



# PEDIATRIC TRIAGE

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## Importance of Standard Pediatric Assessment Tool

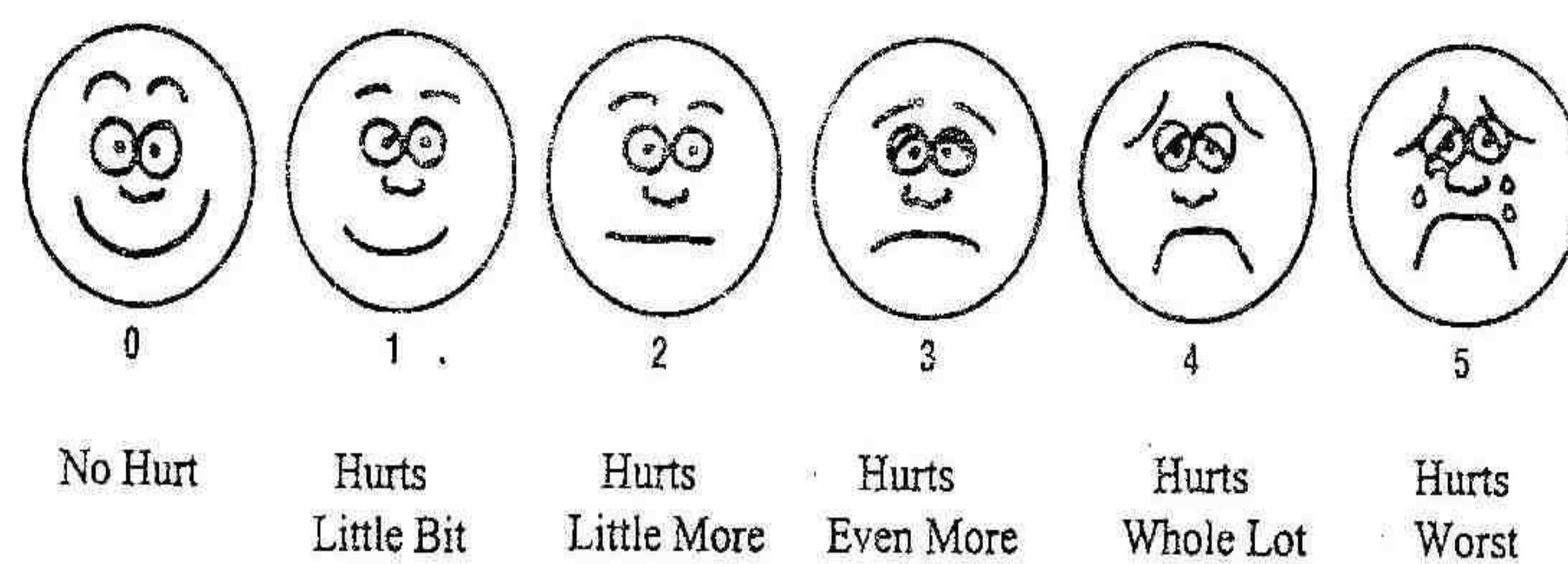
- According to the American College of Emergency Physicians and the Emergency Nurses Association a reliable and valid five-level triage acuity system such as the Emergency Severity Index (ESI) is recommended to prioritize patient care.

Fernandes, C., Tanabe, P., Gilboy, N., Johnson, L. A., McNair, R. S., Rosenau, A. M., . . . Suter, R. E. (2005). Five-level triage: A report from the ACEP/ENA five-level triage task force. *Journal of Emergency Nursing*, 31(1), 39-50. doi: 10.1016/j.jen.2004.11.002

- Health deterioration in children can present with different physiological changes compared to adults and can be easily misinterpreted by nurses who are mainly trained with adult care.

Adshead, N., & Thomson, R. (2009). Use of a pediatric early warning system in emergency departments. *Emergency Nurse*, 17(1), 22-25.

Faces Pain Rating Scale



## Pediatric Assessment Key Points

- Observe skin color, respiratory pattern and overall appearance
- Critical to observe, auscultate & touch infants
- Approach kids in a nonthreatening manner, get down to their eye level and allow a trusted caregiver to stay with them the entire time
- Elementary and school aged children can present their own chief complaint
- Don't mistake size for maturity
- Signs of severe illness may be subtle and easily overlooked in neonate and young infant
- Infants, toddlers, and preschoolers have increased risk for heat and fluid loss
- Hypotension is late marker of shock in prepubescent children
- Obtain pediatric weight in triage
- Use the appropriate sized equipment for vital signs

Gilboy, N., Tanabe, P., Travers, D., & Rosenau, A. (2011). *Emergency severity index (ESI): A triage tool for emergency department care*. Retrieved from <http://www.ahrq.gov/research/esi/esihandbk.pdf>

## Standard Approach to Pediatric Triage Assessment

- Appearance, work of breathing, circulation
- Airway, breathing, circulation, disability, exposure and environmental control (ABCDE)
- Pertinent health history
- Vital signs: essential to use correct equipment
- Fever present?
- Pain present? Use pediatric pain scale.
  - Pain is subjective and children's scores need to be seen as reliable. Triage nurses in ED assign significantly lower pediatric scores when evaluating children

Rajasagaram, U., Taylor, D., Braitberg, G., Pearsell, J., & Capp, B. (2009). Paediatric pain assessment: Differences between triage nurse, child and parent. *Journal of Paediatrics and Child Health*, 45(4), 199-203. doi:10.1111/j.1440-1754.2008.01454.x

Gilboy, N., Tanabe, P., Travers, D., & Rosenau, A. (2011). *Emergency severity index (ESI): A triage tool for emergency department care*. Retrieved from <http://www.ahrq.gov/research/esi/esihandbk.pdf>

## Future of Triage

- Emerging technologies are converging to create a new generation of smart sensors which will allow for quick identification of severely injured patients
- Development of pediatric-specific educational materials in order to strength validity and reliability for triage

Moulton, S. L., Haley-Andrews, S., & Mulligan, J. (2010). Emerging technologies for pediatric and adult trauma care. *Current Opinion in Pediatrics*, 22(3), 332-338. doi:10.1097/MOP.0b013e328338da83

Travers, D. A., Waller, A. E., Katzenbach, J., & Agans, R. (2009). Reliability and validity of the Emergency Severity Index for Pediatric Triage. *Academic Emergency Medicine*, 16(9), 843-849. doi: 10.1111/j.1553-2712.2009.00494.x

## ESI Triage Algorithm

