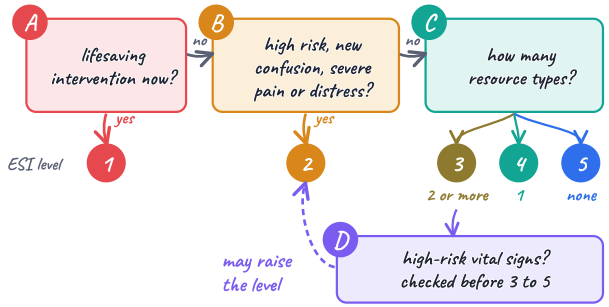
ER BASICS · ONE-PAGER

ED Triage and ESI

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

14 sources + more detail
erbasics.com/sheets/triage-esi.html
checked Oct 2026

HOW IT WORKS Decision points A to D



1 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.

2 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.

3 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.

4 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.

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

6 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.

MORE Decision point C: predicting resources

Point C applies only after A and B are ruled out. Predict what a typical ED would use to reach a disposition for this presentation, not what one provider tends to order; teaching and community hospitals should count the same (v5 Ch. 5). A resource takes people or equipment beyond routine bedside nursing, which is why v4 counted MRI, a psychiatry consult and a one-to-one observer but not a cardiac monitor.

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