TRIAGE

TRIAGE : IMPLEMENTASI STANDAR NASIONAL AKREDITASI RS

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SEMINAR DAN WORKSHOP KEPERAWATAN

MEITHA ROOSMEILANY

PRAKTISI KEPERAWATAN KRITIS

SUPERVISOR KEPERAWATAN

RSUP DR. HASAN SADIKIN BANDUNG.

Meitha roosmeilany · meitharoosmeilany · meitharoosmeilany

Out line

TRIAGE

1. PENDAHULUAN
2. KEBIJAKAN DAN STANDAR
3. METODE ASESMEN ACUTE ILLNESS SEVERITY
4. SUMBER DAYA PENDUKUNG
5. MONITORING DAN EVALUASI
6. APLIKASI TRIAGE DI TATANAN KLINIS

A

TRIAGE

Menentukan dg cepat prioritas pasien yang harus diprioritaskan

B

EWS

peringatan dini dan pemicu terhadap kewaspadaan

C

TRC

Sistem respon cepat terhadap aktivasi kegawatan pasien

D

CODE BLUE

Sistem aktivasi thd pasien henti jantung

E

MORTALITAS

Kematian PAsien

Apa Yang Anda Pikirkan ??

TRIAGE

Situasi gawat darurat pasien yang menyebabkan kesibukan

Membutuhkan managemen waktu yang baik

Banyak Profesional pemberi asuhan yang terlibat

Kompleksitas kasus pada penyakit Akut

PERKEMBANGAN TRIAGE

TRIAGE

- Military roots
- Masuk ke *setting* RS pada awal tahun 1960 --->

Adanya peningkatan kasus di RS
Orang-orang dengan kondisi yang tidak *urgent* masuk ke IGD untuk meminta dilakukan tindakan

DEFINISI

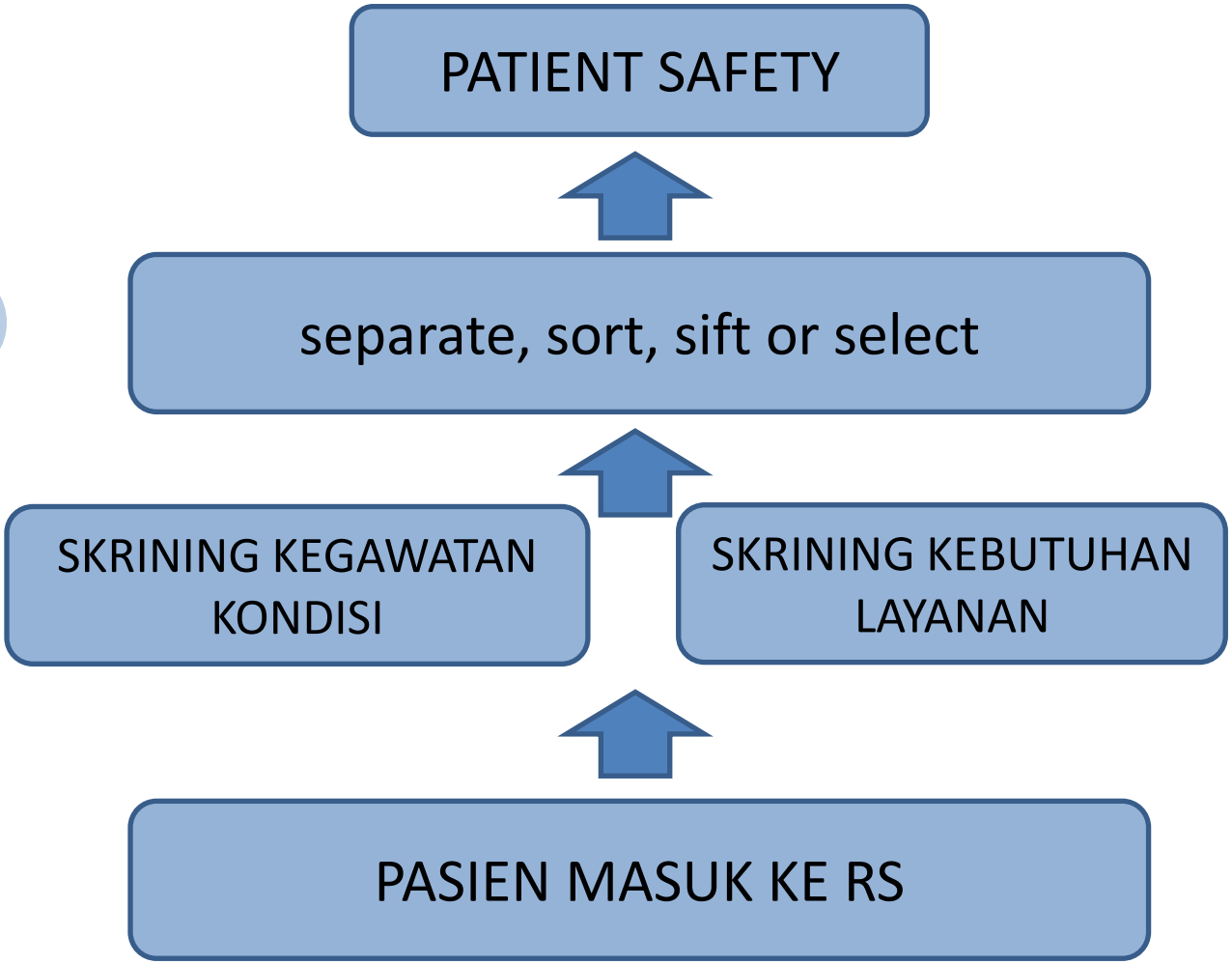
- TRIAGE → TRIER (French) = SORTIR

"Evaluasi berdasarkan kriteria fisiologis untuk menentukan kebutuhan medis dan urgensi pada masing2 pasien dalam waktu terbatas"

"*Triage is a dynamic process and is usually done more than once*"

"*Meaning to separate, sort, sift or select*"

MENGAPA DIPERLUKAN TRIAGE DI RUMAH SAKIT??



TUJUAN

- Mengidentifikasi dengan cepat pasien dengan kondisi mengancam jiwa untuk mendapatkan perawatan.
- Menentukan derajat/tingkat keparahan kondisi pasien
- Mengarahkan pasien ke tempat perawatan yang sesuai
- Mengevaluasi kembali kondisi pasien yang menunggu tempat perawatan
- Mengurangi lama perawatan.

TRIAGE

MANFAAT

- Memperpendek aliran pasien.
- Mengurangi risiko cedera / kerusakan lebih lanjut.
- Meningkatkan komunikasi.
- Meningkatkan kerja tim.
- Identifikasi persyaratan sumber daya.
- Menetapkan tolok ukur nasional.

PRINSIP TRIAGE

TRIAGE

Melakukan penapisan secara proporsional (efektif dan efisien) pada semua pasien yang masuk ke ED dan kemudian menempatkannya sesuai dengan hasil penapisan.

PENTING DALAM TRIAGE

TRIAGE

- Pasien harus memiliki penilaian triase dalam waktu 10 menit setelah tiba di ED.
- Triage yang akurat adalah kunci untuk pola operasional yang efisien dari ED.
- Triase yang efektif didasarkan pada pengetahuan, keterampilan, dan sikap staf triase.

- Triage adalah proses yang dinamis
- Kondisi pasien dapat membaik atau memburuk selama menunggu perawatan
- Penilaian ulang, penilaian kembali, penilaian kembali

Triage Process

TRIAGE

- Menilai dan menentukan tingkat keparahan atau ketajaman masalah yang muncul.
- Memproses pasien ke tingkat level kegawatan pasien.
- Tentukan dan arahkan pasien ke area perawatan yang sesuai.
- Secara efektif dan efisien menetapkan sumber daya kesehatan manusia yang tepat.

