Curso
TRIAGE HOSPITALARIO PEDIÁTRICO

Actualización teórico-práctico
para médicos y enfermeros

Coordinadores:

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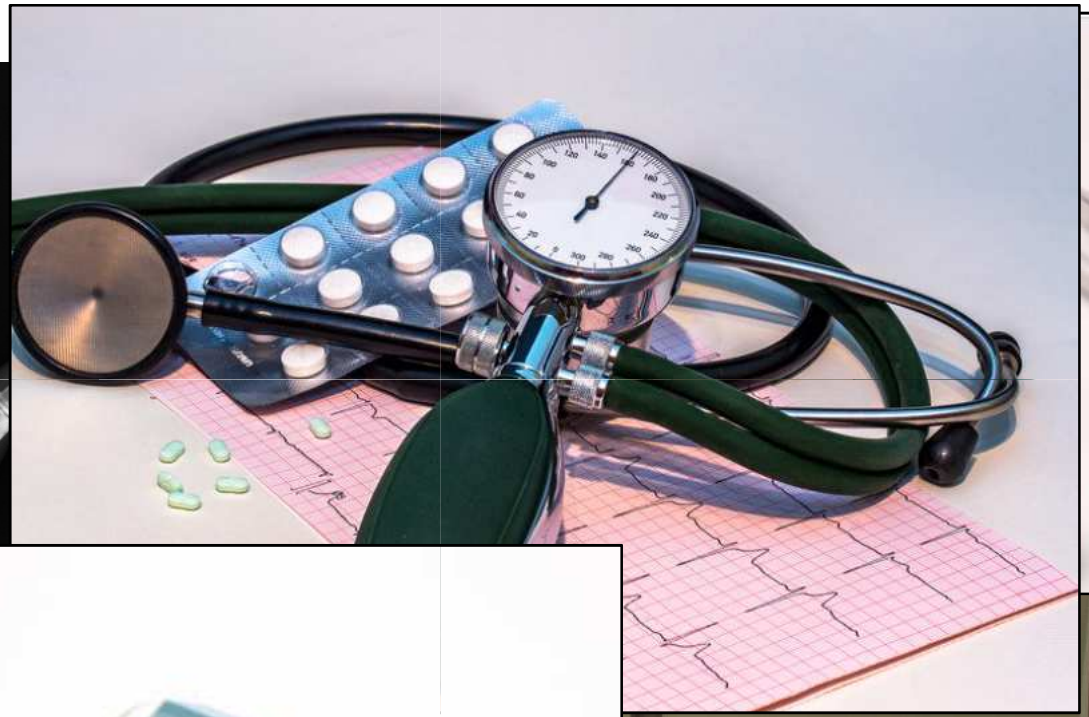
SO ARGENTINO
PEDIATRÍA
Educar en prevención
hacia una vida plena

TRIAGE AVANZADO



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¿QUÉ ES?

Serie de acciones previamente protocolizadas que realiza el agente que efectúa el triage de manera autónoma

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¿QUÉ ACCIONES INCLUYE?

Cuidados, tratamientos y/o solicitudes de exámenes complementarios que deben estar previamente protocolizados en la institución

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¿CUÁNDO SE REALIZA?

- Luego de la clasificación del paciente y antes de la valoración médica
- Siempre y cuando sea posible por la demanda asistencial
- NO DEBE RETRASAR LA CLASIFICACIÓN DE LOS DEMÁS PACIENTES

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EQUISITOS

- Instrucción sobre criterios preestablecidos y circunstancias específicas en las que se efectúa
- Conocimiento y aplicación de protocolos cuando corresponda
- Disponibilidad inmediata de consulta de protocolos en el sector del triage
- Registro de las acciones efectuadas (hora, dosis, etc.)

