

Attachment 9: Medical Care Triage Guidelines

Contents:

- Utah Pandemic Influenza Hospital and ICU Triage Guidelines for Adults
- Utah Pandemic Influenza Hospital and ICU Triage Guidelines for Pediatrics
- Initial Triage for Pandemic Influenza
- Adult Patient Worksheet for Pandemic Influenza Triage
- Pediatric Patient Worksheet for Pandemic Influenza Triage
- Caring for Someone with Influenza at Home

Utah Pandemic Influenza Hospital and ICU Triage Guidelines for ADULTS

Prepared by UTAH HOSPITALS AND HEALTH SYSTEMS ASSOCIATION
for the Utah Department of Health

Version 4b, January 28, 2010

Purpose:

These guidelines were developed by the Utah Hospitals and Health Systems Association (UHA) Triage Guidelines Workgroup. The purpose is to guide the allocation of patient care resources during an influenza pandemic or other public health emergency, when demand for services dramatically exceeds supply. **Application of these guidelines will require physician judgment at the point of patient care.**

Basic premises:

- **Graded guidelines** should be used to control resources more tightly as the severity of a pandemic increases.
- **Priority should be given to patients for whom treatment would most likely be lifesaving** and whose functional outcome would most likely improve with treatment. Such patients should be given priority over those who would likely die even with treatment and those who would likely survive without treatment.

Scope:

- **These triage guidelines apply to all healthcare professionals, clinics, and facilities in the state of Utah.**
- **The guidelines apply to all patients 14 years and older.** Please see *Hospital and ICU Triage Guidelines for Pediatrics* for patients 13 years and younger.

When activated:

Guidelines should be activated in the event of pandemic influenza or other public health emergency declared by the Governor of the State of Utah.

Hospital and medical staff planning:

- **Each hospital should:**
 - **Establish a peer-based structure** for the review of hospital admission, Intensive Care Unit (ICU) admission, and termination of life-sustaining treatment. Consider a team of at least 3 individuals, including an intensivist and 2 or more of the following: the hospital medical director, a nursing supervisor, a board member, an ethicist, a pastoral care representative, and one or more independent physicians.
 - **Institute an action team** to provide counseling and care coordination and to work with the families of loved ones who have been denied life-sustaining treatment.
- **Medical staff** should establish a method of providing peer support and expert consultation to physicians making these decisions.

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OVERVIEW OF PANDEMIC TRIAGE LEVELS

Triage Level 1 Early in the pandemic

- Hospitals recognize the need to surge bed capacities.
- Emergency departments are experiencing increased numbers.
- Note: In the event of a severe and rapidly progressing pandemic, start with Triage Level 2.

Triage Level 2 Worsening pandemic

- Hospitals have surged to maximum bed capacity, and emergency departments are overwhelmed.
- There are not enough beds to accommodate all patients needing hospital admission, and not enough ventilators to accommodate all patients with respiratory failure.
- Hospital staff absenteeism is 20% to 30%.

Triage Level 3 Worst-case scenario

- Hospitals have already implemented altered standards of care regarding nurse/patient ratios and have already expanded capacity by adding patients to already occupied hospital rooms.
- Hospital staff absenteeism is 30% to 40%.

PRE-HOSPITAL SETTINGS

Initial Triage

Applies to: Patients who appear for care in physician offices or clinics, or in pre-evaluation spaces for emergency departments;

Implemented by: Physicians, clinic staff, pre-screening staff

Other uses: Publish in newspapers, place in websites, etc. for self-use by public.

ALL Triage Levels: Use **INITIAL TRIAGE TOOL** (*Appendix A*) to provide initial triage screening, as well as instructions and directions for patients who need additional care or medical screening.

EMS, Physician Offices, and Clinics

Applies to: Patients who present for care or call for guidance for where to go or how to care for ill family members;

Implemented by: Primary care staff, hospital help lines, community help lines, and health department help lines

Triage Level 1:

- Use **INITIAL TRIAGE TOOL** (*Appendix A*) to evaluate patients before sending to hospital ED or treating in an outpatient facility.

Triage Levels 2 and 3:

- Continue to use **INITIAL TRIAGE TOOL** (*Appendix A*).
- Initiate **EXCLUSION CRITERIA for Hospital Admission** (page 5) to evaluate patients. Do not send patients meeting **EXCLUSION CRITERIA** to the hospital for treatment. Send home with care instructions (*Appendices pending*).

