Triage Children's Emergency Department (Nursing) – Full Paediatric Guideline – Derby Sites only

Reference no.: CH CLIN C58

Introduction

Every Child that attends Children's Accident and Emergency should be assessed by a clinical professional within 15 minutes of arriving into the department (RCPH,2012) and should take no more than 5 minutes to complete.

Aim and Purpose

Identify the requirements needed for a nurse to be able to triage, also the tools that are used. Also the standards that need to be met and the process of triage.

Definitions, Keywords

Triage – a clinical assessment of patients on arrival into the Emergency Department that will determine their clinical prioritisation.

Streaming - a process where we can refer patients to other clinical areas or services that are deemed more suitable for their presentation.

Triage Guideline – Children's Emergency Department

Aim and purpose

Identify the requirements needed for a nurse to be able to triage, also the tools that are used. The standards that need to be met and the process of triage.

Process of triage and standards

Every child that attends Children's Accident and Emergency should be assessed by a clinical professional within 15 minutes of arriving into the department (RCPH,2012) and should take no more than 5 minutes to complete.

What should be included in a triage?

The triage will consist of 3 main elements:

a) History and Assessment
   - This should be completed and recorded in a systematic way. The use of SBAR is recommended to give a clear, concise review of the patients reason for attendance

b) Observations
   - A full set of observations should be completed to gain a POPS score. This should also include a baseline blood pressure, the patient's weight and height and potentially a blood glucose test if the presenting condition warrants it.
   - A request for the next set of observations should be placed for an appropriate length of time (minimum 1 hourly).

c) Initial treatment/tests
   - Analgesia should be given to those children in pain (CH CLIN C49 – CED)
   - Anti-pyretics may be required for an unsettled child with a fever (CH CLIN C49 – CED)
   - Urine tests should be requested if required
   - Fluid challenges to be commenced if required
   - X-ray requests if necessary (with appropriate IMMER training) (CG-RAD/2019/003)
   - Wound Care and closure
   - Referral to the GP service (Streaming and GP co-location SOP)

What does each triage category mean?

There are 5 categories (numbered 1-5) which indicate the priority and speed in which a patient should be seen.

Category 1 – Immediate review within 10 minutes – these patients should be seen in Resus

Category 2 – Very Urgent review within 20 minutes – Consider Resus if necessary

Category 3 – Urgent review within 1 hour

Category 4 – Standard review within 2 hours

Category 5 – Non-Urgent review within 3 hours (Consider streaming to GP service)

<u>When can a nurse start triaging?</u>

This will all depend on previous experience.

Previous children's accident and emergency experience – **3-6months** in department (this will vary on level of experience).

No previous experience in children's accident and emergency or newly qualified – **1 year in the department**.

All nurses should then attend a triage study day allocated to them, following this they should complete the competency package and been fully signed off by their mentor. *It is the responsibility of the nurse and the mentor to recognise when competent to be signed off.*

Bank staff that have completed the triage competency package previously will have to demonstrate and complete five peer reviewed triages if they have taken significant time away from the department. As an example - absences for over a month will need to be done on each subsequent shift but if they are here frequently i.e weekly they will only have to complete the competencies once during that month.

All nurses in CED will have to provide evidence of five peer reviewed triages yearly at their annual appraisal.

<u>Tools used for triage</u>

Triage tool – this was developed from the RCEM standards and identifies the categories that patients should be triaged in depending on their presentation.

Streaming Tool – SOP developed to enable nurses to stream patients arriving into CED to the GP co-location service.