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VENTAJAS

- Mejora la calidad asistencial agilizando el proceso asistencial
- Mejora la percepción del tiempo de espera y hace que sea más confortable
- Aumenta la satisfacción de los médico/a, enfermero/a, paciente y familia
- Genera un tiempo de espera del paciente más eficiente adelantando determinadas acciones protocolizadas
- Otorga mayor dinámica a proceso asistencial, creando una continuidad de los cuidados

TRIAGE AVANZADO

- Requiere mayor conocimiento y adiestramiento por parte del agente que ejecuta el triage

- Puede retrasar la clasificación del resto de pacientes en caso que no se efectúe de manera adecuada

“DESVENTAJAS

TRIAGE AVANZADO

¿QUÉ ACCIONES **DIAGNÓSTICAS** PROTOCOLIZADAS SE PUEDEN EFECTUAR?

- Solicitar de examen de orina en paciente continente con disuria
- Solicitar de radiografía en paciente con sospecha de fractura
- Agilizar interconsultas con otras especialidades, etc.

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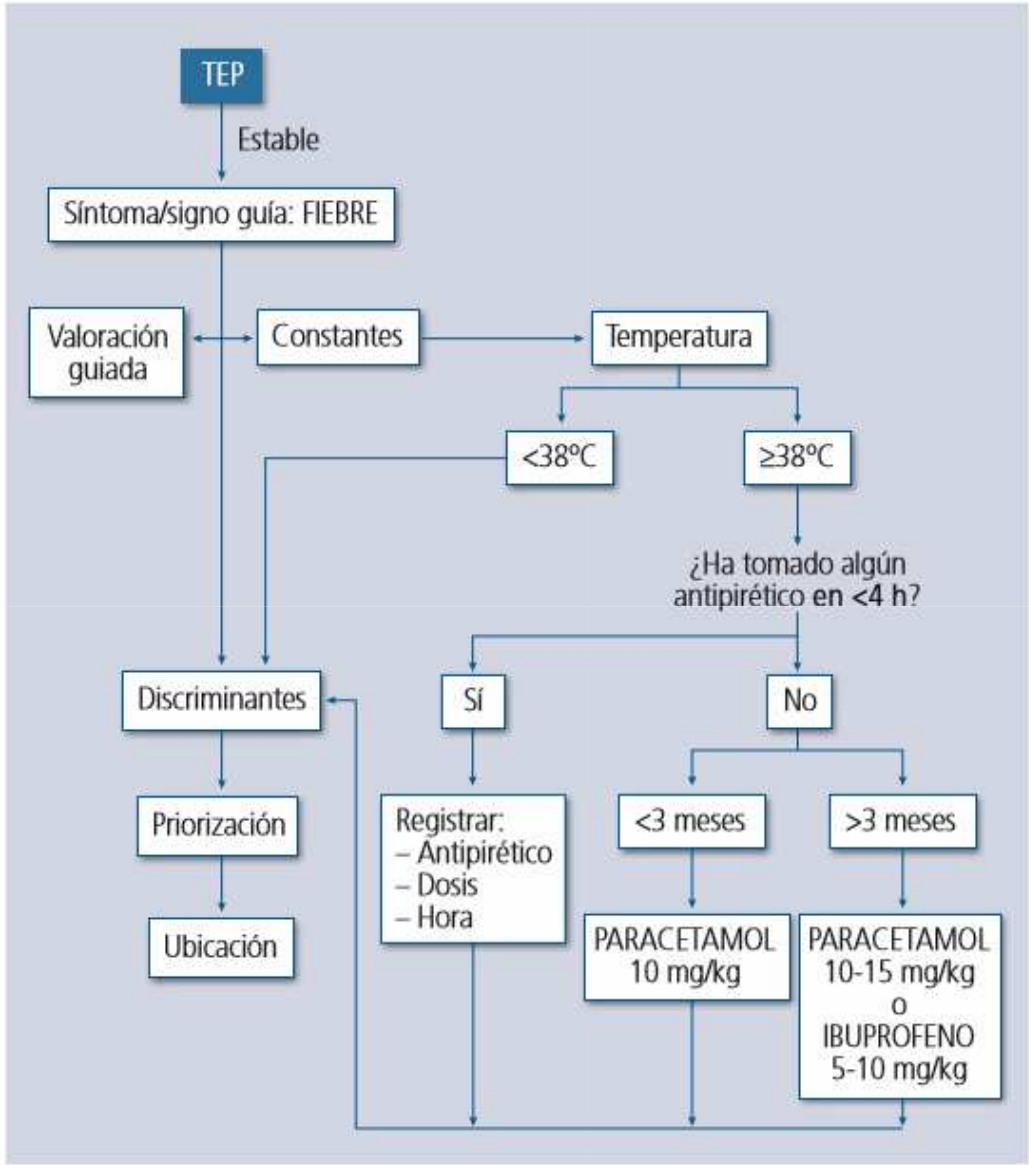
UÉ ACCIONES **TERAPÉUTICAS** PROTOCOLIZADAS PUEDEN EFECTUAR?

