Team Name: Critical Care and Medicine Team Lead: Regional Director - Acute Care Approved by: Executive Director - Mid	Reference Number: CLI.5110.PL.005 Program Area: Critical Care (ER, Observation, SCU) Policy Section: General
Issue Date: December 16 2016 Review Date: Revision Date: June 18 2018	Subject: Triage and Waiting Room Monitoring

POLICY SUBJECT:
Triage and Waiting Room Monitoring

PURPOSE:
To ensure that all patients presenting to the Emergency Department (ED):

- Receive timely services based on the severity of their presenting complaints. This is achieved with prompt nursing assessment to determine the severity of the patient's condition, reflected in the Canadian Triage and Acuity Score (CTAS); and to consistently inform prioritization of care.
- Receive assistance congruent with all their needs, from ED presentation to discharge.
- Have their condition(s) reassessed while in the ED waiting room at pre-established regular intervals.
- Possess information that directs them through the process of receiving care in the EDs regarding services, expected care and waiting times.

BOARD POLICY REFERENCE:
Executive Limitation (EL-02) Treatment of Clients
Executive Limitation (EL-01) Global Executive Restraint and Risk Management

POLICY:
All Southern Health-Santé Sud EDs promote patient safety from the time of presentation to the ED area and throughout each patient's stay by adhering to standardized registration, triage, and reassessment processes.

All Southern Health-Santé Sud staff, irrespective of their specific position/role, have the responsibility to report to the ED nurse any person observed to be in need of assistance.

CTAS is used to define the level of acuity for each patient's presenting complaint.

CTAS informs the prioritization of each patient's timely access to the appropriate care/care provider.

DEFINITIONS:

Triage Assessment: rapid evaluation and decision making to determine the patient's presenting complaint, level of acuity, and assigning the patient to a treatment area or the waiting room will occur within 15 minutes. For patients assigned to the waiting room, it includes providing symptom relief based on established protocols, and regular reassessments based on CTAS level of acuity.

Canadian Triage and Acuity Score (CTAS): a five-level triage scale that quantifies the type and severity of each patient's presenting complaint. These are:

Level I	Level II	Level III	Level IV	Level V
Resuscitation	Emergent	Urgent	Less Urgent	Non-Urgent

CTAS Level 1 – Resuscitation: conditions that are threats to life or limb (or imminent risk of deterioration) requiring aggressive interventions. Examples are: cardiac arrest, respiratory arrest, major trauma (in shock), shortness of breath or severe respiratory distress, altered level of consciousness /unconscious with a Glasgow Coma Scale 3-9.

CTAS Level 2 – Emergent: conditions that are potential threat to life, limb, or function, requiring rapid medical intervention by physician or medical directive .Some examples are moderate respiratory distress, vomiting blood, hypertension, high fever, and chest pain with cardiac features.

CTAS Level 3 – Urgent: conditions that could potentially progress to a serious problem requiring emergency intervention.

CTAS Level 4 – Less Urgent: conditions that relate to patient age, distress, or potential for deterioration that would benefit from intervention or reassurrance within one to two hours .

CTAS Level 5 – Non-Urgent: conditions that may be acute but non-urgent as well as conditions which may be part of a chronic problem with or without evidence of deterioration .

Critical first look: it involves an across-the-room scan within 5 minutes of persons entering the ED area. This involves taking a quick look at the patient. For adults, scan airway, breathing, circulation, and disability. For pediatrics, scan general appearance, work of breathing, and circulation inclusive of a quick assessment relative to and as applicable to presenting complaint (e.g. concern of bleeding post circumcision or injury).

Dead on Arrival (DOA): refers to patients who are deceased prior to arrival at the facility; often for placement in the morgue. These patients are not counted within ED visits and do not require any ED documentation.

Hand over: transfer of responsibility of care for a patient from one health care provider to another, verbally or in writing.

Registration: The process of registering the presenting patient and associated demographic information in the facility's electronic registration system.

Vulnerable patient: Person(s) presenting to the ED with cognitive, emotional, and/or physical needs that can impact their safety.

