
Separate But Equal: Developing Excellence in the Triage of Pediatric Patients

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This handout has been provided as a follow up to the lecture given on Saturday March 12, 2005 in Ft. Lauderdale FL at ENA Leadership Challenge, and includes notes on those areas only which were specifically mentioned during the lecture. Participants should refer to their hand written notes for the full breadth of the lecture.

Triage First, Inc. offers a comprehensive emergency department triage course, which includes live or online training in the use of the Canadian Triage Acuity Scale (CTAS) in the use of the Emergency Severity Index (ESI) as well as live or online training module in adult/pediatric clinical expertise and a new Pediatric clinical expertise module. Post test(s) included.

Outline

- I. Definition and philosophy of pediatric triage
 - A. Child-friendly environment
 - B. Policy issues
 - C. Consideration of parents
- II. Educational guidelines for nurses triaging pediatric patients
 - A. Regulatory considerations

In order to satisfy all the regulations promulgated by governing and accrediting bodies, we need a more highly classified and standardized triage acuity system. Accurate acuity assignment can solve many of the problems which have led to legislative intervention.

 - **EMTALA** – dictates that an MSE not be delayed in order to obtain demographic or financial information. Occasionally a medically unsophisticated or distracted parent may present with a child and understate the child's condition ("She has a fever, and I just want her checked out.") To send a child to be registered without at least a quick-look rapid triage assessment may be dangerous.
 - **HIPAA** – outlines privacy needs and ensures methods are implemented to provide confidentiality (Parents as well as children may not be willing to share pertinent information in a public arena.)
 - **Accrediting bodies** – promote quality assessment and education
 - **ENA** – Our professional organization provides support and research so that caregivers are able to provide evidence-based care
 - B. Training programs
 - Pre-test
 - Background reading materials
 - Triage conceptual information
 - Triage clinical expertise
 - Specific acuity scale/tool training
 - High-risk discriminators identified
 - Practice cases
 - Post-test
 - C. Determining best practice

III. Guidelines for obtaining history and assessment in the pediatric patient at triage

A. Rapid Survey

a. Pediatric Assessment Triangle

The Pediatric Assessment Triangle (PAT) was developed by an Emergency Medical Services for Children (EMSC) project and adopted by the American Association of Pediatrics (AAP) Pediatric Education for the Pre-hospital Professional (PEPP) course. It is a brief observational assessment of initial general appearance and gives the triage nurse a first impression of physiologic stability. It forms the "general impression" and helps to establish the severity of illness or injury and urgency of intervention. It DOES NOT diagnose. The PAT consists of three components. The first is appearance, the second is work of breathing and the third is circulation to skin. So:

- If the child's appearance is normal and the work of breathing is increased and the circulation to the skin is normal, the child is in respiratory distress.
- If the child's appearance is abnormal and work of breathing is increased or decreased with circulation to skin being normal or abnormal, the child is in respiratory failure.
- If appearance is abnormal, work of breathing is normal and circulation to skin is abnormal, the child is likely in shock.
- If only the appearance is abnormal, the child likely has a primary central nervous system or metabolic abnormality.

b. Sick or not sick?

B. History

C. Chief Complaint

D. Acuity guidelines for pediatric patients

a. Preventing "triage drift"

b. High-risk presentations (discriminators) which **MAY** escalate acuity

1. Hemodynamic stability (dehydration one of the most common in peds)
2. Altered level of consciousness (mental status)
3. Vital-sign parameters (Degree of respiratory distress, LOC, Temperature, Blood glucose level)
4. High-risk medical history – (Age, immune status, co morbidity, past health, events leading up to illness or injury)
5. Pain / distress (psych and social included) – Central vs. peripheral and acute vs. chronic
6. Trauma criteria (mechanism of injury, anatomic criteria, physiologic criteria)
7. Waiting room issues (risk mitigation, pat and significant other anxiety, fear or emotional suffering, need for isolation, security issues)
8. Experience / intuition.

c. Administrative visits and/or rechecks - Patients returning to the ED for scheduled follow-ups, suture removals, rechecks etc., are a common presentation to triage and may give the triage nurse a false sense of comfort in that they usually will be assigned a low acuity. However, all of these patient's should receive a rapid or comprehensive triage assessment based on their present symptoms, *as well* as the situation surrounding their visit.

- d. Acuity based on physiological status – Other factors besides physiological status must be considered, but it is a good place to start with pediatric patients and it is a good tool for confirmation of a safe acuity assignment.