- Administración de antitérmicos
- Administración de analgésicos menores
- Administración de sales de rehidratación oral
- Administración de broncodilatadores
- Aplicación de medidas de soporte respiratorio (O_2)
- Inmovilización con férula ante sospech de fractura de extremidad
- Aplicación de frío local en contusiones
- Aplicación de anestésico tópico en heri susceptibles de sutura
- Limpieza, desinfección y cura plana de heridas



ALGORITMO 1. Administración de antitérmico en triage.

Míguez Navarro MC, Guerrero Márquez G, Ignacio Cerro MC (Editores). Manual de clasificación y triage del paciente pediátrico e urgencias. Madrid, Ergon, 2015

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GESTIÓN MÁS EFICIENTE

Fast tracking

Fast tracking

¿POR QUÉ?

Variable calidad de demanda asistencial con cambios constantes

No existe control de esa demanda

Situaciones de saturación, sobre todo en épocas invernales

Aumento de tiempos de espera (que puede llevar a deterioro clínico durante la espera)

Aumenta de la espera del conjunto de pacientes (entre ellos, pacientes con mayor nivel de urgencia)

- Insatisfacción de pacientes y familias
- Frustración y estrés del personal de urgencias
- Menor tiempo asistencial por consulta (¿adecuado?)
- Aumento de la demanda de pacientes de baja complejidad

Fast tracking

OBJETIVO

Rápida resolución
de pacientes no urgentes
(niveles IV y V)

Fast tracking

ACTORES CLAVE

- Área dedicada a pacientes no urgentes
- Personal exclusivo con competencia para tomar decisiones, con experiencia
- Recursos físicos exclusivos
- Selección adecuada de pacientes, con criterios preestablecidos
- Mantener una vía abierta y rápida hacia el servicio de urgencias

Fast tracking

- Idealmente, sectores separados dentro del servicio de urgencias (o por fuera, pero cercanos)

- Pacientes de baja complejidad en espera de manera separada de aquellos con problemas más graves

Fast tracking

Optimización del flujo de pacientes

Simplificación y aceleración de la atención de pacientes de baja complejidad

Gestión rápida de gran volumen de pacientes

Prevención de tiempo de espera excesivo

- Alivio de la sala de espera "principal" del servicio de emergencias
- Mayor satisfacción del paciente y l familia
- Menor estrés del personal

VENTAJAS

Fast tracking

“DESVENTAJAS”

Alteración del funcionamiento adecuado del la atención primaria (por impulsar procesos que agilizan la resolución ágil de problemas de baja complejidad en los servicios de urgencias)

Mayor demanda asistencial de problemas no urgentes

Efecto negativo sobre la organización correcta de un sistema sanitario

Frustración de profesionales más experimentados en emergencias por asistencia sostenida de muchos pacientes con problemas de baja complejidad

Efecto negativo sobre la especialización de profesionales en urgencias

Fast tracking

MEJORA DE INDICADORES

Disminuye los tiempos de espera de los niveles IV y V

También disminuye los tiempos de espera de los niveles II y III

Disminuye la morbilidad asociada a la prolongación de los tiempos de espera (demora en la atención)