IMPORTANT POINTS TO CONSIDER

This policy addresses the recommendations listed in the Brian Sinclair Inquest Recommendations (Preston, 2014) and as identified in the Manitoba Health, Healthy Living and Senior Policy - Emergency Department Registration, Triage and Waiting Room Monitoring Standards.The recommendations addressed are numbers: 12, 13, 14, 15, 17, 19, 22, 24, 33, 52, 53, and 54.

PROCEDURE:

1. The triage nurse performs an across-the-room **critical first look** scan within 5 minutes of persons entering the ED area. This involves taking a quick look at the patient. For adults, scan airway, breathing, circulation, and disability. For pediatrics, scan general appearance, work of breathing, and circulation.
   1.1. Address **critical** presenting status STAT.
   1.2. Document critical first look scan of each patient in the description of how they presented to the ED within the objective assessment on the *Triage and Emergency Department Record* (CLI.5110.PL.005.FORM.01) or in Emergency Department Information System (EDIS).
   1.3. Every time the triage nurse enters the waiting area, conduct a quick scan identifying vulnerable patients requiring assistance or patients requiring immediate care where their condition may have changed.
2. Registration and triage should occur concurrently:
   Registration Clerk/Alternate:
   2.1. Immediately register each person that presents to the ED to access care, electronically or manually.
      - When 3 or more people are waiting to be registered, the triage nurse prioritizes the order of patient registration.
      - NB: Patients who are dead on arrival (DOA), deceased prior to arrival to hospital, are not registered into the ED database.

2.2. Print applicable registration forms when registration is complete (e.g. "Emergency/Urgent Care Treatment Record" and "Clinical Circumstances Sheet") and patient identifiers.
   - Apply patient identiband.

2.3. Alert the triage nurse of any observed difficulties experienced by the patient.

2.4. **Non-Canadian Residents:**
   - If an individual is not a Canadian resident, obtain a signed *Foreign Residents Agreement* (CLI.4110.PL.008.FORM.04) or *Foreign Residents Agreement – French* (CLI.4110.PL.008.FORM.04F) from the patient/designate.
     - Health Information Management and Nursing Services are jointly responsible for ensuring this agreement is signed.

3. The triage nurse and **prioritization** of care:

3.1. If multiple patients are waiting to be triaged, prioritize triage order based on critical first look and presenting complaint.

3.2. Assess the patient's first order modifiers and applicable second order modifiers.

3.3. Determine CTAS level. The initial CTAS acuity level number does not change.

3.4. Complete the triage section of the *Triage and Emergency Department Record* or in EDIS.

3.5. Direct the patient to a treatment room/area or to the ED waiting room.
   - Patients assessed as **CTAS level 1**: Proceed to a treatment area for immediate complete assessment and aggressive interventions by physician or alternate healthcare provider.
     - Provide continuous monitoring until the patient proceeds to treatment area.
   - Patients assessed as **CTAS level 2**: Goal is within 15 min. to treatment room/area for physician assessment and aggressive interventions. Patient may wait in ED waiting room while a treatment room/area is vacated, reassessed q15 min.
   - Patients assessed as **CTAS level 3**: Patient may wait in ED waiting room until a treatment room/area becomes available, reassessed every 30 min.
   - Patients assessed as **CTAS level 4 and level 5**: Patient may wait in ED waiting room and reassessed as per CTAS guidelines.
     - For patients assessed as a CTAS level 5, the triage nurse can inform the patients of anticipated wait times and alternate community sites available to access care (e.g., family physician clinics, quick care clinics, urgent care clinics, or primary care clinics).
     - If the patient chooses to seek services elsewhere, please document and indicate patient's choice of self-discharge.

3.6. Triage patients arriving by ambulance based on acuity and within the context of all the other patients. Goal for off-loading is 30 minutes.