Standar Nasional Akreditasi Rumah Sakit (SNARS)

Standar ARK 1

Penerimaan pasien rawat inap /pemeriksaan pasien rawat jalan sesuai kebutuhan pelayanan pasien

Standar ARK 1 : Penerimaan pasien ranap/Pemeriksaan pasien rajal sesuai kebutuhan pelayanan pasien

TRIAGE

1. Regulasi tentang skrining di dalam maupun di luar RS
2. Ada pelaksanaan proses skrining baik di dalam maupun di luar RS.
3. Ada proses pemeriksaan penunjang yang diperlukan/spesifik untuk menetapkan apakah pasien diterima atau dirujuk.
4. Berdasarkan hasil skrining ditentukan kebutuhan pasien sesuai dengan kemampuan RS.
5. Pasien diterima bila RS dapat memberi pelayanan rawat jalan dan rawat inap yang dibutuhkan pasien.
6. Pasien tidak dirawat, tidak dipindahkan atau dirujuk sebelum diperoleh hasil tes yang dibutuhkan tersebut.

Standar Nasional Akreditasi Rumah Sakit (SNARS)

Standar ARK 1.1

Pasien dengan kebutuhan gawat dan/atau darurat, atau yang membutuhkan pertolonga segera diberikan prioritas untuk asesmen dan tindakan

Standar ARK 1.1 : Prioritas untuk asesmen dan tindakan bagi pasien gawat dan/atau darurat

- **Pasien dengan kebutuhan gawat dan/atau darurat, segera diidentifikasi.**

a) Ada regulasi tentang proses triase berbasis bukti.

b) Ada pelaksanaan penggunaan proses triage untuk memprioritaskan pasien sesuai dengan kegawatannya.

c) Staf sudah terlatih menggunakan kriteria berbasis bukti.

d) Pasien dengan kebutuhan mendesak diberikan prioritas.

e) Kondisi pasien distabilisasi sebelum ditransfer atau dirujuk dan didokumentasikan

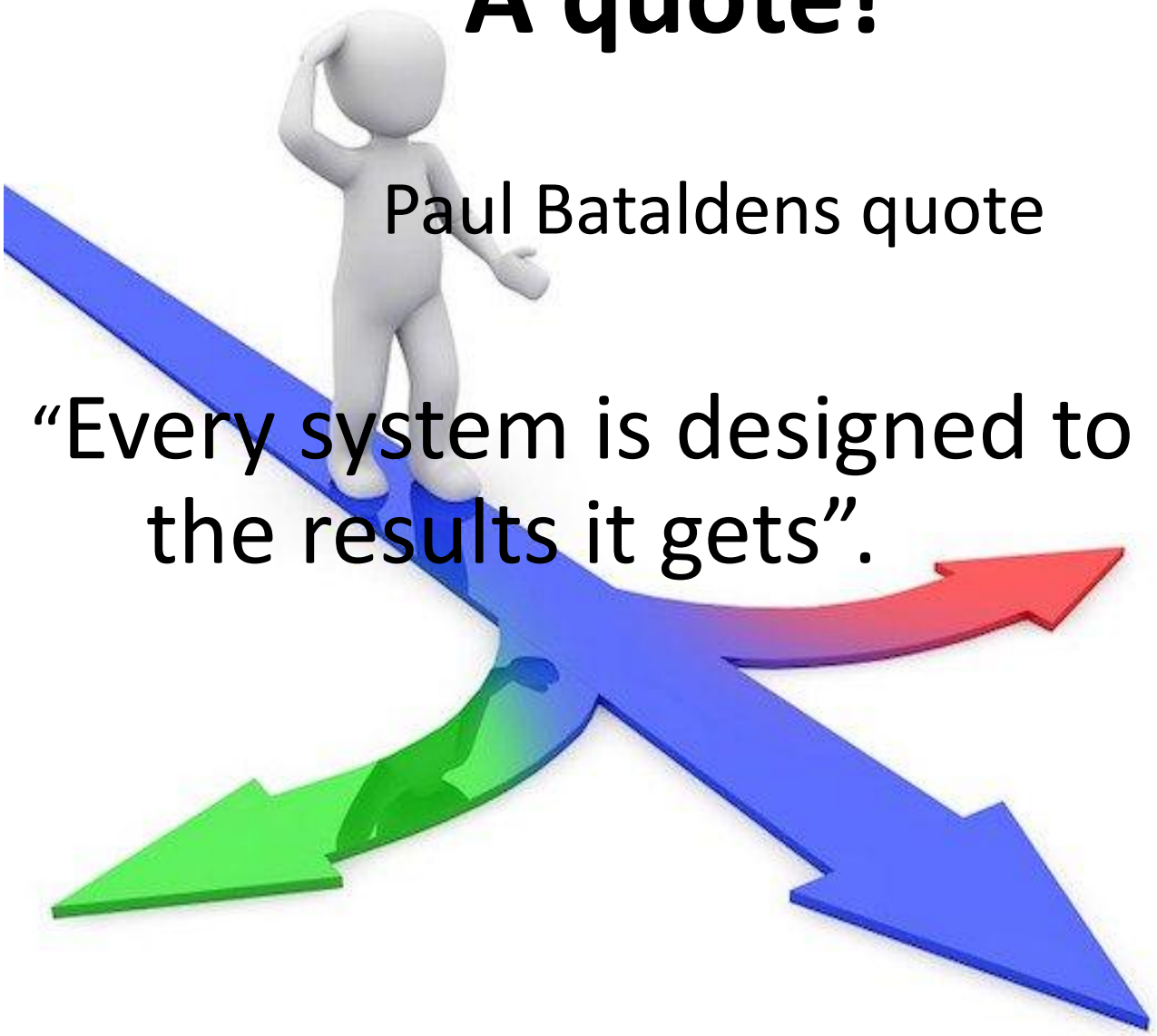
METODE TRIAGE

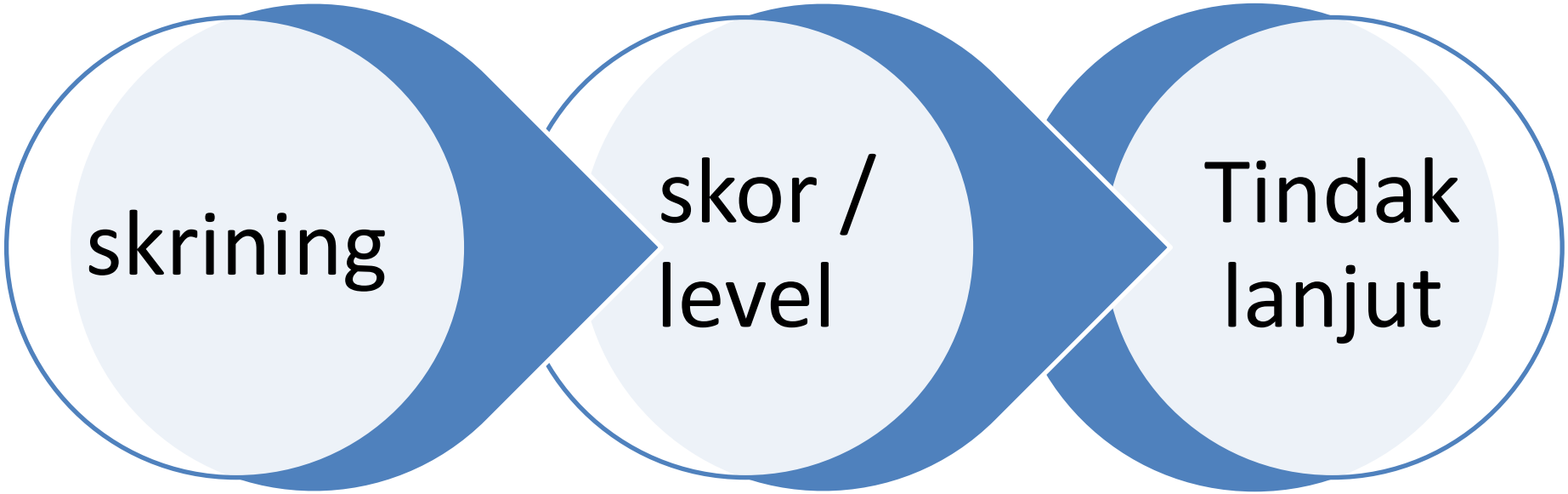
A quote!