POP's score – please see relevant guideline (CH CLIN C32/Aug 19/v003) – using this enable the nurse to categorise the patient depending on their POPs score. (POPS score shouldn't replace nurses gut feeling on a patient)

POPS below 2 – Category 4

POPS 3-7 – Category 2 or 3

POPS 8+ - Category 2 or 1 (consider resus)

Toe injuries management guideline – using this guideline identifies those patients that are able to be discharged from triage. (CH CLIN C54/March 2019/v001)

Wound guideline – After being triage competent for 1 year nurses are able to use this guideline to identify patients that can be treated and discharged by the nurse in triage. This involves both minor wounds and head injuries. (CH CLIN C56/Feb/v001)

X-Ray from triage – Once triage competent, nurses are able to attend additional training (IRMER) to be able to x-ray from triage.

1. References (Including any NICE Guidelines)

POP's clinical guideline, accessible from NETI - CH CLIN C32/Aug 19/v003

Toe injuries – management and nurse form discharge – accessible from NETI - CH CLIN C54/March 2019/v001

Nurse assessment of any wound – accessible from NETI - CH CLIN C56/Feb/v001

Royal college of paediatrics and child health – standards for children and young people in Emergency care setting, 2012

SBAR tool https://improvement.nhs.uk/documents/2162/sbar-communication-tool.pdf

Single Checking of Analgesia during Triage in the Children's Emergency Department CH CLIN C49

Radiological Imaging (IRMER) – Requesting CG-RAD/2019/003

2. Documentation Controls

<table>
<tr><td>Reference Number

CH CLIN C58</td><td colspan="2">Version:
Version 4</td><td colspan="2">Status

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<tr><td>Version /
Amendment History</td><td>Version
4</td><td>Date
22.05.23</td><td>Author
Sally Welsh
Jenny Li</td><td colspan="2">Reason
Review and update</td></tr>
<tr><td colspan="6">Intended Recipients: Staff in Children’s Accident and Emergency at Derby Royal</td></tr>
<tr><td colspan="6">Training and Dissemination: High compliancy already exists: this guideline is reflective of current imbedded practice in CED.
All staff will be updated and sent a copy of the new Guideline.</td></tr>
<tr><td colspan="6">To be read in conjunction with :
• POP’s Clinical guideline, accessible from NETI –CH CLIN C32/Aug 19/v003
• Toe injuries – management and nurse form discharge – accessible from NETI – CH CLINC54/March2019/v001
• Nurse assessment of any wound – accessible from NETI – CH CLIN C56/Feb/v001
• Royal College of paediatrics and child health – standards for children and young people inEmergency care setting,2012
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• Single Checking of Analgesia during Triage in the Children’s Emergency Department CHCLIN C 49
• Radiological Imaging (IMER) – Requesting CG-RAD/2019/003Streaming SOP
• GP Co-location SOP</td></tr>
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<tr><td colspan="3">Contact for Review</td><td colspan="3">Sister Sally Welsh
Staff Nurse Jenny Li</td></tr>
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3. Appendices

