Policy Title: Patient Triage and Priority		
Department/Unite: Nursing Unit.	**Policy Number:** UOJ-MSA-NR-P/12	**Replaces No:**
Creation Date: 09/04/2023	**Effective Date:**	**Review Date:**

Revision History			
Subject	**Changes made**	**Done by**	**Revision date**

1. **CONDITIONS:** 1.1 All Nursing staff of MSA.

2. **PURPOSE:** 2.1 To provide guidelines to be followed in classification and prioritizing of patients according to their medical need.

2.2 To rapidly identify patients with urgent, life threatening conditions, for proper place of treatment on a suitable time.

3. **DEFINITIONS:** 3.1 **Patient Triage:** is the process of assessing patients and determining the priority of patients' treatments based on the severity of their condition.

3.2 **Life Threatening cases:** Are conditions that are threats to life or limb (or imminent risk of deterioration) requiring immediate interventions.

3.3 **Emergent Cases:** Are conditions that are a potential threat to life, limb or function, requiring rapid medical intervention.

3.4 **Urgent Cases:** Are conditions that could potentially progress to a serious problem requiring emergency intervention.

3.5 **Non Urgent cases:** 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.

3.6 **Nonscheduled visits:** Patient visit to the health facility without a previous appointment as in: emergency room and general clinics.

3.7 **Scheduled visits:** patient visits to the health facility with a booked appointment as in: Antenatal care, chronic disease clinic, ...etc.

4. **Related Documents:** N/A

5. **POLICY:** 5.1 All incoming patients with nonscheduled visits are triaged or Prioritized by a specifically trained and experienced nurse and sometimes by the reception staff to rapidly identify patients with urgent, life threatening conditions to prevent unnecessary loss of life and promptly relieve the suffering patients.

6. **PROCEDURES:**

6.1 TRIAGE is a dynamic process which provide ongoing assessment of patients;

6.1.1 All incoming patients with nonscheduled visits should be assessed, (usually based upon chief complaint) by the nurse triage, to prioritize them based upon the severity of their condition.

6.1.2 All patients should be assessed (at least visually) within 10 minutes of arrival.

6.1.3 Full patient assessments should not be done in the triage area (treatment nurse should complete assessment). Only information required to assign a triage level should be recorded.

6.1.4 A rapid assessment (Just brief visual assessment 0-30 seconds) may be necessary in case of crowdedness to ensure patient flow and reduce delays to contact with a health provider.

6.1.5 A patient's condition may improve or deteriorate during the wait for entry to the treatment area.

6.2 Patient Entry;

6.2.1 On Patient arrival to the MSA, the Reception staff will give the patient a serial number and send him to the nursing triage station, as the patient will wait in the waiting area for his number to be called by the triage nurse.

6.2.2 Emergency cases should be seen directly by the triage nurse without waiting, Simply, If the Reception staff suspect an emergent case, he can ask the patient– **Do you have an urgent problem?**

6.2.3 The Reception staff should be trained on identification of the high risk patients to send them directly to the emergency room without delay, and should be trained & updated on CPR procedures (BCLS- Basic Cardiac Life Support) on 2-year basis according to the guidelines of the Saudi Heart Association.

6.3 In the triage room, The triage nurse should;

6.3.1 have rapid access or be in view of the registration and waiting areas at all times.

6.3.2 Performs brief visual assessments.

6.3.3 Triages patients into priority groups using appropriate guidelines.

6.3.4 Documents the assessment clearly in triage form with assigned triage level

(signed and stamped).

6.3.5 Transports patient to Emergency Room when necessary and inform the physician about the patient.

6.3.6 Gives report to the emergency room nurse, documents who report was given to and returns to the triage area.

6.3.7 Instructs waiting patients to notify triage nurse of any change in condition.

6.4 Triage Assessment includes:

6.4.1 Chief complaint:

6.4.1.1 Onset/Course/Duration.

6.4.1.2 Pain scale (If pain is present); The more intense the pain (8-10/10) the more the care provider should be concerned about the need to identify or exclude serious illnesses.

