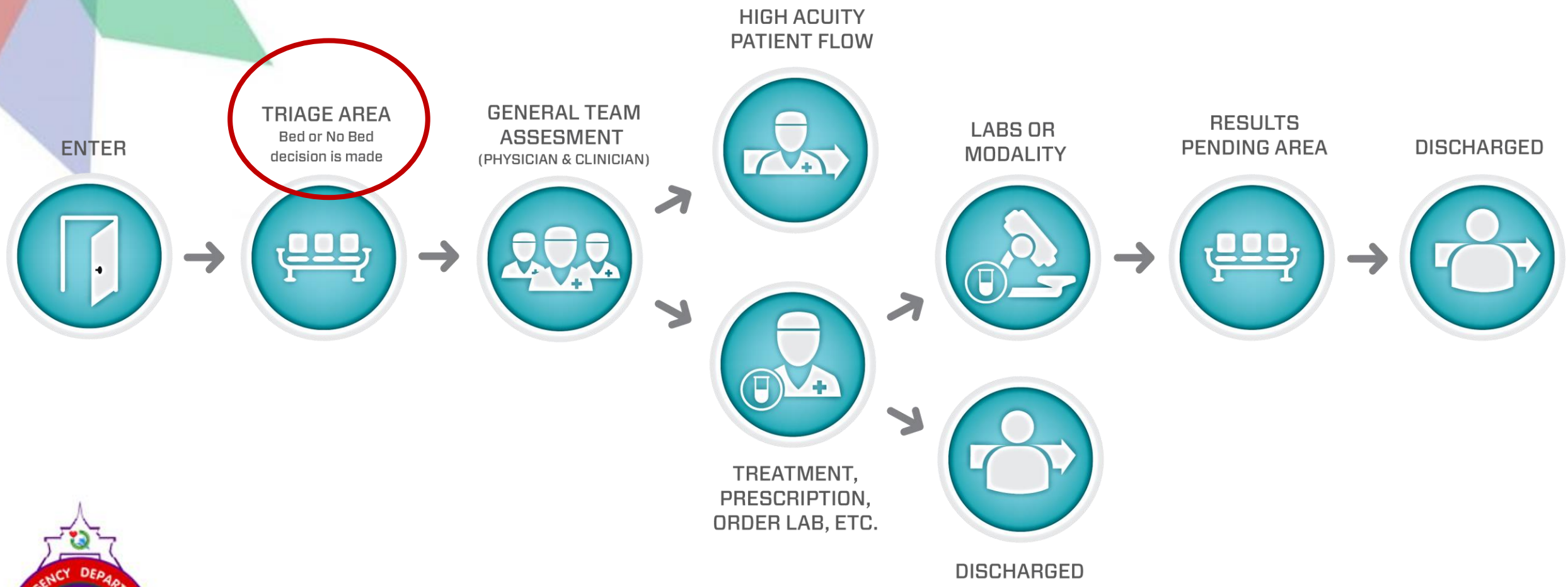
Safety Triage

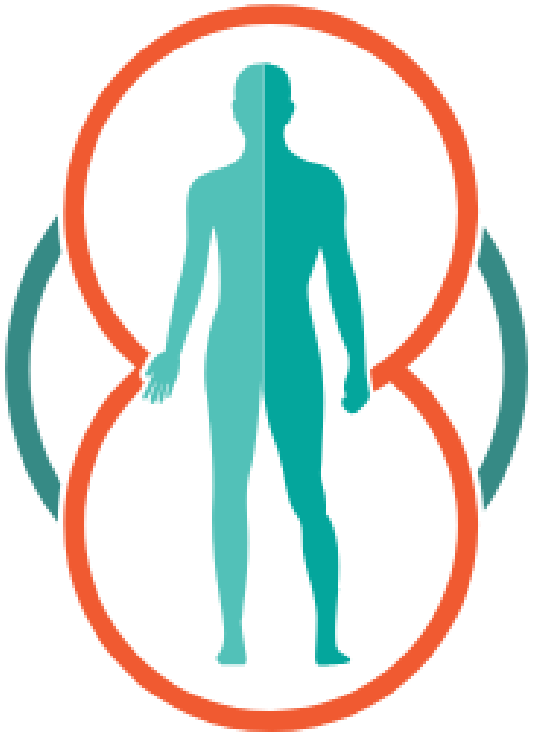
Narudee Srisang

Emergency Physician

Khon Kaen Hospital


ENTER
TRIAGE AREA
Bed or No Bed
decision is made
GENERAL TEAM
ASSESMENT
(PHYSICIAN & CLINICIAN)
HIGH ACUITY
PATIENT FLOW
TREATMENT,
PRESCRIPTION,
ORDER LAB, ETC.
LABS OR
MODALITY
RESULTS
PENDING AREA
DISCHARGED
DISCHARGED

