

NURSING SERVICE GUIDELINES Emergency Department

Guideline: Pediatric Triage

Policy Number Superseded:

Responsibility: Trained Emergency Department (ED) staff to include; Registered Nurses (RN) and physician providers

Purpose of Guideline: To establish a standardized procedure for triaging the pediatric population that presents to the Emergency Department

- Ensure timely identification of life-threatening conditions
- Prioritize care based on acuity using the Emergency Severity Index (ESI)
- Promote safe patient flow
- Maintain compliance with EMTALA and regulatory standards



Effective Date: 5/2026

Initial Effective Date:
5/2026

Procedure:

(A) Utilization of the Pediatric Assessment Triangle (PAT); a rapid hands-off visual auditory assessment tool used to identify physiological instability in infants and children. Allows the medical providers to form a general impression within seconds of patient contact. There are three components:

- Appearance-Assesses neurologic status and overall condition using tone, interactiveness, consolability, look/gaze, and speech/cry.
- Work of Breathing – Evaluates respiratory effort, including abnormal airway sounds, retractions, nasal flaring, and positioning.

- Circulation to Skin – Assesses perfusion through observation of skin color (pallor, mottling, cyanosis).

(B) Patients are visually assessed upon arrival using PAT principles to rapidly identify life-threatening conditions.

(C) Patients with immediate life-threatening conditions are escorted directly to a treatment area.

(D) Registration may occur at bedside if clinically necessary

(E) Pediatric patients shall:

- Be weighed in kilograms only
- Receive an identification band using two identifiers
- Have isolation needs assessed

(F) If patients are not immediately brought to an ED room, ongoing monitoring is needed.

- Patients in the waiting area are monitored visually
- Vital signs are reassessed at a minimum every 4 hours and as clinically indicated
- Acuity may be upgraded if there is a change in condition while in the waiting area

(G) Vital Sign Requirements:

- All patients presenting to the ED to be seen for treatment shall receive a full set of vital signs:
 - i. Heart Rate
 - ii. Respiratory Rate
 - iii. Blood Pressure (age dependent)
 - iv. Pulse Oximetry

- v. Temperature
- vi. Mental Status assessment when clinically indicated
- If a patient is triaged as an Emergency Severity Index (ESI) Level 1 or 2 and is roomed immediately, the assigned bedside nurse shall obtain and document the full set of vital signs, as soon as clinically able.
- An abnormal vital sign shall be considered in determining an ESI level and may be an indication for an acuity upgrade.

(H) Special considerations:

- Suspected Child Abuse/Neglect
 - i. Triage according to symptoms
 - ii. Document social work, family services, and/or law enforcement involvement
- Behavioral Health
 - i. Triage according to presentation
 - ii. Implement safety precautions
- Children and Youth with Special Healthcare Needs
 - i. Have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition
 - ii. Require health and related services beyond those required by children
 - iii. May be at increased risk for rapid or subtle clinical deterioration

(I) Secondary pediatric triage assessment:

- To include:
 - i. Subjective data: Chief complaint, Past medical and surgical history, Medications, allergies, Immunizations
 - ii. Objective data: Full set of vital signs, Weight if not already obtained
 - iii. Additional focused assessments along with psychological screening when indicated

ESI Triage Acuity Classification:

- **Level 1 – Critical**
 - Immediate life-saving intervention required
- **Level 2 – Emergent**
 - High-risk situation; rapid intervention required
- **Level 3 – Urgent**
 - Stable but requires multiple resources
- **Level 4 – Semi-Urgent**
 - Stable; requires one resource
- **Level 5 – Non-Urgent**
 - Stable; requires no resources

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Reviewed by Policy & Standard
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