TRIAGE

Paul Bataldens quote

“Every system is designed to get the results it gets”.




skrining
skor / level
Tindak lanjut

FOKUS UTAMA TRIAGE

TRIAGE

- Keluhan utama.
- Riwayat penyebab singkat.
  Cedera atau penyakit (tanda & gejala).
- Penampilan umum.
- Tanda-tanda vital.
- Penilaian fisik singkat pada triase.

SISTEM TRIAGE YANG DIGUNAKAN SAAT INI

TRIAGE

- CTAS ~ Canadian Triage and Acuity scale
- ESI ~ Emergency Severity Index
- ATI ~ Australian Triage Index
- SATS ~ South Africa Triage Scale

TRIAGE

The Canadian Association of Emergency Physicians
L'Association canadienne des médecins d'urgence

National Emergency Nurses Affiliation Inc.
L'affiliation nationale des infirmiers/infirmières d'urgence incorporée

L'association des Médecins d'urgence du Québec

The Canadian E.D. Triage and Acuity Scale

Patients should have an *INITIAL TRIAGE ASSESSMENT WITHIN 10 MINUTES** of arrival

TRIAGE LEVEL I - *RESUSCITATION*

Time to NURSE Assessment: ***IMMEDIATE****

Time to PHYSICIAN Assessment: ***IMMEDIATE****

USUAL PRESENTATION	SENTINEL DIAGNOSIS
Code / Arrest	Traumatic Shock
Major Trauma	Pneumothorax - Traumatic / Tension
Shock States	Facial Burns with Airway Compromise
Near Death Asthma	Severe Burns > 30% TBS
Severe Respiratory Distress	Overdose with Hypotension / Unconscious
Altered Mental State (unconscious, delerious)	AAA
Seizures	AMI with Complications / CHF / Low BP
	Status Asthmaticus
	Head Injury - Major / Unconscious
	Status Epilepticus

TRIAGE LEVEL II - *EMERGENT*

Time to NURSE Assessment: ***IMMEDIATE****

Time to PHYSICIAN Assessment: ***15 MINUTES****

USUAL PRESENTATION	SENTINEL DIAGNOSIS
Head Injury (Risk Features ± Altered Mental State)	Head Injury
Severe Trauma	Trauma, Multiple Sites, Multiple Rib Fracture, Neck Injury / Spinal Cord
Altered Mental State (lethargic, drowsy, agitated)	
Chemical Exposure - Eyes	Alkaline / Caustic Occular Burns
Allergic Reaction (Severe)	Anaphylaxis
Chest Pain • Visceral, Non-Traumatic • ± Associated Symptoms	AMI, Unstable Angina, CHF, Chest Pain NOS, Gastroesophageal Reflux
Overdose (conscious), Drug Withdrawal	Unspecified Drug / Medicinal Overdose, "d.t.'s"
ABD Pain (Age >50) with Visceral Symptoms	AAA, Appendicitis, Cholecystitis
Back Pain (Non Trauma, Not MSK)	
GI Bleed with Abnormal Vital Signs	Gastrointestinal Bleed, Hypotension
CVA with Major Deficit	CVA
Asthma Severe (PEFR <40%)	Severe Asthma
Moderate / Severe Dyspnea / Diffuculty Breathing	COPD, Croup
Vaginal Bleeding • Acute, Pain scale >5 • ± Abnormal Vital Signs	Spontaneous Abortion Ectopic Pregnancy / Rupture
Vomiting and/or diarrhea (with suspicion of dehydration)	
Signs of serious infection (purpuric rash, toxic)	
Chemotherapy or immunocompromised	
Fever (age ≤ 3 months) Temp ≥ 38.0 (rectal)	Epiglottitis, Meningitis, Sepsis
Acute Psychotic Episode / Extreme Agitation	Acute Psychotic Episode / Agitation
Diabetes: Hypoglycemia, Hyperglycemia	Hypoglycemia, Diabetic Ketoacidosis, Hyperglycemia
Headache (Pain Scale 8 - 10/10)	Migraine
Pain Scale 8-10 (CVA, Back, Eye)	Renal Colic, LBP / Strain (Disc), Keratitis, Iritis
Sexual Assault	
Neonate (≤ 7 days old)	

TRIAGE LEVEL III - *URGENT*

Time to NURSE Assessment: ***30 MINUTES****

Time to PHYSICIAN Assessment: ***30 MINUTES****

USUAL PRESENTATION	SENTINEL DIAGNOSIS
Head Injury, Alert, Vomiting	Head Injury
Moderate Trauma	Anterior Dislocated Shoulder, Tibia / Fibula Fracture, Bimalleolar, Trimalleolar Ankle Fracture
Abuse / Neglect / Assault	
Vomiting and/or diarrhea (≤ 2 years)	
Dialysis problems	
Signs of Infection	Pyelonephritis
Mild / Moderate Asthma (PEFR > 40%)	Asthma without Status / COPD
Mild / Moderate Dyspnea	Bronchiolitis / Croup, Pneumonia
Chest Pain • No Visceral Symptoms (Sharp/MSK) • No Previous Heart Disease	Chest Pain NOS (MSK, GI, Resp)
GI Bleed with Normal Vital Signs	GI Bleed, No complications
Vaginal Bleeding Acute, Normal Vital Signs	Spontaneous Abortion
Seizure, Alert on Arrival	Seizure
Acute Psychosis ± Suicidal Ideation	Acute Psychosis ± Suicidal Ideation
Pain Scale 8 - 10 / 10 with minor injuries	
Pain Scale 4 - 7 / 10 (Headache, CVA, Back)	Migraine, Renal Colic, LBP / Strain (Disc)

TRIAGE LEVEL IV - *LESS URGENT*

Time to NURSE Assessment: ***60 MINUTES****

Time to PHYSICIAN Assessment: ***60 MINUTES****

USUAL PRESENTATION	SENTINEL DIAGNOSIS
Head Injury, Alert, No Vomiting	Head Injury, Alert, No Vomiting
Minor Trauma	Colles Fracture, Ankle Sprain
ABD Pain (Acute)	Appendicitis, Cholecystitis
Earache	Otitis Media / Otitis Extema
Chest Pain, Minor Trauma or MSK, No Distress	Chest Pain NOS (MSK, GI, Resp), Gastroesophageal Reflux
Vomiting and diarrhea (>2 years/no dehydration)	
Suicidal Ideation / Depression	Suicidal Ideation / Depression
Allergic Reaction (Minor)	Urticaria
Corneal Foreign Body	Corneal Foreign Body
Back Pain (Chronic)	LBP /Strain
URI Symptoms	URI
Pain Scale 4 - 7	
Headache (Non Migraine / Not Sudden)	

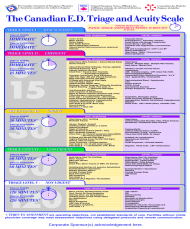
TRIAGE LEVEL V - *NON URGENT*

Time to NURSE Assessment: ***120 MINUTES****

Time to PHYSICIAN Assessment: ***120 MINUTES****

USUAL PRESENTATION	SENTINEL DIAGNOSIS
Minor Trauma, Not Necessarily Acute	LBP / Strain
Sore Throat, No Resp Symptoms	URI
Diarrhea alone (no dehydration)	Gastroenteritis
Vomiting alone normal mental status (no dehydration)	Vomiting
Menses	Disorders of Menstruation
Minor Symptoms	Dressing Changes
ABD Pain (Chronic)	Cast Changes
Psychiatric complaints	Constipation
Pain Scale < 4	Symptoms / Neurotic, Personality and Nonpsychotic Mental Disorders
	Unspecified Superficial Laceration(s)

* *TIMES TO ASSESSMENT* are operating objectives, not established standards of care. Facilities without onsite physician coverage may meet assessment objectives using delegated protocols and remote communication.