Personnel Safety

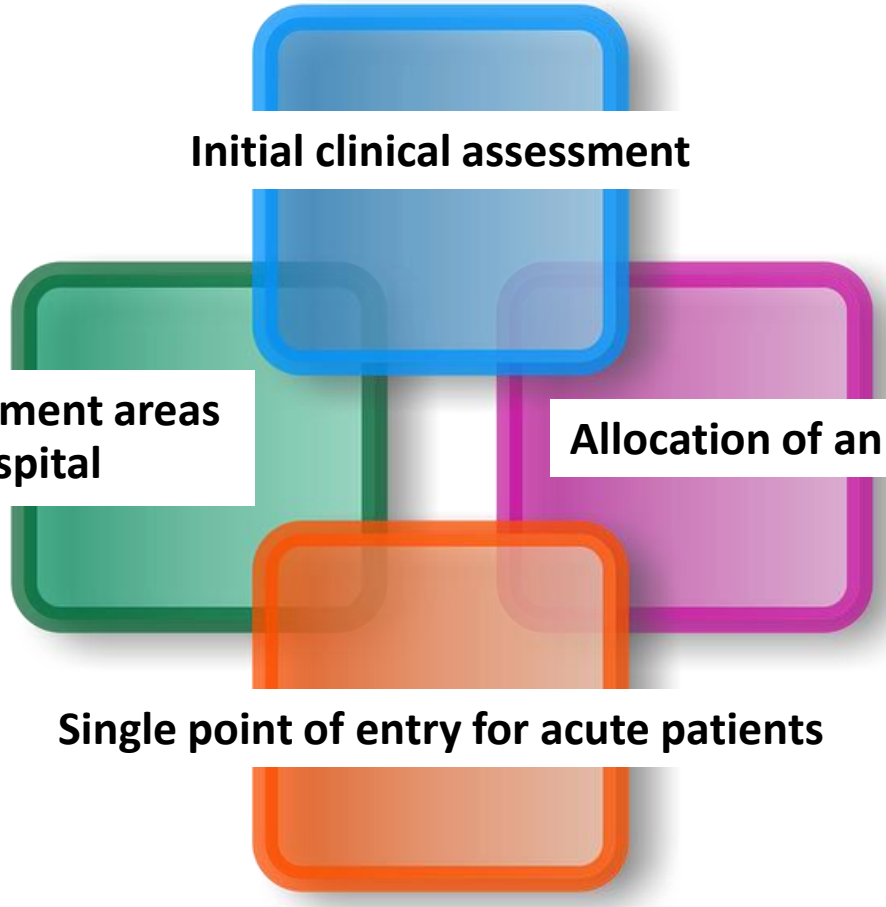


Patient Safety

Safety Triage

The	with the	in the	at the	with the
RIGHT	RIGHT	RIGHT	RIGHT	RIGHT
number of staff	skill level	place	time	assignment

Triage area is designed for



To fulfil the concept of ‘triage first’

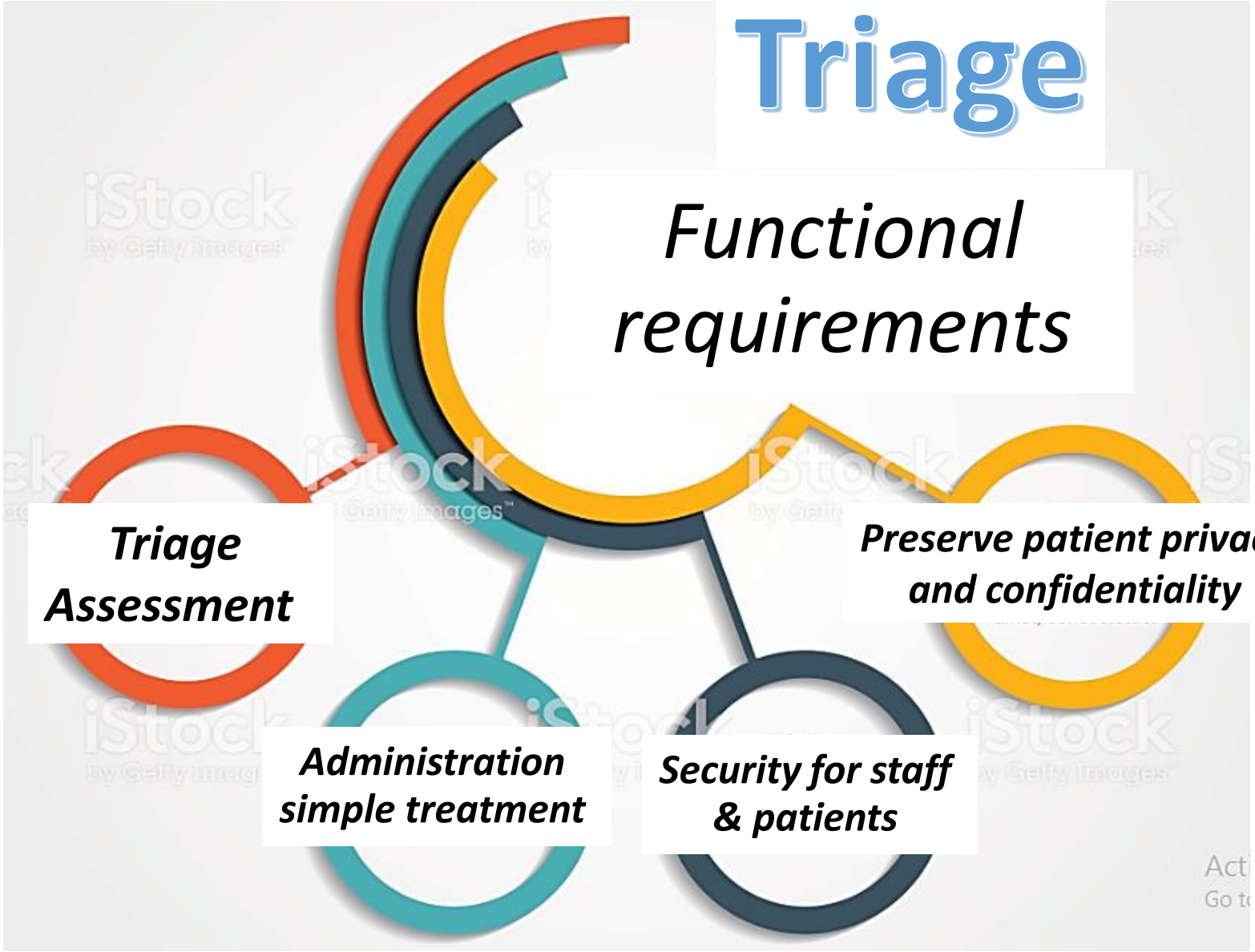
- The triage and reception areas should be designed
- First point of contact for patients is the *Triage Nurse*