Patients may be assigned to Level 1 (Resuscitation) or Level 2 (Emergent) categories after a limited assessment; however, [pediatric] patients assigned to lower triage categories [who will wait for a medical screening exam] should undergo a full triage evaluation to avoid missing subtle presentations of serious illness, particularly in infants. {3}

Level 1 – Resuscitation: Any child or infant who requires continuous assessment and intervention to maintain physiological stability

Level 2 – Emergent: Any physiologically unstable child. Dehydration is difficult to accurately assess. Any suspicion (or evidence) should cause concern.

Level 3 – Urgent: Child or infant who is alert, oriented, well hydrated, minor alterations in vital signs.

Level 4 – Less Urgent: Alert child with fever and simple complaints such as ear pain, sore throat, or nasal congestion.

Level 5 – Nonurgent: Alert child who is afebrile, well hydrated w/ normal vital signs

E. Documentation issues

F. Reassessment - Scheduled reassessments should be performed on all pediatric patients. No acuity scale is 100% accurate, and when under triage occurs, illness may progress and patients who appear stable upon presentation may deteriorate.

“Progression of illness during the waiting period must be anticipated and should not automatically be considered a failure of the triage process.” {3}

- Based on acuity
- Change in patient’s status
- Change in vital signs
- To evaluate a treatment intervention
- Specific LIP (Licensed Independent Practitioner) order

IV. Legal and ethical considerations in pediatric triage

- A. Informed Consent
- B. COBRA / EMTALA
- C. Guidelines for people with limited English-speaking skills
- D. Do Not Resuscitate
- E. End-of-Life care

V. Pediatric patient-safety issues at triage

- A. Policy Alert
 - a. Reduce pediatric exposure to ill or injured adults
 - b. Child safety measures
- B. Pediatric errors in triage
- C. Challenges
 - a. Equipment
 - b. Protocols
- D. Some solutions
 - a. Information technology / computerized order entry
 - b. Evaluation of pediatric triage care

- c. Tools
- d. Implementing
- e. Coaching

References

1. Sheehy, S. (2003). *Emergency Nursing Principles 5th Edition*. St. Louis: Mosby.
2. Murphy, K. (1997). *Pediatric Triage Guidelines*. St. Louis: Mosby.
3. National Triage Task Force. (2001). Canadian Pediatric Triage and Acuity Scale: Implementation Guidelines For Emergency Departments. *Canadian Journal of Emergency Medicine*, 3(4), S1-S27.
4. National Emergency Medical Services for Children Resource Alliance. (1998). Committee on Pediatric Equipment and Supplies for Emergency Departments. *Annals of Emergency Medicine*, 31(1), 54 - 58.
5. Hohenhaus, S. M., & Frush, K. S. (2004, February). Pediatric Patient Safety: Common Problems in the Use of Resuscitative Aids for Simplifying Pediatric Emergency Care. *Journal of Emergency Nursing*, 30(1), 40 - 51.
6. Hohenhaus, S. (2001, December). Is this a drill? Improving pediatric emergency preparedness in North Carolina's emergency departments. *Journal of Emergency Nursing*, 27(6), 568 - 570.
7. Romig, L. (2002, July). Pediatric Triage. A system to JumpSTART your triage of young patients at MCIs. *JEMS*, 52(8), 60 - 63.
8. American Academy of Pediatrics. (2000). *Pediatric Education for Prehospital Professionals*. Elk Grove Village, IL: Jones and Bartlett.
9. LeVasseur, S., Charles, A., Considine, J., Berry, D., Orchard, T., Woiwod, M., Villaneuva, E., Castle, C., & Sugarman, M. (2001, July). Consistency of Triage in Victoria's Emergency Departments.
10. Murray, M., Bullard, M., Grafstein, E., &. (2004). Revisions to the Canadian Emergency Department Triage and Acuity Scale Implementation Guidelines. *Canadian Journal of Emergency Medicine*, 6(6), 421 - 427.
11. Beveridge, R., Clarke, B., Janes, L., Savage, N., Thompson, J., Dodd, G., Murray, M., Jordan, C., Warren, D., & Vadeboncoeur. (1998, December). Implementation Guidelines for The Canadian Emergency Department Triage & Acuity Scale (CTAS).
12. Bernardo L., & Lesniak D. (2003). Ethical and Legal issues. In L. & O. Bernardo, D. (Ed.), *Core Curriculum for Pediatric Emergency Nursing*. Boston: Jones and Barlett.
13. ENA. (2002). *End of Life Care in the Emergency Department*. Des Plaines, IL: Author.
14. Field, M., & Behrman, R. (2003). *When Children Die: Improving Palliative and End-of-Life Care for Children and Their Families*. Washington, DC: The National Academies Press.