CANADIAN TRIAGE AND ACUITY SCALE (CTAS) NATIONAL GUIDELINES

- **Level 1 - Patients need to be seen by a physician immediately 98% of the time.**
- **Level 2 - Patients need to be seen by a physician within 15 minutes 95% of the time.**
- **Level 3 - Patients need to be seen by a physician within 30 minutes 90% of the time.**
- **Level 4 - Patients need to be seen by a physician within 60 minutes 85% of the time.**
- **Level 5 - Patients need to be seen by a physician within 120 minutes 80 % of the time.**

CTAS

Level	Time to Primary RN assessment	Time to MD assessment	Reassessment Time
Level 1	immediate	immediate	continuous
Level 2	immediate	≤ 15 min	15 min
Level 3	≤ 30 min	≤ 30 min	30 min
Level 4	≤ 1 hour	≤ 1 hour	1 hour
Level 5	≤ 2 hour	≤ 2 hour	2 hours

EMERGENCY SEVERITY INDEX (EMI)

The Emergency Severity Index is a 5 level tool for use in emergency department triage. Experienced ER nurses use the ESI to rate patient's acuity on a scale of 1-5.

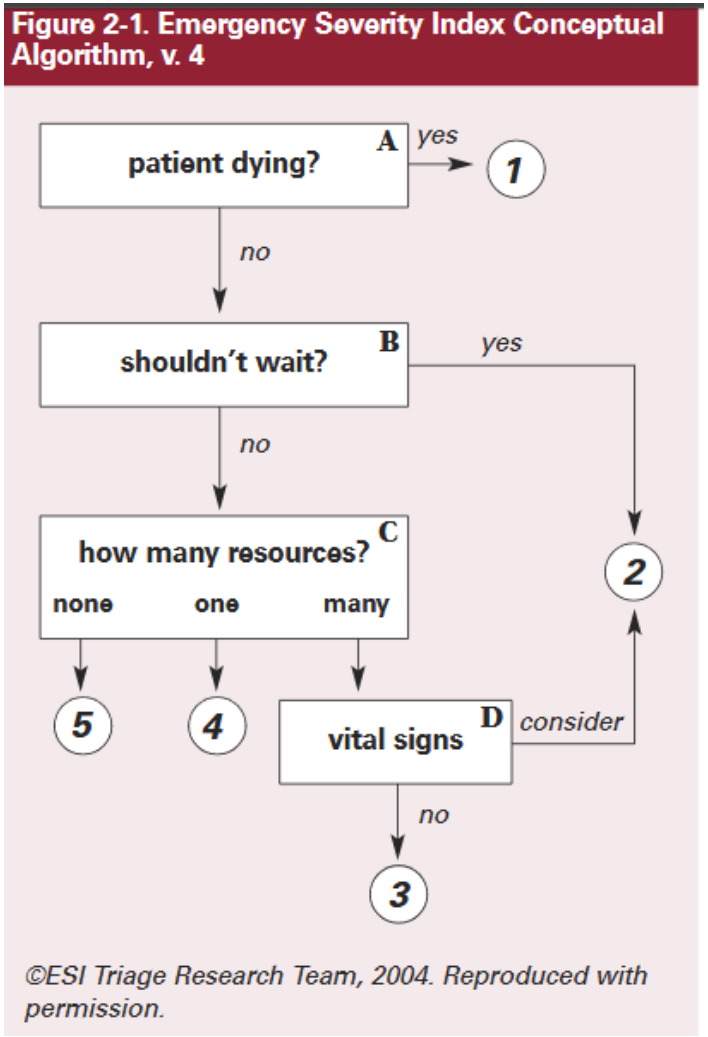
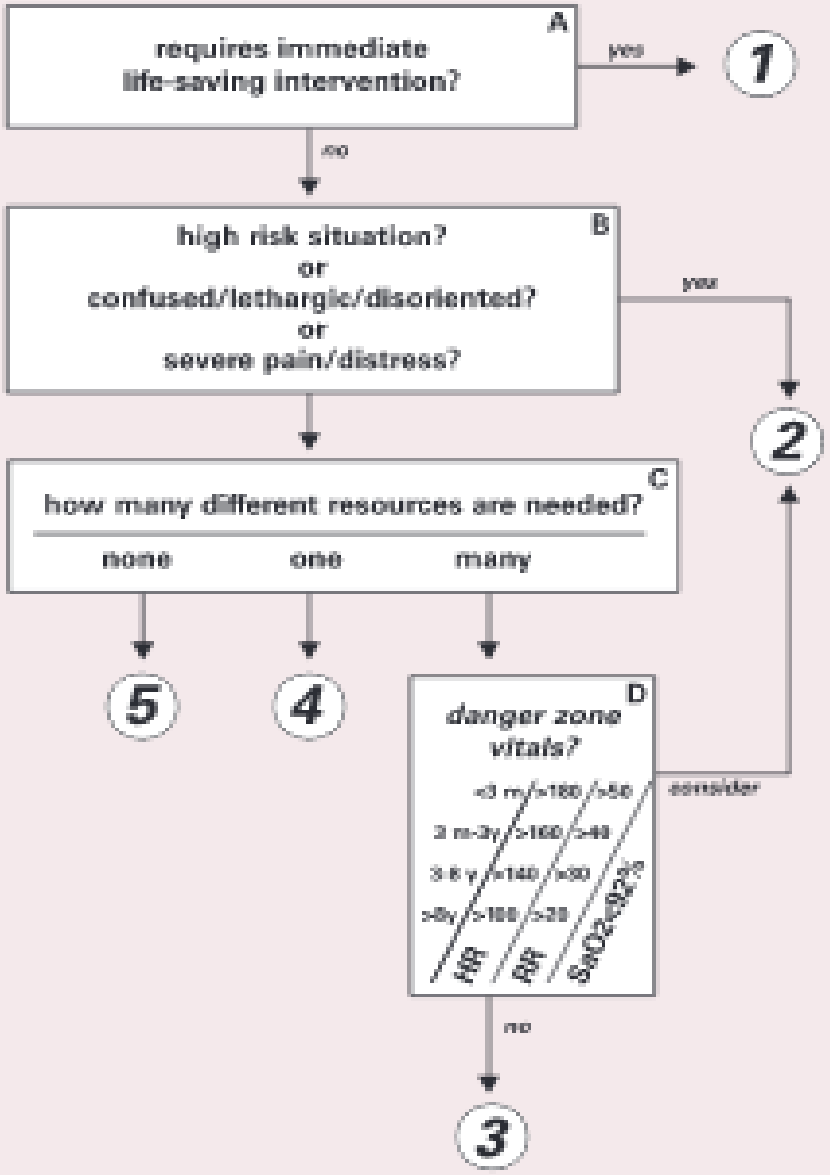


Figure 2-1a. ESI Triage Algorithm



A. Immediate life-saving intervention required: airway, emergency medications, or other hemodynamic interventions (IV, supplemental O2, monitor, ECG or labs DO NOT count); and/or any of the following clinical conditions: intubated, apneic, pulseless, severe respiratory distress, SPO_2<90, acute mental status changes, or unresponsive.

Unresponsiveness is defined as a patient that is either:
(1) nonverbal and not following commands (acutely); or
(2) requires noxious stimulus (P or U on AVPU) scale.

B. High risk situation is a patient you would put in your last open bed.

Severe pain/distress is determined by clinical observation and/or patient rating of greater than or equal to 7 on 0-10 pain scale.

C. Resources: Count the number of different types of resources, not the individual tests or x-rays (examples: CBC, electrolytes and coags equals one resource; CBC plus chest x-ray equals two resources).