Size

- The maximum number of triage staff expected to be present at any given time, in proportion to patient census

Triage

Functional requirements



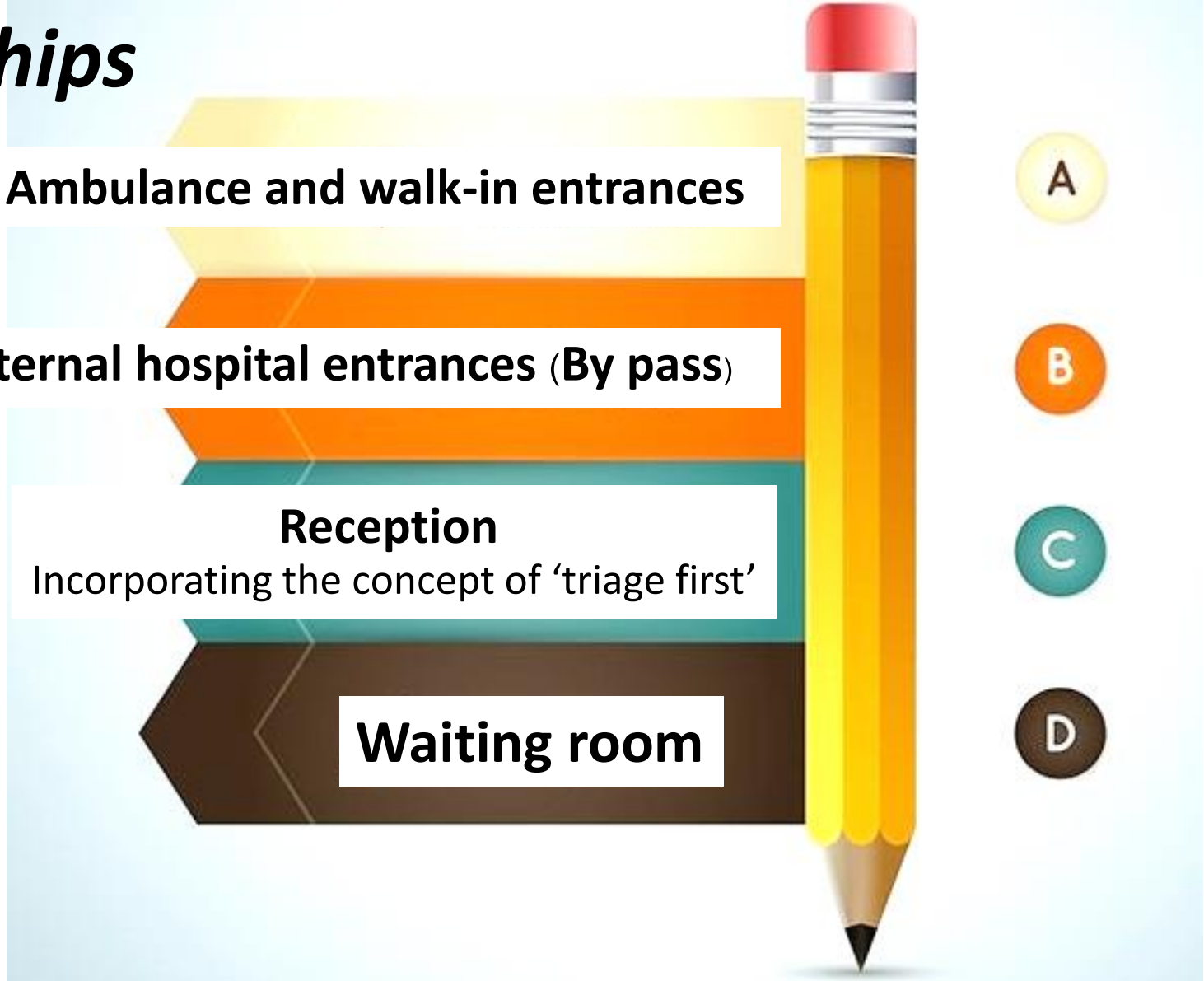
Triage Assessment

Preserve patient privacy and confidentiality

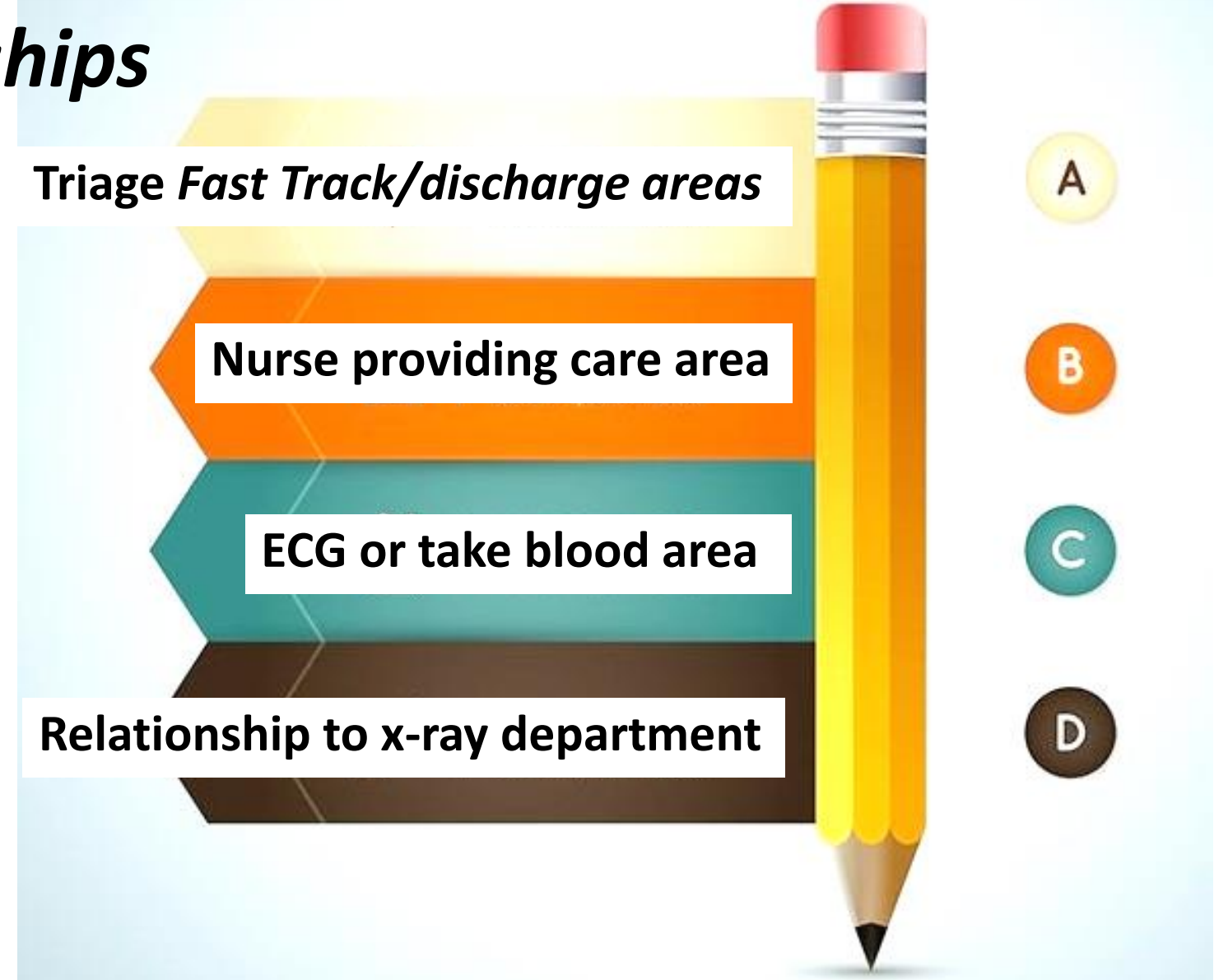
Administration simple treatment

Security for staff & patients

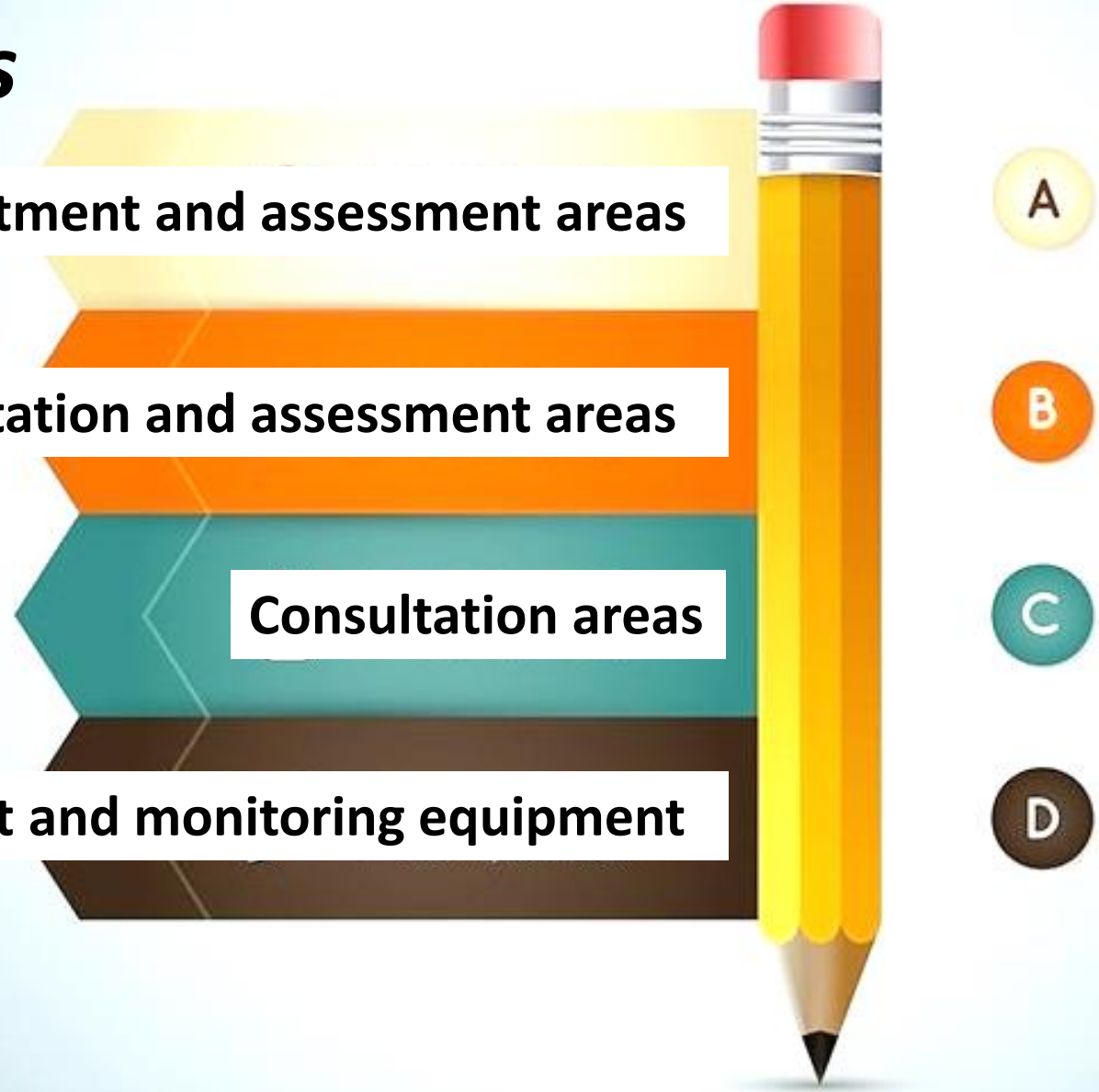
Spatial relationships



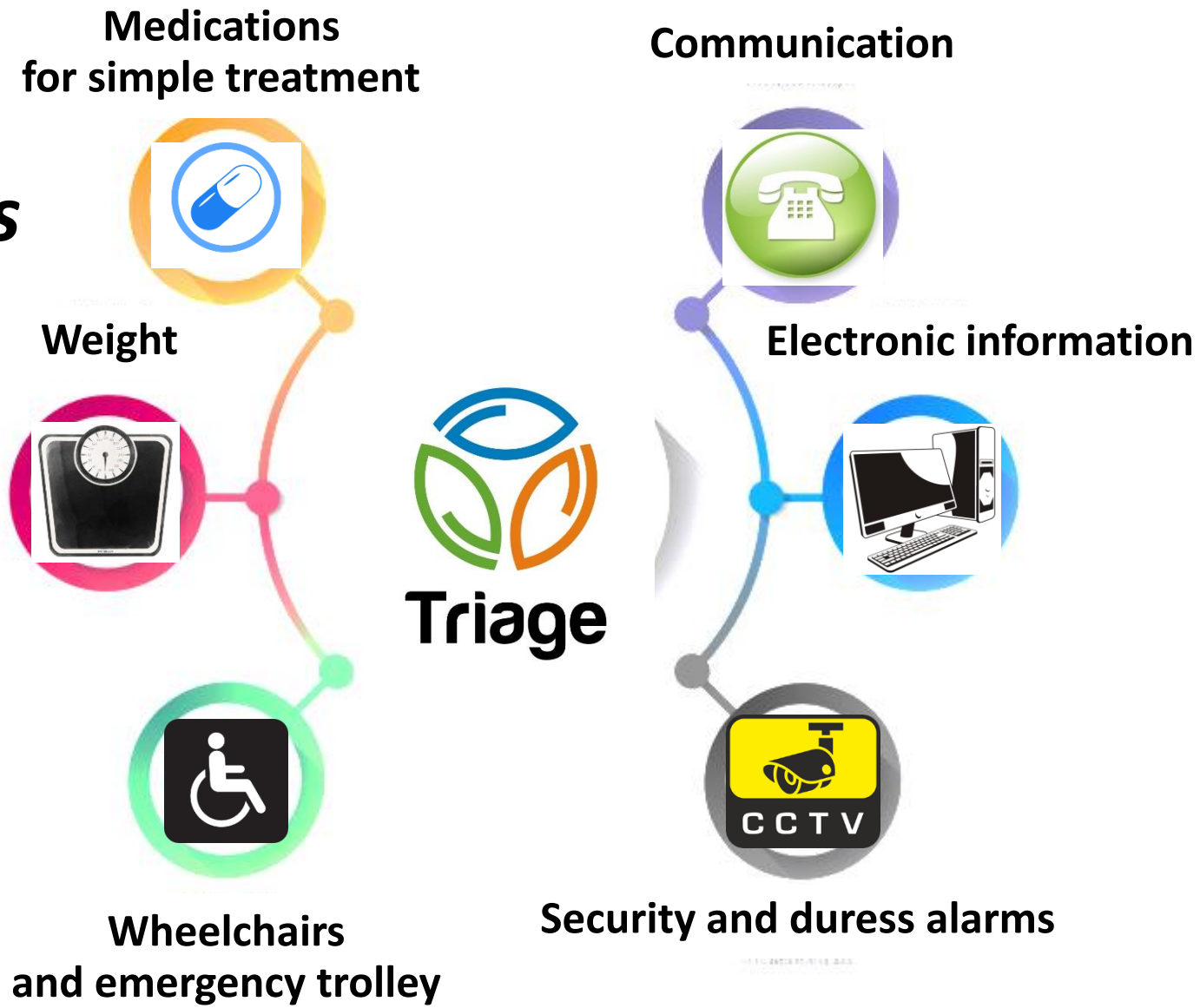
Spatial relationships



Spatial relationships



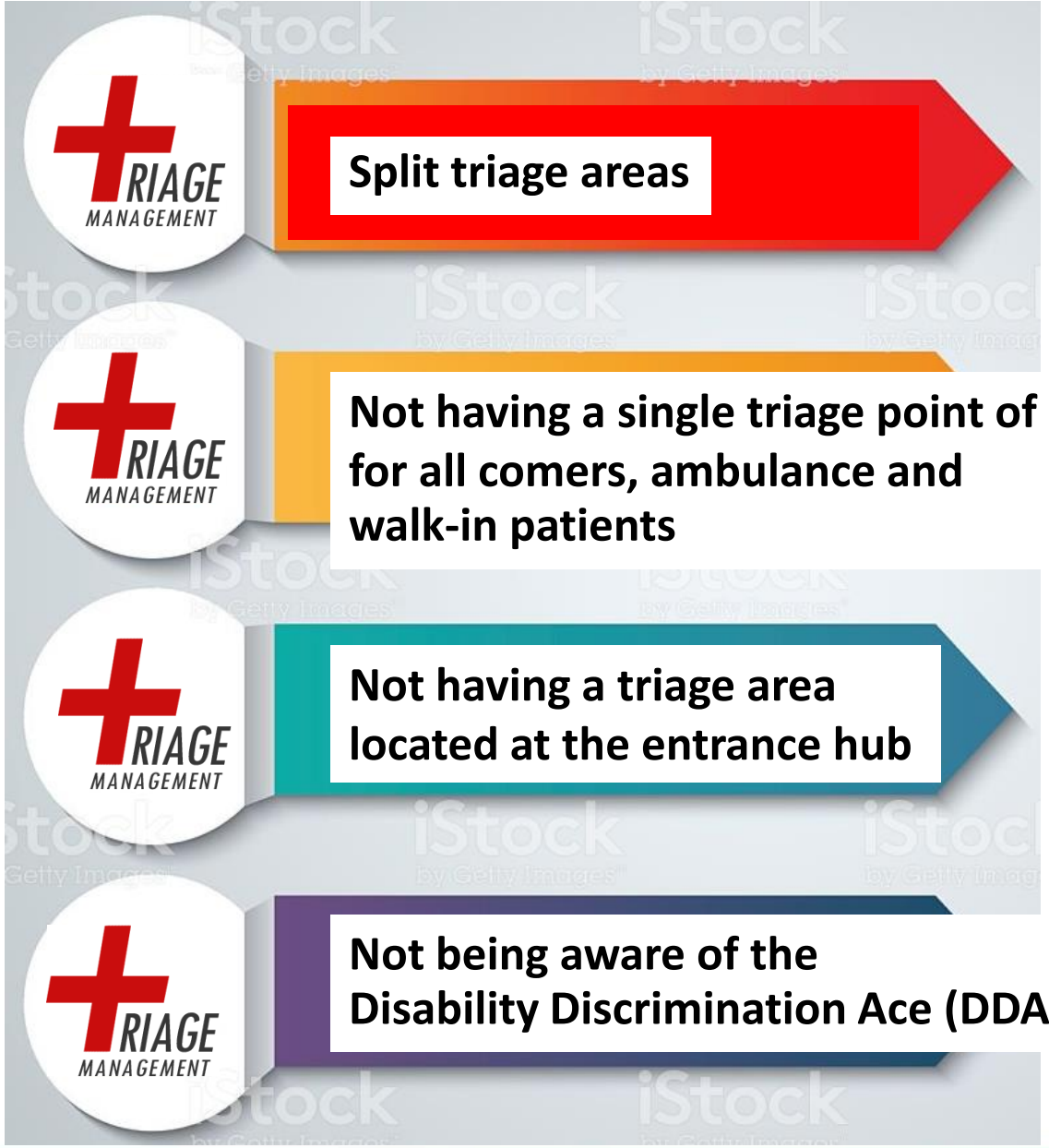
Equipment requirements



Other considerations

1. Clear line of sight into waiting room
2. Additional Triage Nurse during busy periods
3. Ability to accommodate a Waiting Room Nurse and their equipment requirements