Triage Tool

	1	2	3	4	5	Action / considerations ABCDE
A	Airway compromise Immediate risk to airway Cyanosis / ashen / blue Witnessed apnoea Poor respiratory effort	Apnoea reported at home Stridor at rest Grunting / drooling	Barking cough / no stridor	No compromise Difficulty swallowing – all without any respiratory distress	No compromise	Airway opening manoeveres to aid breathing High flow oxygen Do not distress children with airway distress such as suspected FB or croup
B	Respiratory arrest Severe recession Sternal recession Oxygen saturations below 95% despite 15L oxygen Exhaustion	Moderate recession Tracheal tug Nasal flaring Head bobbing Sighing respirations Unable to speak in sentences	Mild to moderate recession Oxygen between 93 – 95% in air Audible wheeze Wheeze treated with O2 and nebuliser by another health care professional	Respiratory rate normal for age of child Oxygen saturations above 95% in air Able to speak in sentences	Normal Respiratoty rate for age No increased effort	Recession in over 5's indicated severe respiratory distress Exhaustion is a pre-terminal sign
C	Cardiac arrest Major trauma requiring trauma team activation Tachycardia over 200BPM Pallor Heart rate below 50BPM	Inappropriate tachycardia Cap refill 2 – 3 secs Pale / mottled Cold extremities	Appropriate tachycardia	Normal heart rate Cap refill < 2 secs		Consider sepsis 6
D	Unresponsive child Pain score server after analgesia GCS 13 or less Weak or high pitched irritable cry Not responding to parents/carers voice Hypoglycaemic <2MMOL/L Baby stiff to handle / neck stiffness Photophobia	Pain score moderate – severe after analgesia Crying / distressed baby. Irritable Hypoglycaemia 2 – 2.6MMOLS Hyperglycaemia 10MMOLS + Child very quiet GCS 14 Behavioural / psychiatric – violent / aggressive Active threat to self / others	Moderate limb injury On-going risk of self-harm Agitated / withdrawn Potentially aggressive Child at risk of abuse / suspected non accidental injury Psychiatric / behavioural – very distressed	Bright and alert Interacting well Playing Non-specific abdominal pain		Observe interactions with parents Give analgesia suitable for pain score and reassess Perform blood sugar in vomiting / lethargic children or those with symptoms of diabetes Consider stareing a VISA
E	Non blanching spreading rash Urticarial rash with airway symptoms	Fever 38+ in baby under 3 months – reported or documented Fever 39+ in baby 3 – 6 months Non-blanching rash Testicular pain ?torsion	Unexplained fever more than 5 days	Controlled fever in over 1 No unexplained rashes		Consider sepsis 6
POPS	8+	5 - 7	3 - 5	2 or less	2 or less	
Actions for each category	Call help / 2222 Start high flow oxygen Move to resus Start sepsis 6 protocol Frequent observations Blood pressure Blood gas	Start oxygen if necessary Blood pressure Finish full triage assessment Commence nursing treatments : Analgesia / antipyretics / ametop / urine collections Minimum hourly observations Consider blood gas	Prepare for treatment Fluid challenge Ametop Urine collection Hourly observations	Normal healthy child New complaint / acute Health promotion / signposting	Normal healthy child	

APPENDIX 2

CED Streaming Flow Chart

Has the patient been referred by a GP? Or been seen in CED within the last 7 days?

If **NO** continue with flow chart

Does the patient have?

- New continuous cough
- High temperature
- Loss of, or change in, your normal sense of taste or smell (anosmia) *(Public Health England,*

NO → **STREAM TO GREEN**

YES → **STREAM TO RED**

Is the child 2 years of age or older?

YE → **Continue with streaming algorithm**

NO → Stream to triage nurse (**RED**/**GREEN**) as appropriate for full triage

Streaming nurse to ask -

- Brief summary of reason for attendance
- Relevant past medical history
- Social Work consideration
- Consider who's accompanied child

Happy to proceed?

Health Care Assistant (HCA)/Streaming nurse to take -

Heart Rate, SPo2%, Respiratory Rate, and Temperature

YES → Any concerns regarding?

- Reduced fluid intake (<50% of normal feed)
- Increased Thirst
- Frequent urination
- Weight loss
- Tired/lethargy

NO → Stream to triage nurse (**Red**/**Green**). Allocate triage score

YES → Stream to triage nurse (**RED**/**GREEN**) as appropriate for full triage

NO → For Streaming HCA to transfer to **RED**/**GREEN** GP co located service with

APPENDIX 3

Co-located GP

Co-located service is available 24 hours a day 7 days a week (unless at capacity).

The number should you need it is 85520

Child who should be excluded from streaming and should be seen in CED :

- Babies under 3months
- Referred by another souce i.e 999, GP, HV, Midwife, WIC. Some of these children may be appropriate to be streamed but must be discussed with senior CED Dr.
- Children with complex needs.
- Children with child protection concerns or CAMHS
- Re-attends within 72 hours with same problem
- Children with a POPs of >2
- Children with a minor injury who will need an XR or wound management.

Minor head injuries with no red flags can be streamed at the triage nurses discretion