3.7. Reassess triaged patients in ED waiting room based on the CTAS level of acuity, as per the table below:

CTAS level	**Level I**	**Level II**	**Level III**	**Level IV**	**Level V**
Descriptor	Resuscitation	Emergent	Urgent	Less Urgent	Non-Urgent
Reassessment time	Continuous nursing care	Every 15 min.	Every 30 min.	Every 60 min. (hourly)	Every 120 min. (q 2 hours)

- If triage nurse is not able to complete all the reassessments of patients in the waiting room, request assistance from another team member.
- If a patient's condition deteriorates:
  - Do not change the initial CTAS acuity level.
  - If indicated, reassess priority for moving to treatment room/area based on the current presentation in the context of all other patients that require further assessment and treatment.
  - Continue further reassessments based on the new/current level of acuity.
  - Document the outcome of each reassessment on the *Triage and Emergency Department Record* or in *EDIS*.
- If patient/family repeatedly approaches triage nurse, or are presenting in an escalated manner, they may be having difficulty communicating changes in patient status – reassess the patient.

4. The triage nurse/designate monitors the **waiting room**:
   4.1. Scan the waiting room area every 15 min. for persons who have not registered and identify their purpose for being in the waiting room.
   4.2. Identify **vulnerable patients** requiring assistance and identify the appropriate care provider(s) to meet the patient's needs.
   4.3. Review **with** all persons in the ED waiting room their purpose for being on site at a minimum of every three (3) hours. Document in the *Waiting Room Monitoring Record* (CLI.5110.PL.005.FORM.04).
   4.4. Assist persons in the waiting room with their health care needs (e.g., vomiting, choking).
5. **Hand-over** care practices:
   5.1. When a patient is moved to a treatment room/area, the triage nurse provides a verbal report to the care provider accepting the patient, focusing on the acuity level and key issues, and the documentation on the *Triage and Emergency Department Record* or in EDIS.
   5.2. When a change in triage nurse coverage occurs, the out-going triage nurse reviews all patient charts (triaged and waiting to be triaged) and provides a verbal report to the incoming triage nurse highlighting individual patient's acuity level and key issues.
6. **Evaluation** of triage process:
   6.1. In May and November, complete 20 chart audits in regional centres and 10 chart audits for non-regional centres using the *Triage Record Audit* (CLI.5110.PL.005.FORM.03).
   6.2. In May and November, complete the *Triage Process Time Audit* (CLI.5110.PL.005.FORM.02)

6.3. Review the *Waiting Room Monitoring Record* monthly. Evaluate the data using the *Waiting Room Monitoring Data Evaluation* (CLI.5110.PL.005.FORM.05) tool.
6.4. Review audit results and identify trends to inform quality improvement plans.
6.5. Forward a copy of audit results and waiting room data to the Regional Acute Care Manager.

SUPPORTING DOCUMENTS:

CLI.5110.PL.005.FORM.01	Triage and Emergency Department Record
CLI.5110.PL.005.FORM.02	Triage Process Time Audit
CLI.5110.PL.005.FORM.03	Triage Record Audit
CLI.5110.PL.005.FORM.04	Waiting Monitoring Room Record
CLI.5110.PL.002.SD.07	Waiting Room Monitoring Data Evaluation
CLI.5110.PL.005.SD.01	Triage and Emergency Department Record: Guidelines for Completion

REFERENCES:

Accreditation Canada. (2016). *Qmentum program: Standards, emergency department* (ver. 11). Ottawa, ON: Author.

Canadian Association of Emergency Physicians. (2011). *The Canadian triage and acuity scale: Combined adult/paediatric educational program.* Ottawa, ON: Author.

Manitoba Health, Healthy Living and Seniors. (2016). *Emergency department registration, triage and waiting room monitoring standards* [Draft]. Winnipeg, MB: Author.

Prairie Mountain Health. (n.d.). *Canadian triage and acuity scale* [Draft #2]. Brandon, MB: Author.

Preston, T. (2014). *Provincial Court of Manitoba: Brian Sinclair Inquest Recommendations.* Retrieved from http://www.manitobacourts.mb.ca/site/assets/files/1051/brian_sinclair_inquest_-_dec_14.pdf

Winnipeg Regional Health Authority. (2010, June). *Emergency department triage*. Winnipeg, MB: Author.

CLI.4110.PL.008.FORM.04	Foreign Residents' Agreement
CLI.4110.PL.008.FORM.04.F	Foreign Residents' Agreement - French