Disminuye la tiempo de permanencia en el servicio de urgencias

Disminuye el número de pacientes que se retiran sin ser vistos

Fast tracking

riterios
otocolizados

- Generalmente pacientes con nivel IV o V
- Problemas de baja complejidad, sin condiciones crónicas de riesgo, sin necesidad de pruebas complementarias
- Pacientes dudosos se discuten con el médico gest o permanecen en el servicio de emergencias
- Tampoco se deben enviar pacientes con historia n fiables, riesgos sociales, barreras idiomáticas u otr

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. Fast track and the pediatric
ency department: resource
on and patients outcomes.
merg Med. 1999 Nov;6(11):1153-9.

ACADEMIC EMERGENCY MEDICINE • November 1999, Volume 6, Number 11 **1153**

Fast Track and the Pediatric Emergency Department: Resource Utilization and Patient Outcomes

LOUIS C. HAMPERS, MD, MBA, SUSIE CHA, MD, DAVID J. GUTGLASS, MD, HELEN J. BINNS, MD, MPH, STEVEN E. KRUG, MD

Abstract. **Objective:** To examine differences in the evaluation, management, and outcomes for patients seen in an on-site "fast track" (FT) vs the main ED. **Methods:** Over a three-month period, patients presenting to an urban pediatric ED were prospectively assessed. Patients included were: triaged as "nonurgent"; aged 2 months to 10 years; not chronically ill; and had fever, or complaint of vomiting, diarrhea, or decreased oral intake. Evening and weekend care was provided in the FT; at all other times these low-acuity patients were seen in the ED. Seven days after the visit, families were interviewed by telephone. **Results:** Four hundred seventy-nine and 557 patients were seen in the FT and ED, respectively. The patients in the two settings did not differ in age, clinical condition, race, or commercial insurance status. Patient mean test charges were $27 and $52 for the FT and ED, respectively ($p < 0.01$). Twenty-four percent of the FT patients vs 41% of the ED patients had tests performed ($p < 0.01$). Average length of stay was 28 minutes shorter in the FT (95% CI = 19 to 36, $p < 0.01$). Follow-up was completed for 480 of 755 families with telephones (64%). The FT and ED patients did not differ at follow-up: 90% vs 88% had improved conditions ($p = 0.53$), 18% vs 15% had received unscheduled follow-up care ($p = 0.44$), and 94% of the families in both groups were satisfied with the visit ($p = 0.98$). **Conclusions:** Compared with those in the main ED, the study patients seen in the FT had fewer tests ordered and had briefer lengths of stay. These findings were not explained by differences in patient ages, vital signs, or demographic characteristics. No difference in final outcomes or satisfaction was detected among the families contacted for follow-up. **Key words:** fast track; resource utilization; outcomes; urgent care. ACADEMIC EMERGENCY MEDICINE 1999; 6:1153–1159

Pacientes atendidos en fast track

- Menor tiempo de estancia en el hospital
- Menor número de exámenes complementarios
- Sin diferencias en la satisfacción de las familias
- Sin diferencias en la evolución de los pacientes

Fast track

- Disminuye los tiempos de estancia en urgencias de los pacientes atendidos en la unidad *fast track*
- No altera el tiempo de espera ni la estancia de los pacientes atendidos en el servicio de emergencias (área principal)

EDITOR'S CHOICE

Effect of emergency department fast track on emergency department length of stay: a case–control study

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ABSTRACT

Objective: To examine the effect of fast track on emergency department (ED) length of stay (LOS).

Design and setting: Pair-matched case–control design in a public teaching hospital in metropolitan Melbourne, Australia.

Participants: Patients treated by the ED fast track (cases) between 1 January and 31 March 2007 were compared with patients treated by the usual ED processes (controls) from 1 July to 15 November 2006 (n = 822 matched pairs).

Intervention: ED fast track was established in November 2006 and focused on the management of patients with non-urgent complaints.

Main outcome measures: The primary outcome measure was ED LOS for fast-track patients. Secondary outcomes were waiting times and ED LOS for other ED patients.

