ED Triage and ESI

ESI v5, resources, high-risk vital signs, MCI triage and EMTALA for CEN review

ESI V5 AT A GLANCE

A–B find ESI 1–2; C predicts resources for 3–5; D checks full vitals before 3–5 and may raise the level. Follow institution policy.

ESI	DECISION RULE	EXAMPLE
1	A: needs a lifesaving intervention now	Apneic opioid overdose
2	B: high risk, new confusion, or severe pain/distress	Possible ectopic, stable
3	C: 2 or more resource types	RLQ pain: labs and CT
4	C: 1 resource type	Ankle injury: x-ray only
5	C: no resources	Prescription refill

EXAM TIP v5 dropped 'last open bed' at point B: triage risk, not crowding. Re-level only upward, before placement, if the condition changes; document why.

LEVEL 1 AND LEVEL 2 CUES

ESI 1: intubated, apneic, pulseless, unresponsive (acutely nonverbal and not following commands, or P or U on AVPU), severe respiratory distress, profound hypotension or hypoglycemia. A stroke CT is diagnostic, not lifesaving.

- Chest pain suspicious for ACS, or an abnormal ECG (goal: within 10 minutes)
- Stroke signs; new confusion (assume new if baseline unknown); post-ictal
- Fever on chemotherapy or after a transplant
- Suicidal, homicidal, psychotic or violent
- Pregnant or postpartum, SBP under 90 or over 150
- Severe pain (renal colic, sickle cell crisis); 7/10 or more: consider, not automatic

SAFETY Undertriage risk (v5): older adults, women with chest pain, patients of color, mental health or substance use history.

COUNTING RESOURCES (POINT C)

Summarized from ENA ESI v5 (2023).

TYPE	COUNTS (1 PER TYPE)	NOT A RESOURCE
Tests	Labs; ECG, x-rays; CT, MRI, ultrasound	Point-of-care tests; exam, even pelvic
Treatment	IV fluids; IV, IM or nebulized meds	Oral meds; tetanus shot; saline lock
Procedures	Lac repair or Foley = 1; procedural sedation = 2	Dressing or recheck; splint, sling, crutches
People	Specialty consult	Call to primary care

EXAM TIP Count types, not tests: CBC, BMP and urinalysis = 1; labs plus an x-ray = 2; an x-ray plus a CT = 2.

HIGH-RISK VITALS AND PEDIATRIC FEVER (POINT D)

ESI v5. Any age: SpO2 under 92%.

AGE	HR OVER	RR OVER
Under 1 month	190	60
1–12 months	180	55
1–3 years	140	40
3–5 years	120	35
5–12 years	120	30
Over 12 years	100	20

- 28 days or younger, T over 38 °C (100.4 °F): at least ESI 2; 1–3 months: consider ESI 2
- 3 months and older: consider ESI 2 or 3 if T over 39 °C (102.2 °F), incomplete immunizations or no clear source
- Any age: T under 36 °C (96.8 °F) is a sepsis red flag

EXAM TIP v4 (older books): adult HR/RR cutoffs over age 8; vitals only for 2+ resources. v5: adult cutoffs over age 12; vitals for every ESI 3–5.

MASS CASUALTY TRIAGE

MCIs use the disaster plan, not ESI; re-triage often.

TAG	START / JUMPSTART	SALT
Red	Immediate	Immediate
Yellow	Delayed	Delayed
Green	Minor	Minimal
Gray	Not used	Expectant
Black	Dead or expectant	Dead

- START: walkers green; apneic after airway opening black; breathes once opened red
- START red: RR over 30, no radial pulse or cap refill over 2 s, or can't follow commands; else yellow
- JumpSTART (child-appearing): apneic with a pulse gets 5 rescue breaths; red if RR under 15 or over 45, no peripheral pulse, or P-inappropriate or U on AVPU
- SALT: sort (still, wavers, walkers), assess, lifesaving interventions (bleeding, airway with 2 breaths for a child, chest decompression, antidote), treat or transport

EMTALA BASICS

- Medicare hospital EDs screen anyone asking for care of any condition (or appearing to need it); elsewhere on campus, anyone seeking emergency care
- Medical screening exam (MSE) by a qualified medical person (QMP) per bylaws; triage starts it but is not the MSE
- Never delay the MSE or stabilization for payment questions or a minor's parental consent
- Stabilize within capability; in labor, stable means infant and placenta delivered
- Unstable transfer: written request or physician certification (with no physician present, a QMP signs after consulting one, who countersigns); treat to minimize risk; receiver accepts with space and staff; send records, qualified crew, equipment
- Burn, trauma and NICU centers with capacity must accept appropriate transfers

SAFETY Diversion ends once a patient is on hospital property. Holding EMS patients on the stretcher does not delay the duty; if EMS must briefly stay, still assess and prioritize. Seek written informed refusals.

Sources (14) are listed with links at icubasics.com/sheets/triage-esi.html. For education and exam preparation only. Not medical advice; follow current guidelines and your institution's protocols. ICU Basics is an independent study aid not affiliated with any certifying body.