Resources	Not Resources
• Labs (blood, urine) • ECG, X-rays • CT-MRI-Ultrasound-angiography	• History & physical (including pelvic) • Point-of-care testing
• IV fluids (hydration)	• Saline or heplock
• IV or IM or nebulized medications	• PO medications • Tetanus immunization • Prescription refills
• Specialty consultation	• Phone call to PCP
• Simple procedure—1 (ie nail, foley cath) • Complex procedure—≥ (conscious sedation)	• Simple wound care (dressings, recheck) • Crutches, splints, slings

D. Danger Zone Vital Signs
Consider uptriage to ESI 2 if any vital sign criterion is exceeded.

Pediatric Fever Considerations
1 to 28 days of age: assign at least ESI 2 if temp >38.0 C (100.4F)
1-3 months of age: consider assigning ESI 2 if temp >38.0 C (100.4F)
3 months to 3 yrs of age: consider assigning ESI 3 if: temp >39.0 C (102.2 F), or incomplete immunizations, or no obvious source of fever

EMERGENCY SEVERITY INDEX (EMI)

- Level 1: Immediate life saving intervention required
- Level 2: High risk situation (Confused, lethargic, disoriented, severe pain or distress)
- Level 3: Multiple Resources are required.

(Consider upgrading to level 2 if vital signs are in the danger zone (<3 months HR >180, >RR 50 and O2 sats <92%, 3 months to 3 years HR >160, RR >40 and O2 sats <92%, 3 years to 8 years HR >140, >RR 30 and O2 sats < 92% and over 8 years, HR >100, RR >20 and O2 sats < 92%)

- Level 4: One resource required
- Level 5: No resources needed

AUSTRALIAN TRIAGE INDEX (ATI)

4. URAIAN SKALA

ATS CATEGORY	PENGOBATAN PERAWATAN (Waktu tunggu maksimum)	KINERJA INDIKATOR AMBANG
ATS 1	Segera	100%
ATS 2	10 minutes	80%
ATS 3	30 minutes	75%
ATS 4	60 minutes	70%
ATS 5	120 minutes	70%

SOUTH AFRICA TRIAGE SCORE (SATS)

In 2004 the South African Triage Group (SATG) formerly known as the Cape Triage Group) was convened under the auspices of the Joint Division of Emergency Medicine and the University of Cape Town and Stellenbosch. The aim of the STAG was to produce a triage score for use throughout South Africa.

5 Level Triage

TRIAGE

- Level 1 *Resuscitative*
- Level 2 *Emergent*
- Level 3 *Urgent*
- Level 4 *Less urgent*
- Level 5 *Non-urgent*


immediate
very urgent
urgent
standard
non-urgent

3 KATEGORI USIA PADA TEWS:

TRIAGE

~INFANT (50 CM TO 95 CM ~ ONE WEEK TO ALMOST 3 YEARS OF AGE)

~CHILDREN (96 CM – 150 CM 3 YEARS TO 12 YEARS OF AGE)

~ADULT (OVER 150 CM)

TAHAPAN TRIAGE

~ Tahap 1 : Kaji riwayat dan keluhan utama dan dokumentasikan

~ Tahap 2 : Kaji tanda-tanda vital dan dokumentasikan

~ Tahap 3: Kalkulasikan TEWS dan hitung total skor

~ Tahap 4: Lakukan rekomendasi sesuai dengan total skore dan **observasi** hal penting lainnya diluar TEWS

~ Tahap 5: Dokumentasikan kode triage pasien dan lakukan tindakan yang sesuai dengan kebuthan pasien.

TRIAGE

TEWS CALCULATOR

2 HAL PENTING YANG HARUS DIPERHATIKAN DALAM TEWS ADALAH :

VITAL SIGNS AND MOBILITY

Physiological Symptoms affected by Vital Signs

TRIAGE

~Tekanan darah dan nadi berhubungan dengan sistem cardiovascular

~Respiratory rate menunjukan fungsi respirasi secara umum

~Perubahan suhu mengindikasikan masalah dalam thermoregulatory system

~AVPU tingkat kesadaran berhubungan dengan masalah sentral persyarafan

~Kemampuan mobilisasi mengkaji gangguan pada sistem musculoskeletal, termasuk adanya nyeri

~Trauma refers to the presence of any injury

Riwayat Kesehatan

- Lakukan anamnesa singkat tentang keluhan utama pada pasien , keluarga pendamping atau informais dari surat rujukan dengan seksama
- Tanyakan apa yang membawa pasien ke ED / RS saat ini

Kemampuan Mobilisasi

- Dikaji dengan memperhatikan toleransi gerak pasien
- Adanya trauma dikaji pada pasien yang mengalami riwayat /keluhan cedera

Keputusan baru dapat diambil jika semua proses standar telah dilaksanakan secara lengkap

TRIAGE

KASUS

~CHILD TEWS CALCULATOR ~
SCORING EXAMPLE

Seorang anak masuk ke unit gawat darurat dengan RR 32 dan detak jantung 140, suhu 38,3 dan pasien terjaga dan waspada tetapi warnanya pucat dan perut kencang dan buncit.

Ketika ditanyai, orang tua menyatakan bahwa dia telah muntah selama 2 hari dengan nyeri kuadran kanan bawah. Tidak ada tanda-tanda trauma. Ketika perut disentuh, pasien berteriak kesakitan. (Hitung kode warna)

Triage Early Warning Score (TEWS) - Children

CHILD TRIAGE SCORE
(3 to 12 years old / 96 to 150 cm tall)

	3	2	1	0	1	2	3
Mobility				Walking	With Help	Stretcher/ Immobile	
RR	less than 15	15-16		17-21	22-26	27 or more	
HR	less than 60	60-79		80-99	100-129	130 or more	
Temp		Feels cold OR Under 35		35-38.4		Feels hot OR Over 38.4	
AVPU		Confused		Alert	Reacts to Voice	Reacts to Pain	Unresponsive
Trauma				No	Yes		

CHILD TEWS Scoring

TRIAGE

~Mobilitas ~ Berjalan ~ 0
~ Laju pernapasan ~ 32 ~ 2
~ Detak jantung ~ 140 ~ 2
~ B / P ~ n / a ~ Suhu ~ 38.3 ~ 0
~ AVPU ~ terjaga dan waspada ~ 0
~ Trauma ~ tidak ada tanda-tanda cedera atau memar ~ 0
Total skor ~ 4
(Kode warna apa ini?)
Diskusi ..... Faktor-faktor apa yang akan Anda pertimbangkan dalam keputusan penilaian Anda?

Colour	RED	ORANGE	YELLOW	GREEN	BLUE
TEWS	7 or more	5-6	3-4	0-2	DEAD
Target time to treat	Immediate	less than 10 mins	less than 60 mins	less than 240 mins	
Mechanism of injury		High energy transfer			
Presentation		Shortness of breath - acute		ALL OTHER PATIENTS	DEAD
		Coughing blood			
		Chest pain			
		Haemorrhage - uncontrolled	Haemorrhage - controlled		
	Seizure - current	Seizure - post ictal			
		Focal neurology - acute			
		Level of consciousness reduced			
		Psychosis / Aggression			
		Threatened limb			
		Dislocation - other joint	Dislocation - finger or toe		
		Fracture - compound	Fracture - closed		
	Burn – face / inhalation	Burn over 20%	Burns - other		
		Burn - electrical			
		Burn - circumferential			
		Burn - chemical			
		Poisoning / Overdose	Abdominal pain		
	Hypoglycaemia – glucose less than 3	Diabetic - glucose over 11 & ketonuria	Diabetic - glucose over 17 (no ketonuria)		
		Vomiting - fresh blood	Vomiting - persistent		
		Pregnancy & abdominal trauma or pain	Pregnancy & trauma		
			Pregnancy & PV bleed		
Pain		Severe	Moderate	Mild	
	Senior Healthcare Professional's Discretion				

~ ADULT TEWS CALCULATOR ~
SCORING EXAMPLE

TRIAGE

Seoreng pasien dewasa datang dengan kursi roda didapatkan RR 28 x/mnt, Nadi 129 x/mnt, tekanan darah 200/98 MmHg, Suhu 37.0 C, kesadaran compos mentis.

