VIEWPOINT

Triage: beyond red and blue tagging

Triaje: más allá del rojo y el azul

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The rapid spread of infection caused by the SARS-CoV-2 coronavirus [Coronavirus Infectious Disease-19 (COVID-19)] has generated a major global health emergency and a situation of overload on our healthcare system. As has been evident since the beginning of the pandemic, triage in hospital emergency medical services (EMS) is a cornerstone in decision making for the efficient management of this imbalance between the clinical needs of the population and the effective availability of resources.

It has been 5 years since the term triage was included in the Diccionario de la Lengua Española (DLE)[1], although we can consider that its meaning as the mere fact and effect of triaging falls short in its definition of "choosing, separating, sorting out". It is more than evident that triage, beyond the fact of establishing the level of priority according to the urgency-gravity of the patients, is fundamental in the appropriate distribution of patients attending the ED to one or another care circuit, separating those patients suspected of or infected by COVID-19 from those who are not, and this has been evident since the beginning of the health crisis[2]. In the last year, a large number of EDs have found themselves in the urgent need to totally or partially restructure their usual care circuits. Triage professionals have also adapted their protocols and guidelines, which aim to guarantee the greatest good for the greatest number of patients, using criteria for decisions that seek to achieve speed, efficacy, safety and ethics.

Thus, understanding that triage meets the four bioethical principles that guarantee the fundamental rights of patients, such as the principles of autonomy, nonmaleficence, beneficence and justice[3], we can affirm that the triage professional has not only guaranteed equity in healthcare, taking into account the level of priority of urgency/severity, but has also been responsible for ensuring, in the first instance, the safety of both the professionals and the rest of the patients present in the ED. To this end, it has been necessary to optimize all available resources for the detection of signs or symptoms compatible with possible COVID-19 infection, as well as those patients with possible epidemiological criteria for close contact.

The truth is that the triage nurse has found it necessary to apply all his knowledge, skills and experience in extreme situations, under early risk prediction, prevention and therapeutic interventions. Being the first contact of the patient upon arrival at the ED, the triage nurse is required to discriminate any patient with a minimal risk of infection by COVID-19. Thus, since the beginning of the pandemic, the triage nurse has discriminated the possibility of COVID-19 infection as high, low or no risk, taking into account the signs and symptoms presented by the patient. With the terrible handicap that COVID-19 infection presents a high lack of specificity in its symptomatology.

Nevertheless, patients presenting with suggestive signs and symptoms have been classified as high risk, the most common of which are: fever, anosmia, ageusia, dry cough, fatigue, shortness of breath, odynophagia, headache, myalgia or arthralgia, chills, nausea or vomiting, nasal congestion, diarrhea, hemoptysis and conjunctival congestion, and a variety of neurological and dermatological symptoms. Based on currently available data, neither the absence nor the presence of these signs or symptoms individually are sufficiently accurate to rule out or confirm COVID-19.

However, with the inexcusable need to avoid transmission between patients and ED staff, the presence of fever, myalgias/arthralgias, fatigue and headache can be considered to have a probability coefficient of at least 5 and a specificity of over 90%. This could mean that, in the presence of these symptoms, the probability of infection by COVID-19 increases, especially in situations of high community transmission[4].

Beyond the nurse's acuity in cataloguing the risk of infection by COVID-19 in terms of signs and symptoms and epidemiological data, the primary objective of triage should not be forgotten, which is to establish the level of priority. To this must be added the need for communication skills and empathy, since the hygienic rules of safety and accompaniment must be explained to both patients and family members. And all this with an added effort of communication, empathy and understanding, given that on many occasions accompaniment was not possible due to safety issues.

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Article Information: Received: 28-2-2021. Accepted: 7-6-2021. Online: 10-9-2021.
Editor in charge: Òscar Miró.

Frontline healthcare, especially in the ED, has been associated with an increased susceptibility to develop stress, anxiety, depression, insomnia or burnout among healthcare professionals[5]. This, added to the overpressure of performing triage itself[6], makes it essential to equip and care for the healthcare professional who performs triage functions. For this reason, all the recommendations regarding the professional profile, capabilities, qualities and skills that a triage nurse should have should be applied, such as at least 1 years' experience in an ED, and specific training in emergency medicine and triage, among others[7-9].

With the uncertainty of the future, the unknowns of what lies ahead, and the lessons learned to date, we must consider the ED to be vulnerable without efficient, high-quality triage. In the ED, the triage nurse is the pillar on which the cornerstone of safe and equitable care for all patients' rests. Thus, there is a clear need to "invest" in the highly qualified, trained and experienced human capital required in triage. And this means, among other things, being professionals with the specialty of emergency nursing.

Conflict of Interest Disclosures: The authors declare no conflict of interest in relation to this article.

Funding: The authors declare the non-existence of funding in relation to the present article.

Ethical responsibilities: All authors have confirmed the maintenance of confidentiality and respect for the rights of the patients in the document of author responsibilities, publication agreement and assignment of rights to EMERGENCIAS.

Article not commissioned by the Editorial Committee and with external peer review.

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