6.4.2 Physical assessment:

6.4.2.1 Physical assessment must be rapid concise, and focused; (Not a head to toe assessment).

6.4.2.2 Physical assessment, accompanies the triage interview, is chiefly through observation; e.g. Assessment may begin with the observation that the patient can speak and therefore has a patent airway.

6.4.2.3 Effective triage requires the use of sight, hearing, smell and touch. - Look for severe distress; facial grimaces, cyanosis, fear...etc. - Listen for a cough, hoarseness, labored respiration...etc. - Touch the patient; assess heart rate and skin temperature and moisture. - Notice odors such as the smell of ketones, alcohol, or infection.

6.4.2.4 Vital signs (VS) will be done on patients if required for categorization or if time permits. Otherwise Vital signs are the responsibility of the treatment nurse.

6.5 Triage Categorization;

6.5.1 In case of doubt (the patient looks ill and you are not sure, better to up-level the triage than down-level it).

6.5.2. Levels of Triage Categorization:

6.5.2.1. Level I – Life Threatening Conditions:

6.5.2.1.1. Conditions that are threats to life or limb requiring immediate aggressive interventions, e.g. Unresponsive, absent or unstable vital signs (panic, pulse less) and severe respiratory distress.

6.5.2.1.2. Time to physician: IMMEDIATE

6.5.2.1.3. Patient should be stabilized, given first aid measures and referred immediately to the hospital by the ambulance accompanied by physician and nurse for close monitoring.

6.5.2.2 Level II – (Emergent Cases):

6.5.2.2.1. Conditions that are a potential threat to life limb or function, requiring rapid medical intervention.

6.5.2.2.2. Time to physician: 15 minutes.

6.5.2.2.3. should be re-assessed every 15 minutes and Can be leveled to level 1.

6.5.2.2.4. Should be send immediately to the emergency room, given first aid measures, received treatment, put under observation, urgent investigations will be done and either refer to the hospital for more interventions or discharge home if improved.

6.5.2.3 Level III – Urgent cases:

6.5.2.3.1. Conditions that could potentially progress to a serious problem requiring emergency intervention.

6.5.2.3.2. Time to physician 30 min

6.5.2.3.3. Should be re-assessed every 60 minutes.

6.5.2.3.4. Should be send to the emergency room, received treatment, put under observation, urgent investigations will be done and either discharge home if improved or refer to the hospital for more interventions.

6.5.2.4 Level IV– Non Urgent cases:

6.5.2.4.1. 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.

6.5.2.4.2. Time to physician 2 hours.

6.5.2.4.3. Should be re-assessed every 120 minutes.

6.5.2.4.4. The patients will be distributed to different clinics according to their needs,

received treatment & discharged home if their condition not deteriorate.

7. RESPONSIBILITIES

7.1 The triage nurse:

7.1.1 should have rapid access or be in view of the registration and waiting areas at all times.

7.1.2 Performs brief visual assessments for all patients.

7.1.3 Triages patients into priority groups using appropriate guidelines.

7.1.4 Documents the assessment clearly in triage form with assigned triage level (signed and stamped)

7.1.5 Transports patient to Emergency Room when necessary and inform the physician about the patient.

7.1.6 Gives report to the treatment nurse or emergency physician, documents who report was given to and returns to the triage area.

7.1.7 Keeps patients/families aware of delays.

7.1.8 Reassesses waiting patients as necessary.

7.1.9 Instructs waiting patients to notify triage nurse of any change in condition.

7.1.10 should be trained & updated on CPR procedures (BCLS- Basic Cardiac Life Support) on 2 year basis according to the guidelines of the Saudi Heart Association.

8. Appendix:

8.1 Nurse triage form.

9. REFERRANCES:

9.1 Ministry of Health Manual for Nursing Unit.

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