Dari wawancara didapatkan pasien tidak ada trauma, luka ataupun laserasi

Triage Early Warning Score (TEWS) - Adult

ADULT TRIAGE SCORE
(over 12 years / taller than 150cm)

	3	2	1	0	1	2	3	
Mobility				Walking	With Help	Stretcher/ Immobile		**Mobility**
RR		less than 9		9-14	15-20	21-29	more than 29	**RR**
HR		less than 41	41-50	51-100	101-110	111-129	more than 129	**HR**
SBP	less than 71	71–80	81-100	101-199		more than 199		**SBP**
Temp		Feels cold OR Under 35		35-38.4		Feels hot OR over 38.4		**Temp**
AVPU		Confused		Alert	Reacts to Voice	Reacts to Pain	Unresponsive	**AVPU**
Trauma				No	Yes			**Trauma**

TEWS Scoring

TRIAGE

~Mobilitas ~ Kursi Roda ~ 1

~ Tingkat pernapasan ~ 28 ~ 2

~ Detak jantung ~ 129 ~ 2

~ B / P ~ 200/98 ~ 2

~ Temperatur ~ 37.0 ~ 0

~ AVPU ~ terjaga dan waspada ~ 0

~ Trauma ~ tidak ada tanda-tanda cedera atau memar ~ 0

Total skor ~ 7 (Kode warna apa ini?)

The Color Designation Discriminators are also divided into 3 categories They also include: Infant, Child and Adult

Colour	RED	ORANGE	YELLOW	GREEN	BLUE
TEWS	7 or more	5-6	3-4	0-2	DEAD
Target time to treat	Immediate	less than 10 mins	less than 60 mins	less than 240 mins	DEAD
Mechanism of injury		High energy transfer			
Presentation		Shortness of breath - acute		ALL OTHER PATIENTS	
		Coughing blood			
		Chest pain			
		Haemorrhage - uncontrolled	Haemorrhage - controlled		
	Seizure - current	Seizure - post ictal			
		Focal neurology - acute			
		Level of consciousness reduced			
		Psychosis / Aggression			
		Threatened limb			
		Dislocation - other joint	Dislocation - finger or toe		
		Fracture - compound	Fracture - closed		
	Burn – face / inhalation	Burn over 20%	Burns - other		
		Burn - electrical			
		Burn - circumferential			
		Burn - chemical			
		Poisoning / Overdose	Abdominal pain		
	Hypoglycaemia – glucose less than 3	Diabetic - glucose over 11 & ketonuria	Diabetic - glucose over 17 (no ketonuria)		
		Vomiting - fresh blood	Vomiting - persistent		
		Pregnancy & abdominal trauma or pain	Pregnancy & trauma		
			Pregnancy & PV bleed		

Skor TEWS juga dapat menjadi guideline (Pengetahuan, Skill, dan sikap) Anda untuk menentukan apakah akan meningkatkan penanganan pasien atau meminta masukan supervisor / dokter mengkaji keputusan penempatan triase yang telah diambil.

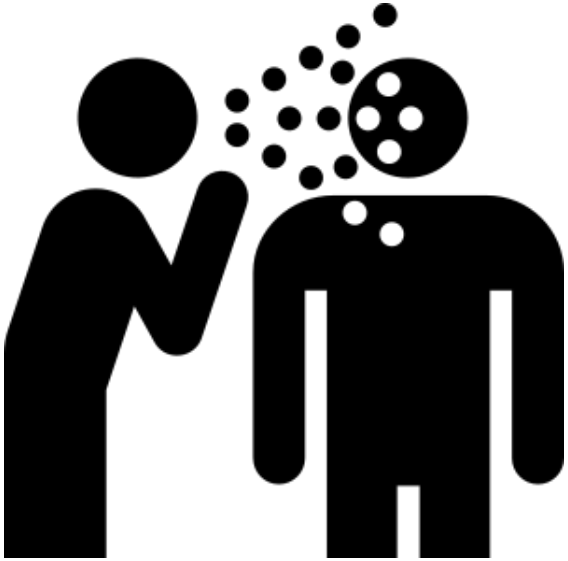
Illness/Injury Specific Considerations

TRIAGE

~ Coughing patient with known TB

~Hemorrhaging Pregnant Woman

~Concerned Parent with Screaming Child



PD-SELF The Noun Project, “Infectious Disease”

(cc) BY Creative Donkey, "Crying Child", flickr

Initial Triage-Based Treatment and Diagnostic Tests

TRIAGE

- Pertolongan Pertama (splints, ice packs, balut tekan)
- Analgesia dan kontrol antipiretik
- Alat bantu diagnostik sederhana (glukometer, denyut nadi)

TRIAGE

Decision Making Process

Prioritization
Time Management
Organization
Resource Utilization
Follow-up

Additional Triage Responsibilities

Waiting Room Management

~Safety of Waiting Room Patients

~Reassessment of Patients

~Privacy

Communication

~Customer Service

~Management of Visitors

Administrative Responsibilities

TRIAGE

Safety
Infection Control
Triage Legalities
Triage Performance Improvement
Triage Data Utilizations

Sumber Daya Yang Diperlukan

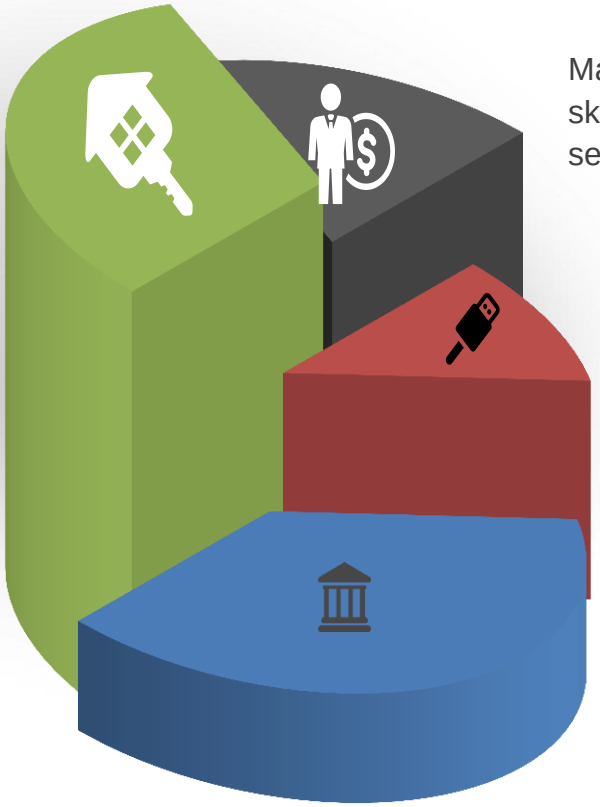
TRIAGE

Dukungan Manajemen

Penetapan kebijakan dan standar TRIAGE di lapangan termasuk monev berkala

SDM Yang terlatih

Mampu melakukan skrining kondisi pasien sesuai SPO



Sistem Informasi Yang baik

Alur penanganan , sistem Komunikasi

Sarana Prasarana Yang memadai

Alat medis dan keperawatan yang menunjang pelaksanaan.

DUKUNGAN MANAJEMEN

KEBIJAKAN

Penetapan kebijakan pelaksanaan sistem diperlukan untuk memulai pelaksanaan skrining di rumah sakit / FasKes

STANDAR

Prosedur operasional skrining /triage harus dibuat untuk menjaga pelayanan yang seragam dan berkelanjutan

SISTEM

Alur pelaksanaan, sumber daya yang diperlukan harus dibangun untuk menunjang pelaksanaan sistem.