Results: Median ED LOS for non-admitted patients was 132 minutes (interquartile range (IQR) 83–205.25) for controls and 116 minutes (IQR 75.5–159.0) for cases ($p<0.01$). Fast-track patients had a significantly higher incidence of discharge within 2 h (53% vs 44%, $p<0.01$) and 4 h (92% vs 84%, $p<0.01$).

Conclusions: ED fast track decreased ED LOS for non-admitted patients without compromising waiting times and ED LOS for other ED patients.

and all had dedicated nursing staff; however, there was variability in time of operation, availability of a dedicated area and whether there was dedicated or shared medical staff.[1]

There is a number of benefits associated with ED fast track including reductions in waiting times,[6 7] decreased ED LOS,[4 8-14] financial savings,[10] increased patient satisfaction[8] and decreased left-without-being-seen rates.[7 14] Despite the rapid growth of ED fast-track systems in Australia, their impact is poorly understood. Most published evaluations of ED fast track are limited to single-site studies using uncontrolled descriptive designs[2] and there is a lack of controlled studies related to ED fast-track outcomes. The aim of this study was to evaluate the effect of ED fast track on ED patient flow using a pair-matched case–control design. The primary outcome measure was ED LOS of fast-track patients. Secondary outcome measures were waiting times and ED LOS of other ED (non-fast-track) patients.

METHODS

Study design

A pair-matched case–control design was used. Approval was obtained from the Human Research and Ethics Committee before undertak-

sidine, J., Kropman, M., Kelly, E., & Winter, C. (2008). Effect of emergency department
track on emergency department length of stay: a case-control study.
rgency Medicine Journal, 25(12), 815–819. doi:10.1136/emj.2008.057919

Fast track

systematic review of triage-related terventions to improve patient flow in mergency departments

Oredsson[1*], Håkan Jonsson[2], Jon Rognes[3], Lars Lind[4], Katarina E Göransson[5,6], Anna Ehrenberg[7], Asplund[8], Maaret Castrén[9] and Nasim Farrohknia[10]

stract

ckground: Overcrowding in emergency departments is a worldwide problem. A systematic literature review was dertaken to scientifically explore which interventions improve patient flow in emergency departments.

thods: A systematic literature search for flow processes in emergency departments was followed by assessment elevance and methodological quality of each individual study fulfilling the inclusion criteria. Studies were luded if they did not present data on waiting time, length of stay, patients leaving the emergency department hout being seen or other flow parameters based on a nonselected material of patients. Only studies with a trol group, either in a randomized controlled trial or in an observational study with historical controls, were uded. For each intervention, the level of scientific evidence was rated according to the GRADE system, nched by a WHO-supported working group.

ults: The interventions were grouped into streaming, fast track, team triage, point-of-care testing (performing oratory analysis in the emergency department), and nurse-requested x-ray. Thirty-three studies, including over ,000 patients in total, were included. Scientific evidence on the effect of fast track on waiting time, length of , and left without being seen was moderately strong. The effect of team triage on left without being seen was tively strong, but the evidence for all other interventions was limited or insufficient.

nclusions: Introducing fast track for patients with less severe symptoms results in shorter waiting time, shorter gth of stay, and fewer patients leaving without being seen. Team triage, with a physician in the team, will bably result in shorter waiting time and shorter length of stay and most likely in fewer patients leaving without ng seen. There is only limited scientific evidence that streaming of patients into different tracks, performing oratory analysis in the emergency department or having nurses to request certain x-rays results in shorter ting time and length of stay.

Oredsson S, Jonsson H, Rognes J, Lind L, Göransson KE, Ehrenberg A, Asplund K, Castrén Farrohknia N. A systematic review of triage-related interventions to improve patient flo emergency departments. Scand J Trauma Resusc Emerg Med. 2011 Jul 19;19:43.

- Menor tiempo de espera
- Menor tiempo de estancia en el servicio de urgencias
- Menor cantidad de pacientes que se retiran sin ser vistos

FAST TRACK

GESTIÓN MÁS EFICIENTE