if patient is appropriate for a given level of care and to ensure that hospital resources are utilized effectively.
d. Manage and treat cases that will lessen ER census and provide faster disposition of the patient.

COVERAGE: This policy shall cover the medical, nursing, admitting and security staff of the Emergency Room.

RESPONSIBILITIES:

I. It shall be the responsibility of the **Overall Team Leader** (Triage Physician) to ensure the efficiency of this policy. He shall determine in conjunctions with the hospital's admitting staff, what beds are available for optimal utilization of resources in order to provide safe care to all patients. He shall either refer patients for admission to ER physician on patients needing admission or from other physicians taking care of patients from other floors who can be transferred because they no longer need that level of care. He shall manage some cases under the management of the Triage Department and elevate cases initially managed but no improvement noted.

II. It shall be the responsibility of the **Triage Head Nurse** to supervise directly the Nursing Team. He shall monitor and evaluates effectively of the various guidelines into the working policy of the HOTS hand in hand with the Overall Triage Team Leader.

III. It shall be the responsibility of the Triage Nurse to evaluate patient's condition as well as any changes, and shall determine their priority for admission to the Emergency Room and also for initial treatment at the triage area. He/she shall provide accurate triage coding/ category and overshoot the overcrowding of patients in the waiting area. He/she may ask for the charge nurse or Supervisor to reassess the situation.

IV. It shall be the responsibility of the **Admitting Staff** to constantly update the ER/Triage physician of availability of beds for optimal utilization of resources to avert overcrowding at the emergency Room.

V. It shall be the responsibility of the hospital **Security Staff** to assist the Triage Nurse in maintaining the peaceful and orderly flow of patients in waiting and treatment areas. He shall ensure the safety of all staff in the area at all times.

PROCEDURE:

I. Upon consultation, the Triage Nurse shall assess briefly the patient.

II. The Triage nurse documents the reason of visit, current medications taken and all allergies of the patient. He/she shall record on the appropriate Triage form the following vital signs of the patient:
   a. Level of Consciousness (i.e. critical/stable/potentially stable)
   b. Pulse Rate
   c. Breathing (Respiratory Rate)
   d. Skin Temperature
   e. Blood Pressure Pain Scale

III. Triage Nurse categorizes the case and tags patient chart using the five (5) Levels of Priority:

CODE - denotes patient who has suffered from cardiac arrest outside of the hospital or someone whose vital signs crash within the Emergency Department. This category also includes people with gunshot wound with possible vital organ involvement and/or altered or absent vital signs.

CRITICAL - denotes a patient with stable vital signs who is exhibiting symptoms or who gives a history that clearly delineates life threatening condition. This might be a patient with chest pain, shortness of breath and profuse sweating (diaphoresis). May include people who have history of vomiting of blood, multiple traumas with head injury, or gunshot or stab wound, diabetic with respiratory distress, skin rashes with respiratory distress, increase BP with weakness, facial asymmetry, and severe dehydration.

URGENT - Represents patients with serious condition requiring medical intervention within two (2) hours. Doctors should see the patient within the hour and patient not made to wait for hours. These are patients with abdominal pain, high fever and/or productive cough,

deep lacerations (3cm and above) with bleeding under control, closed fracture with deformity, and so on. If made to wait due to overwhelming cases, the Triage Nurse shall be obliged to monitor such patients for changes in symptoms with vital signs at least every hour. Patient should be lying on a stretcher and not sitting on the chair, increased BP (symptomatic), VA with head injury (as vomiting), and moderate dehydration.

NON-URGENT DISABLED - The non-urgent disabled individuals, unable to walk or remain in a chair, and those for whom Triage Nurse determines that up to four (4) hours wait is clinically acceptable. The nurse places these people on a stretcher for comfort and safety. Sometimes the disability relates to the presenting problem, such as herniated disc causing severe low back pain. With others, disability does not seem related as in dislodged feeding tube, or bladder urine draining tube, increased BP (asymptomatic, ambulatory), VA with head injury (ambulatory), fever below 39 °C (moderate/ low grade fever), mild dehydration, laceration (2-3cm).

AMBULATORY - This group of patients make up the majority of the waiting room population. Those that do not need emergency care which may include cold, toothaches, headaches, bumps, bruises, abrasions, small lacerations, skin rashes, diarrhea without dehydration, and so on.

IV. Triage Nurse shall alert the Triage/ ER Physician about the patient's condition as to the levels of priority. He/she shall ask the relative of the patient to secure a record at the admitting section.