Home Care, Long-term Care Facilities, and Other Institutional Facilities (e.g., mental health, correctional, handicapped)

Applies to: Patients in institutional facilities

Implemented by: Institutional facility staff

ALL Triage Levels:

- Ensure that all liquid oxygen tanks are full.
- Limit visitation to control infection.

Triage Levels 2 and 3:

- Use **EXCLUSION CRITERIA for Hospital Admission** (page 5) to evaluate patients. Do not transfer patients meeting exclusion criteria to the hospital for treatment.
- Give palliative and supportive care in place.

HOSPITAL SETTINGS

Hospital Administrative Roles - General (refer to page 8 for definitions of elective surgery categories)

Triage Level 1:

- 1) **Preserve bed capacity** by:
 - Canceling all category 2 and 3 elective surgeries, and advising all category 1 elective surgery patients of the risk of infection.
 - Canceling any elective surgery that would require postoperative hospitalization.

Note: Use standard operation and triage decision for admission to ICU since there are still adequate resources to accommodate the most critically ill patients.
- 2) **Preserve oxygen capacity** by:
 - Phasing out all hyperbaric medicine treatments.
 - Ensuring that all liquid oxygen tanks are full.
- 3) **Improve patient care capacity** by transitioning space in ICUs to accommodate more patients with respiratory failure.
- 4) **Control infection** by limiting visitation (follow hospital infection control plan).

Triage Level 2:

- 1) **Preserve bed capacity** by:
 - Canceling all elective surgeries unless necessary to facilitate hospital discharge.
 - Evaluating hospitalized category 1 elective surgery patients for discharge using same criteria as medical patients.
- 2) **Preserve oxygen capacity** by stopping all hyperbaric treatments.
- 3) **Improve patient care capacity** by implementing altered standards of care regarding nurse/patient ratios and expanding capacity by adding patients to already occupied hospital rooms.
- 4) **Provide emotional support** by initiating pre-established action team to provide counseling and care coordination and to work with the families of loved ones who have been denied life-sustaining treatment.

Triage Level 3:

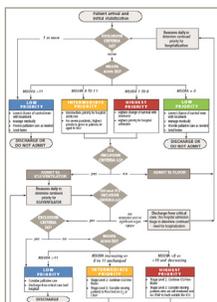
- 1) **Preserve bed capacity** by limiting surgeries to patients whose clinical conditions are a serious threat to life or limb, or to patients for whom surgery may be needed to facilitate discharge from the hospital.

Emergency Department, Hospital, and ICU - Clinical Triage

Use **HOSPITAL AND ICU/VENTILATOR ADMISSION TRIAGE** algorithm and tools (pages 4 and 5) to determine which patients to send home for palliative care or medical management and which patients to admit or keep in hospital or ICU. Note that the *lowest* priority for admission is given to patients with the lowest chance of survival with *or* without treatment, and to patients with the highest chance of survival *without* treatment.

Physician judgment should be used in applying these guidelines. Other factors to consider when applying triage guidelines include:

- Whether the patient is homeless or has someone to care for them at home
- Whether the patient is in the 2nd or 3rd trimester of a pregnancy



See pages 4 and 5 for triage algorithm and supporting tools.

Triage Level 2:

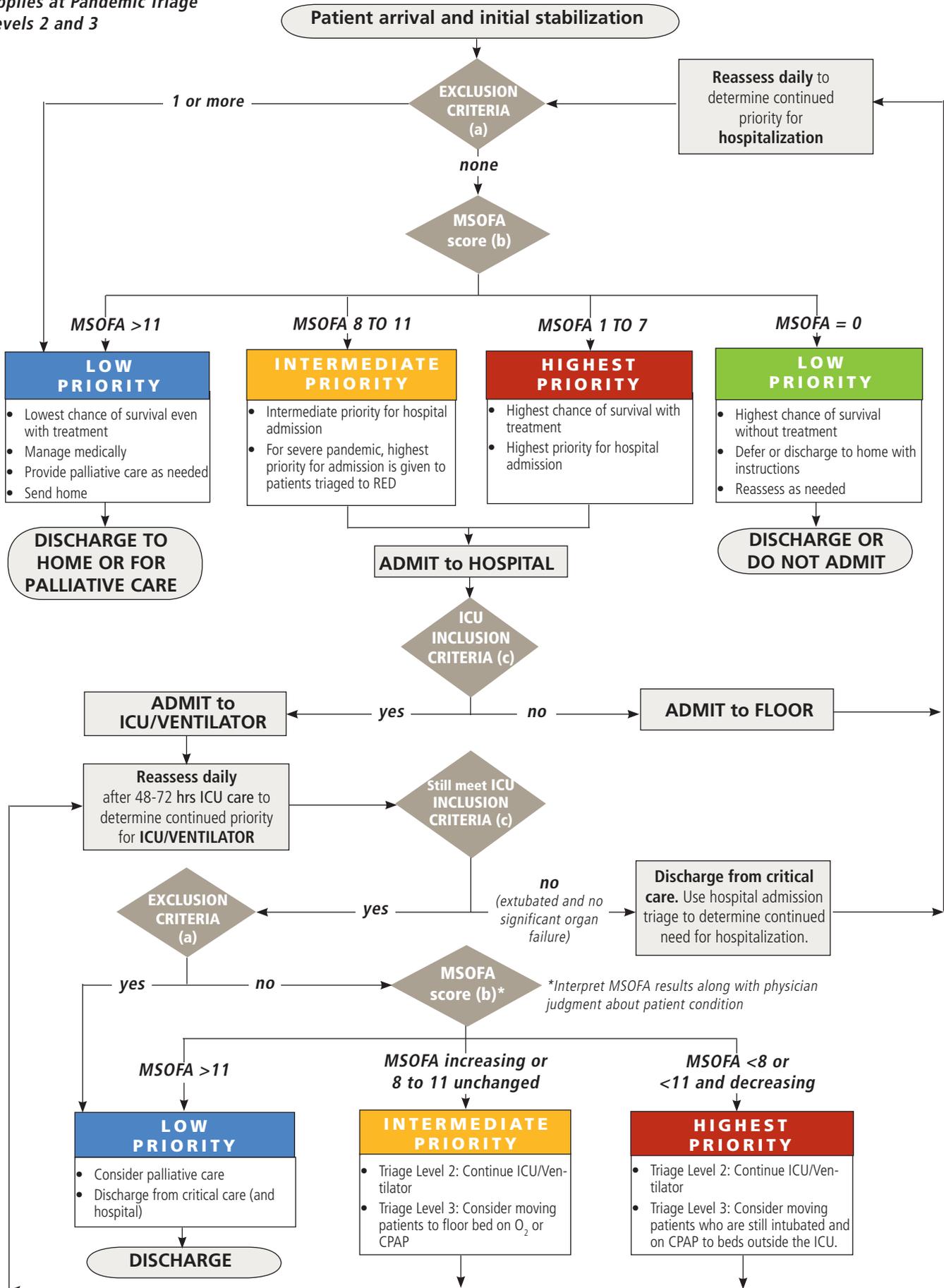
- Initiate **HOSPITAL AND ICU/ VENTILATOR ADMISSION TRIAGE** algorithm (page 4) to determine priority for ICU admission, intubation, and/or mechanical ventilation.
- Reassess need for ICU/ventilator treatment daily after 48-72 hours of ICU care.

Triage Level 3:

- Continue to use **HOSPITAL AND ICU/ VENTILATOR ADMISSION TRIAGE** algorithm (page 4) to determine priority for ICU, intubation, and/or mechanical ventilation.
- Triage more **yellow** patients to floor on oxygen or CPAP.
- Triage more **red** patients who are intubated and on CPAP to floor.

ALGORITHM: HOSPITAL AND ICU/VENTILATOR ADMISSION TRIAGE

Applies at Pandemic Triage Levels 2 and 3



TRiage TOOLS AND TABLES

(a) EXCLUSION CRITERIA for Hospital Admission:

The patient is excluded from hospital admission or transfer to critical care if ANY of the following is present:

- (1) **Known "Do Not Resuscitate" (DNR) status.**
- (2) **Severe and irreversible chronic neurologic condition** with persistent coma or vegetative state
- (3) **Acute severe neurologic event with minimal chance of functional neurologic recovery (physician judgment).** Includes traumatic brain injury, severe hemorrhagic stroke, and intracranial hemorrhage.
- (4) **Severe acute trauma with a REVISED TRAUMA SCORE <2** (see (d) and (e))
 GCS: _____ SBP: _____ RR: _____
 Revised trauma score: _____
- (5) **Severe burns with <50% anticipated survival** (patients identified as "Low" or worse on the **TRIAge DECISION TABLE FOR BURN VICTIMS (f)**). Burns not requiring critical care resources may be cared for at the local facility (e.g., burns that might have been transferred to the University of Utah Medical Center Burn Center under normal circumstances). **Score:** _____
- (6) **Cardiac arrest not responsive to ACLS interventions within 20-30 minutes.**
- (7) **Known severe dementia** medically treated and requiring assistance with activities of daily living.
- (8) **Advanced untreatable neuromuscular disease** (such as ALS or end-stage MS) requiring assistance with activities of daily living or requiring chronic ventilatory support.
- (9) **Incurable metastatic malignant disease.**
- (10) **End-stage organ failure** meeting the following criteria:
 - Heart: NEW YORK HEART ASSOCIATION (NYHA) FUNCTIONAL CLASSIFICATION SYSTEM Class III or IV (g).** **Class:** _____
 - Lung** (any of the following):
 - Chronic Obstructive Pulmonary Disease (COPD) with Forced Expiratory Volume in one second (FEV₁) < 25% predicted baseline, PaO₂ <55 mm Hg, or severe secondary pulmonary hypertension.
 - Cystic fibrosis with post-bronchodilator FEV₁ <30% or baseline PaO₂ <55 mm Hg.
 - Pulmonary fibrosis with VC or TLC < 60% predicted, baseline PaO₂ <55 mm Hg, or severe secondary pulmonary hypertension.
 - Primary pulmonary hypertension with NYHA class III or IV heart failure (g), right atrial pressure >10 mm Hg, or mean pulmonary arterial pressure >50 mm Hg.
 - Liver: PUGH SCORE >7 (h)**, when available. Includes bili, albumin, INR, ascites, encephalopathy.
Total score: _____
- (11) **Age:**
 - Triage Level 1: >95 years
 - Triage Level 2: >90 years
 - Triage Level 3: >85 years

(b) Modified Sequential Organ Failure Assessment (MSOFA)

The MSOFA requires only one lab value, which can be obtain using bedside point-of-care testing (creatinine obtained through ISTAT). MSOFA has not been validated in children, but is currently under study.

MSOFA scoring guidelines						
Variable	Score 0	Score 1	Score 2	Score 3	Score 4	Score for each row
SpO₂/FIO₂ ratio* <i>or</i> nasal cannula or mask O ₂ required to keep SpO ₂ >90%	SpO ₂ /FIO ₂ >400 <i>or</i> room air SpO ₂ >90%	SpO ₂ /FIO ₂ 316-400 <i>or</i> SpO ₂ >90% at 1-3 L/min	SpO ₂ /FIO ₂ 231-315 <i>or</i> SpO ₂ >90% at 4-6 L/min	SpO ₂ /FIO ₂ 151-230 <i>or</i> SpO ₂ >90% at 7-10 L/min	SpO ₂ /FIO ₂ ≤150 <i>or</i> SpO ₂ >90% at >10 L/min	_____
Jaundice	no scleral icterus			clinical jaundice/scleral icterus		_____
Hypotension †	None	MABP <70	dop <5	dop 5-15 <i>or</i> epi ≤0.1 <i>or</i> norepi ≤0.1	dop >15 <i>or</i> epi >0.1 <i>or</i> norepi >0.1	_____
Glasgow Coma Score	15	13-14	10-12	6-9	<6	_____
Creatinine level, mg/dL (use ISTAT)	<1.2	1.2-1.9	2.0-3.4	3.5-4.9 <i>or</i> urine output <500 mL in 24 hours	>5 <i>or</i> urine output <200 mL in 24 hours	_____
MSOFA score = total scores from all rows:						_____

* SpO₂/FIO₂ ratio:

SpO₂ = Percent saturation of hemoglobin with oxygen as measured by a pulse oximeter and expressed as % (e.g., 95%); FIO₂ = Fraction of inspired oxygen; e.g., ambient air is 0.21
 Example: if SpO₂=95% and FIO₂=0.21, the SpO₂/FIO₂ ratio is calculated as 95/0.21=452