SDM Yang Terlatih

TRIAGE

Pengetahuan

Skill

Sikap

Kebutuhan SDM Untuk TRIAGE

Beberapa literatur mengatakan bahwa rasio dokter dan perawat

di Amerika berkisar dari 1: 4 hingga 1: 1.6

di Afrika Selatan Rasio dokter terhadap perawat adalah 1: 8.

Dengan demikian, perawat memiliki peran penting dalam menilai pasien untuk perawatan awal serta dalam pemberian perawatan yang berkelanjutan.

TRIAGE

KUALIFIKASI TENAGA KEPERAWATAN UNTUK TRIAGE

Telah melalui program orientasi ED
Pengalaman kerja di ED minimal 6 bulan
Memiliki kompetensi klinis tentang Keperawatan Gawat darurat.
Memiliki kemampuan analisa yang baik terkait kondisi pasien

Penguatan Kompetensi Staf

TRIAGE

Evaluasi kompetensi perawat dalam melakukan skrining/skoring dan analisa keadaan pasien

Penguatan Kompetensi Staf

TRIAGE

MEMBANGUN SISTEM

TRIAGE

Keseragaman Alur sesuai PPK

Dokumentasi Yang Baik

Pelatihan Staf secara Berkala

Monitoring dan evaluasi berkala

Sistem Rujukan

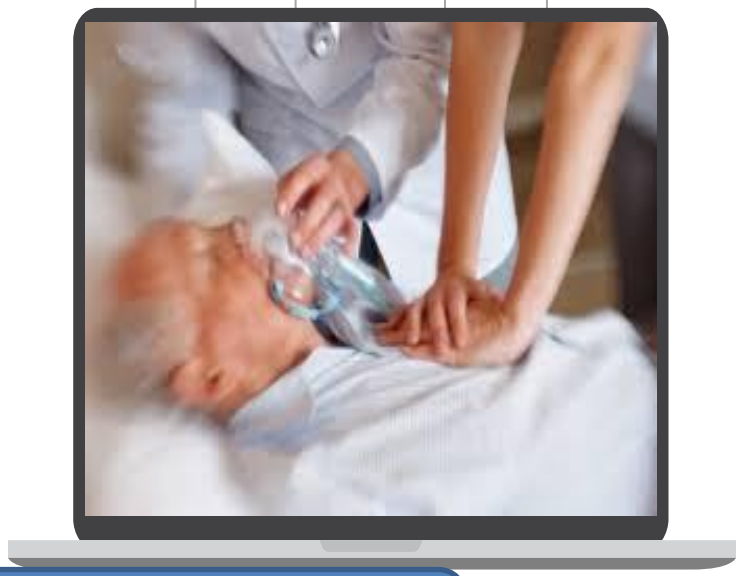
TRIAGE

Obat

Sistem Rujukan

Peralatan Medis dan Keperawatan

Ketersediaan Ruangan Rujukan



SARANA PRASARANA YANG MEMADAI

Monitoring Mutu

TRIAGE

	TC 1	TC 2	TC 3	TC 4	TC 5
Total	1054	13001	51995	34845	1820
Tot admit	747	6438	19994	8403	171
% of TC admitted	71%	50%	38%	24%	9%

	TC 1	TC 2	TC 3	TC 4	TC 5
Pass	100%	57%	31%	50%	102%

Indikator Mutu

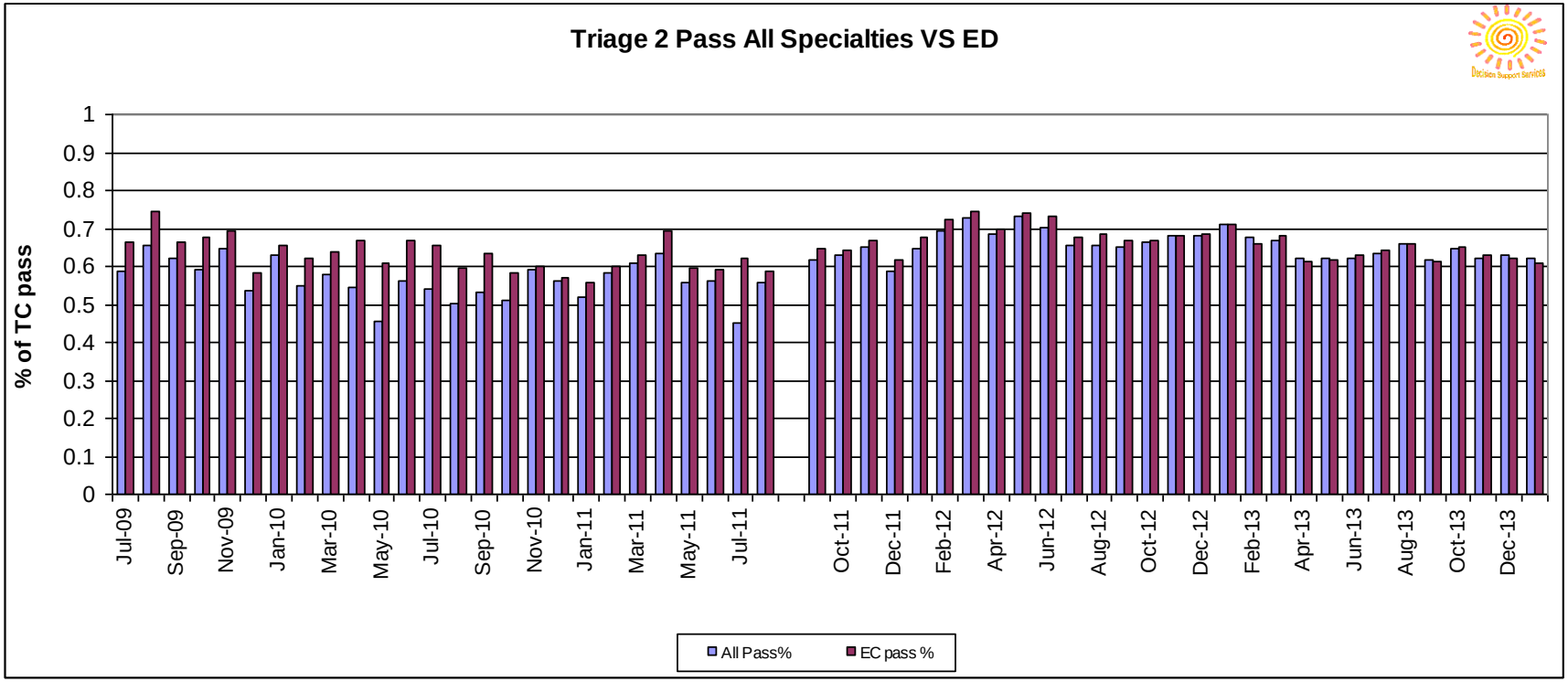
TRIAGE

ATS 1 = 1%	100%TBS 0min
ATS 2 = 12.7%	80% TBS10min
ATS 3 = 50.9 %	75% TBS 30min
ATS 4 = 34.1%	70% TBS 60min
ATS 5 = 1.8%	70% TBS 120min