4. Pneumatic tube system in triage/reception area
5. Secondary triage assessment areas to re-assess waiting room patient

Pitfalls


TRIAGE MANAGEMENT
Split triage areas
TRIAGE MANAGEMENT
Not having a single triage point of entry for all comers, ambulance and walk-in patients
TRIAGE MANAGEMENT
Not having a triage area located at the entrance hub
TRIAGE MANAGEMENT
Not being aware of the Disability Discrimination Ace (DDA)

Triage nurse

01

Personal traits

- **Flexibility**
- **Autonomy**
- **Good communication skills**
- **assertiveness**
- **patience**
- **compassion**
- **willingness to listen and learn**

02

Cognitive characteristics

- **A diverse knowledge base**
- **Knowing when not to act**
- **Critical thinking**
- **Ability to make decisions quickly**
- **Ability to prioritize**

03

Behavioral characteristics

- **Being a patient advocate**
- **Working well under pressure**
- **Being organized**
- **Improvising as needed**
- **Using intuition**
- **Displaying confidence in judgment**
- **Trusting or relying on peers**

- Public relation skills
- Interviewing skills
- Critical thinking skills
- Communication skills

START HERE!

Does the patient have any of the following?

MENINGITIS?

Supporting signs: Fever, neck stiffness, photophobia. Needs urgent assessment.

YES: Droplet precautions for 24 hours.

NO

DIARRHOEA OR VOMITING?

Consider *C. difficile* (recent antibiotics used), norovirus, rotavirus, adenovirus. (Stool for *C.difficile* and norovirus testing).

YES: Contact precautions.

NO

ISOLATE

EMERGENCY DEPARTMENT KHON KAEN HOSPITAL

4th Advanced Emergency Care