V. Triage/ER Physician shall let patients know their treatment priority once they are triaged. After proper evaluation, decision on manner of disposition (admission to ward, discharge with home instruction or transfer) must be swift so as patients do not suffer through long waiting time.

VI. Triage Nurse shall direct patient flow according to priority levels. He/she shall keep track of the amount and classification of treated patients.

VII. Triage Nurse shall ask the assistance of the security staff to ensure that patients know their destinations instead of allowing them to wander of as valuable time is lost attempting to locate patients and/or relatives for procedures or instructions.

VIII. The Triage action officer must always be available for the patients and relatives to allay their worries and anxieties and solve problems concerning treatment, procedures and handle complaints.

IMPORTANT REMINDERS:

a. Listen to your patient's chief complaint. If in doubt, ask or validate.
b. Do not refuse patient or send them away. Be aware of the risk management.
c. Always be a patient advocate. Keep in mind their rights and privacy.
d. Keenly observe the non-verbal and verbal presentation. Develop clinical eye and ears for hidden symptoms by gathering patient history.

OPD Endorsement:

a. After OPD hours, the OPD Nurse shall endorse all the patients and their charts that were untreated with complete vital signs.
b. In case OPD will transfer patient at triage during OPD hours, the OPD Nurse shall accompany the patient with the latest V/S and endorse it to the triage nurse.

Emergency Transfer:

In case of walk –in patient for emergency transfer, after the assessment of the Triage doctor, the triage staff will provide the temporary OPD chart and obtain the initial vital signs and necessary information, secure patient's signature and bring the chart to the admitting section for recording.

OB Cases:

All OB cases with prenatal check up at the OPD will not require triaging. The triage nurse should endorse the patient at the ER. Only walk-in patients will be triaged before endorsing to the ER Staff.

Medico-legal Cases:

Medical clearance for inquest, self-inflicted, sexual abuse, alcoholic intoxication, labor incidents, vehicular accidents are considered medico-legal cases. The Triage Nurse must ask the patient/relative to secure chart at the admitting section for medico-legal chart/form.

Clinical Cases under the Management of the Triage team:

1. All cases of fever without episode of convulsion in adults and children.
2. Rise in blood pressure without accompanying symptoms of bleeding, chest pain and diaphoresis.
3. Ambulatory and/or wheelchair-borne patients in pain (acute or chronic) with stable vital signs (**Code GREEN**)
4. Consultations coded **ORANGE** before and after OPD hours to include change in foley catheter or injections with proper doctor's prescription.
5. Diarrhea with mild to moderate cases of dehydration.
6. Insect or animal bites with no signs of compromise in vital signs.
7. Consultations of head injury with stable vital signs and no open wounds.
8. Allergic reactions to food or drugs with stable vital signs.
9. Newborn delivered in lying0in with proper referral for antibiotic prescription due to TMS.
10. Acute attacks of respiratory wheezing with mild rise in respiratory rate and BP.

NOTE: In the above cases, ancillary procedures shall be minimized as it will always a STAT procedure and cost will be higher. Requests shall be issued if preferred to be done at our institution on OPD basis; if on ordinary days, refer procedures to the nearest health center.

Cases for Management of the ER Physician:

1. All consultations under code **YELLOW** , **RED** and **BLUE.**
2. All Obstetric and gynecologic cases.
3. All open wounds with or without fractures requiring suturing.
4. All cases of convulsion with or without fever.
5. Cases of acute abdomen with unstable vital signs.

6. Consultations initially managed by the Triage Physician but no improvement noted in terms of:
    - Lowering of BP after 2 doses of Clonidine and/or intramuscular antihypertensive
    - No marked improvement in Pain Scale
    - Progression of dyspnea despite 2-3 cycles of nebulisation
    - State of dehydration requiring further management e.g intravenous fluid administration

** Patients shall be endorsed by Triage Physician to the ER Physician: if admission is entertained but no vacancy in the Ward. Triage Physician may opt to do referral of the patient to another institution provided that vital signs are stable.

APPENDIX:

HOTS Flow Chart

DATE OF IMPLEMENTATION:

This policy has been implemented since 2009, revised 2011 reviewed 2016. This policy will continue to be implemented as rewritten.

SCHEDULE FOR POLICY REVIEW:

This policy shall be revised every three (3) years or as deemed necessary.

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HOTS FLOWCHART
(Hospital Operational Triage System)