MMH Performance TC 2

TRIAGE

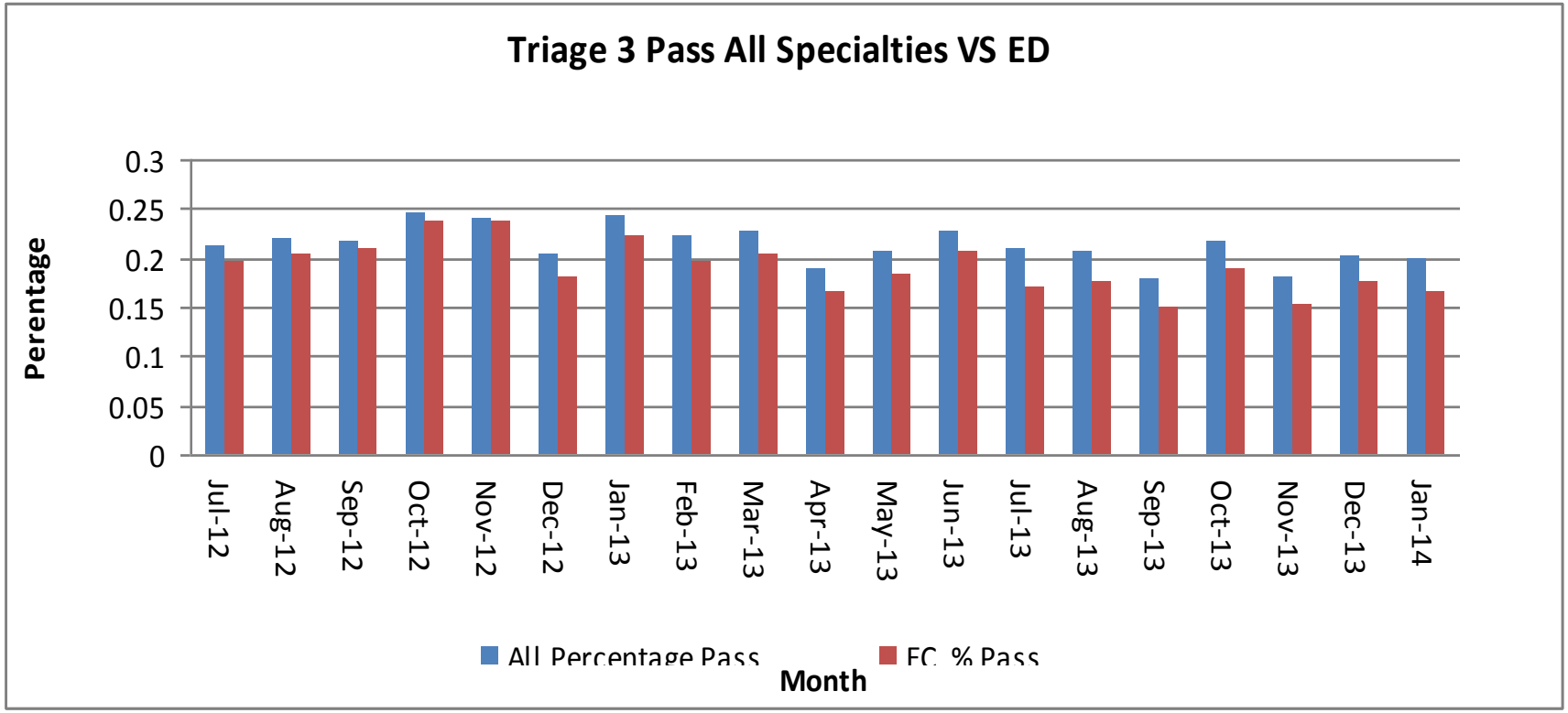
Target 80% seen 10min



Triage Cat 3 patients

TRIAGE

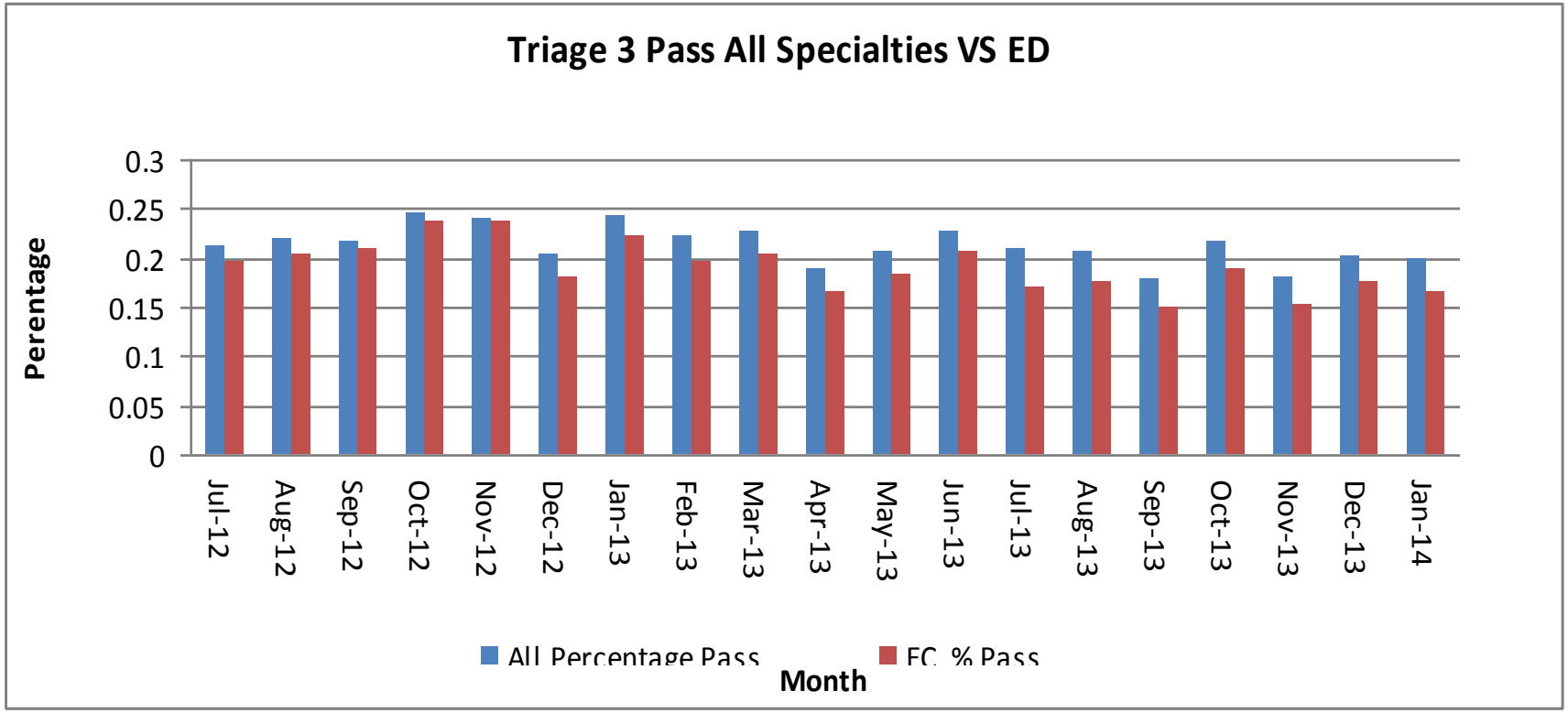
Target 75%seen in 30min



Triage Cat 3 patients

TRIAGE

Target 75%seen in 30min



TRIAGE

Roadmap Program Triage

Keberhasilan pelaksanaan program, sangat ditentukan oleh perencanaan dan monev yang konsisten.

PROGRAM^2 PELATIHAN DAN SOSIALISASI BERKALA

- PROGRAM – PROGRAM YANG DIKEMBANGKAN

TRIAGE

SOSIALISASI STANDAR UTK NURSE

PITSTOP

SOSIALISASI KE KSM/INSTL.

PROGRAM² PELATIHAN DAN SOSIALISASI BERKALA

- PROGRAM – PROGRAM YANG DIKEMBANGKAN

TRIAGE

PELATIHAN

SOSIALISASI

ORIENTASI PEGAWAI

Kesimpulan

TRIAGE

- Triage merupakan tahap pertama yang menentukan tata laksana kegawatdaruratan secara efektif dan efisien.
- Diperlukan latihan dan praktek secara berulang dan terus menerus untuk menciptakan sumber daya perawat yang terlatih dalam melakukan triage.
- Kombinasi pengetahuan, keterampilan dan sikap sangat diperlukan dalam aplikasi Triage.
- Tools Yang mudah dan seragam perlu dikembangkan dan dilaksanakan agar dapat menyelamatkan hidup dan menurunkan morbiditas