Infection Prevention and Control at Triage for Adults

Infection Prevention and Control at Triage for Adults

NO

MRSA or CRE?

Previous colonisation with MRSA, coming from a nursing home or hospital, or have wounds, ulcers, indwelling device, IV lines *in situ*? If yes, needs MRSA screening.
Patient been in or coming from hospital abroad or areas of recent CRE* outbreak? If yes, CRE screening.

YES: Contact precautions. →

NO

RASHES?

Rashes suggesting meningococcus infection (non-blanching rash).

Yes: Droplet precautions for meningococcus until 24 hours on appropriate antibiotics. →

Rashes suggesting chicken pox/shingles (VZV) or measles (cough, coryza and fever).

Only staff with immunity to attend to these patients.
Possible Herpes simplex?

Yes: Airborne precautions for measles.
Yes: Airborne and contact precautions for: chickenpox, disseminated shingles or shingles in immunocompromised patient.
Yes: Contact precautions for: disseminated or severe mucocutaneous herpes simplex, localised shingles lesions that cannot be covered. →

NO

ISOLATE

NO

TB, RSV, FLU?

Supporting signs for TB: Night sweats, weight loss, cough, haemoptysis.

Sputum for AFB and TB cultures.

YES: If TB, Airborne precautions, negative pressure room.

Yes: if respiratory infection, droplet precautions.

NO

WOUND/ ABSCESS?

Abscess or draining wound that cannot be covered?

YES: Contact precautions.

NO

TRAVELLERS FEVER?

Fever or history of fever > 38°C with recent travel to areas where Viral Haemorrhagic Fever is endemic (e.g. Africa) or areas with VHF outbreak in past 12 days?

