AH1000 - EMERGENCY DEPARTMENT TRIAGE AND REASSESSMENT IN WAITING ROOM AND AMBULANCE STRETCHERS

1.0 PURPOSE

To improve the quality and safety of patient care by adopting the Canadian Emergency Department Triage and Acuity Scale Guidelines (CTAS) as a targeted guideline for use in Interior Health Emergency Departments (ED). This tool assists triage nurses to assess patients, determine their priority, initiate clinical protocols, and perform limited examinations and direct patients to the appropriate treatment area and resources (Canadian Triage and Acuity Scale Education Manual, 2013).

In Interior Health ED's applying CTAS is meant to be a rapid process, used to help the triage Registered Nurses (RN) prioritize patients based on presenting acuity and risk, in order to rapidly stream each patient to an appropriate treatment space.

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2.0 DEFINITIONS

TERM	DEFINITIONS
Triage	The initial assessment of a patient upon presentation to the ED.
Triage Reassessment	Subsequent assessment of patients while they wait to be seen.

3.0 POLICY

The ED Triage process is as follows: Critical Look » Infection Control » Presenting Complaint » 1st Order Modifier » Special Modifiers» Order Modifier » CTAS Level – Assign Triage Level » Re-Assessment. (Bullard, et al., 2008).

** The Critical Fist Look is an across the room, 3 – 5 second assessment of the person's airway, breathing, circulation and disability, conducted by an RN within the first 10 minutes of presentation to the ED.

CTAS has developed acuity time targets to ensure appropriate patient prioritization. ED's should strive to achieve these times to initial RN assessment (more thorough than the triage assessment) and initial physician assessment (Bullard, et al., 2017).

OBJECTIVE	TRIAGE LEVEL

	1 Resuscitation	2 Emergent	3 Urgent	4 Less Urgent	5 Non Urgent
Time to Assessment	Immediate	Immediate	30 minutes	60 minutes	120 minutes
Time to Physician	Immediate	15 minutes	30 minutes	60 minutes	120 minutes
Waiting Room Re-Assessment	Continuous	15 minutes	30 minutes	60 minutes	120 minutes

Note: This table is derived from the Revised Canadian Emergency Department Triage and Acuity Scale Guidelines (Bullard et al., 2017).

4.0 PROCEDURES

Triage Nurse:

- Ensure all patients receive a pre-triage Critical First Look assessment within 10 minutes of arrival
- Complete a formal triage to assess and determine severity of presenting complaints
- Ensure patients with emergent, life threatening conditions receive immediate care
- Assign a triage category
- Initiate treatment protocols/first aid measures/symptom relief and/or medical directives as per IH guidelines
- Provide information to the patient and caregivers about services, care and wait times.
- Stream patients to the appropriate treatment area
- Observe and perform timely re-assessments of patients waiting to be seem to identify changing conditions
- Work to decrease congestion in the ED

Documentation of triage must:

- Be clear, concise and objective
- Include any treatments given and patient response
- Include re-assessments completed and findings
- Include time to nurse and time to physician times; and
- Include all required components listed within the Emergency Nursing Assessment Record (ENAR) (form # 826066).

5.0 REFERENCES

Bullard, M. J., Musgrave, E., Warren, D., Unger, B., Skeldon, T., Grierson, R., … Swain, J. (2017). Revisions to the Canadian Emergency Department Triage and Acuity Scale (CTAS) Guidelines 2016. *CJEM, 19*(S2), S18–S27. https://doi.org/10.1017/cem.2017.365

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Emergency Medicine, 10(2), 136–142. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=105694183&site=nup-live&scope=site

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