Contact Microbiologist/ID ASAP.

YES: Airborne, droplet & contact precautions.

NO

NO ISOLATION REQUIRED

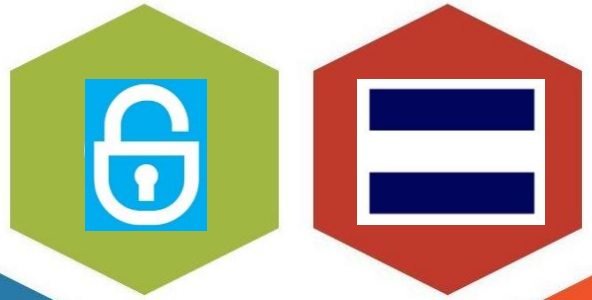
Standard precautions.

ISOLATE

Infection Prevention and Control at Triage for Adults

Safety

Equity



Effectiveness

Efficiency

Patient-Centeredness

Timeliness

Triage quality improvement indicator

Structure : *How care is organized*
(standing protocols which allow nurses to give acetaminophen for fever at triage)

Process : *What is done by caregivers*
(proportion of patients with fever at triage who receive acetaminophen at triage)

Outcome : *Results achieved*
(fever reduction within one hour after arrival)

Triage quality improvement indicator

Aims	Structure, Process, Outcomes	Indicator	Data Source/Method
Safety	Structure	Implementation of Triage (reliable and valid system)	Administrative process
	Process	Assignment of correct ESI triage level (under and over triage levels	Review of triage note by triage expert
	Outcome	Review of all negative outcomes	Review by internal QI or triage committee
Effectiveness	Structure	Implementation of nurse initiated analgesic protocol at triage	Administrative policy
	Process	Proportion of patients with pain eligible for analgesics at triage that received them	Medical record review
	Outcome	Decrease in patient reported pain score within 30 minutes of arrival	Medical record review
Patient-Centeredness	Process	Documentation of a subjective statement by the patient describing reason for visit	Medical record and triage note

Triage quality improvement indicator

Aims	Structure, Process, Outcomes	Indicator	Data Source/Method
Timeliness	Process	Time of arrival to time to physician evaluation	Medical record review
Efficiency	Structure	Staffing policy to allow flexibility in RN staffing pattern to meet the demands of changing influx of patients at triage	Administrative policy
	Process	Increased RN's float to triage during increased influx and move to other patient care areas when triage demand is low	Staffing pattern log reviews
		Length of stay per triage level	Medical record and triage note
		Admission rates per triage level	Medical record and triage note
		Review of all level 4 and 5 cases admitted to the hospital	Medical record and triage note
Equity	Process	All patients eligible for analgesics at triage according to the protocol receive them, regardless of gender or race	Medical record and triage note

Triage quality improvement indicator

แตกตื่นทั้งโรงบาล!! ผู้ป่วยโดนสุนัขกัด โวยวายหมอรักษาช้า รปภ. ล็อกตัวจุ่น จ.มหาสารคาม

สาวพาแฟนเจ็บหูไปโรงพยาบาล หมอห้องอุบัติเหตุลั่น "ถ้าไม่ใกล้ตายไม่ต้องมา"

หมอแจงช่วงเวลารักษา ‘น้องนิว’ ต้องรอวินิจฉัยโรค ก่อนสุดยื้อชีวิตตายคารพ.

ผู้ป่วยถูกส่งตัวมาจากรพ.ชะอำ ถึง รพ.พระจอมเกล้าฯ เวลา 13.30 น. เข้าตรวจที่แผนกอายุรกรรม ต่อมาเวลา 14.04 น. แพทย์ส่งไปเอ็กซเรย์ ในเวลา 14.30 น. ได้ฟิล์มส่งให้แพทย์วินิจฉัย ระหว่างรอผลเด็กเป็นลม หมอทำการเจาะเลือด ปฐมพยาบาล เวลา 14.45 น. จึงส่งมายังห้องฉุกเฉิน โดยเด็กมีอาการความดันตก แพทย์ตรวจให้น้ำเกลือเจาะเลือด จากนั้น เข้าทำซีทีสแกนตรวจคลื่นหัวใจ และทำซีทีสแกนซ้ำ เนื่องจากมีอาการผิดปกติ “เบื้องต้นแพทย์สงสัยเป็นเส้นเลือดใหญ่โป่งพองในช่วงอก ซึ่งเกินกว่าระดับการรักษาของรพ.พระจอมเกล้า จึงประสานเตรียมส่งตัวไปรักษาต่อ แต่ปรากฏผู้ป่วยเริ่มกระสับกระส่าย ชีพจรหยุดเต้น แพทย์ปั๊มหัวใจและให้เลือด แต่ไม่สามารถยื้อชีวิตได้ เด็กเสียชีวิตใน 16.38 น. ช่วงห่างของเวลาเป็นช่วงที่รอฟิล์มเอ็กซเรย์และช่วงแพทย์ต้องวินิจฉัยโรค


thank
you!