† Hypotension:

MABP = mean arterial blood pressure in mm Hg (diastolic + 1/3(systolic - diastolic))
 dop = dopamine in micrograms/kg/min
 epi = epinephrine in micrograms/kg/min
 norepi = norepinephrine in micrograms/kg/min

(c) ICU/Ventilator INCLUSION CRITERIA

Patient must have **NO EXCLUSION CRITERIA (a)** and **at least one of the following INCLUSION CRITERIA:**

- (1) **Requirement for invasive ventilatory support**
 - Refractory hypoxemia (SpO₂ <90% on non-rebreather mask or FIO₂ >0.85)
 - Respiratory acidosis (pH <7.2)
 - Clinical evidence of impending respiratory failure
 - Inability to protect or maintain airway
- (2) **Hypotension* with clinical evidence of shock** refractory to volume resuscitation, and requiring vasopressor or inotrope support that cannot be managed in a ward setting.**
 - *Hypotension = Systolic BP <90 mm Hg or relative hypotension
 - **Clinical evidence of shock = altered level of consciousness, decreased urine output, or other evidence of end-stage organ failure

See Appendix B for a Patient Worksheet based on the above Exclusion and Inclusion Criteria.

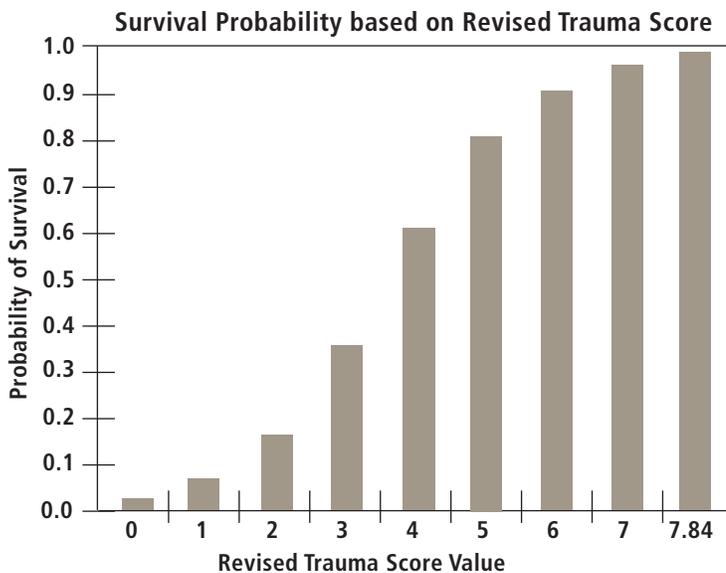
(d) GLASGOW COMA SCORE (GCS)

The GCS is used as part of the REVISED TRAUMA SCORE (RTS) in determining exclusion criteria for hospital admission in the case of pandemic flu at triage levels 2 and 3.

Glasgow Coma Scoring Criteria			
Criteria		Score	Criteria Score
Best Eye Response (4 possible points)	No eye opening	1	_____
	Eye opens to pain	2	
	Eye opens to verbal command	3	
	Eyes open spontaneously	4	
Best Verbal Response (5 possible points)	No verbal response	1	_____
	Incomprehensible sounds	2	
	Inappropriate words	3	
	Confused	4	
	Oriented	5	
Best Motor Response (6 possible points)	No motor response	1	_____
	Extension to pain	2	
	Flexion to pain	3	
	Withdraws from pain	4	
	Localizes to pain	5	
	Obeys commands	6	
Total Score (add 3 subscores; range 3 to 15):			_____

(e) REVISED TRAUMA SCORE (RTS)

Values for the REVISED TRAUMA SCORE (RTS) range from 0 to 7.8408. The RTS is heavily weighted towards the GLASGOW COMA SCORE (GCS) to compensate for major head injury without multisystem injury or major physiological changes. The RTS correlates well with the probability of survival. A Revised Trauma Score of <2 is an exclusion criterion for hospital admission during a pandemic flu at triage levels 2 and 3.



Revised Trauma Score Calculation				Adjusted Score
Criteria	Score	Coded value	Weighting	
Glasgow Coma Score	3	0	x 0.9368	_____
	4 to 5	1		
	6 to 8	2		
	9 to 12	3		
	13 to 16	4		
Systolic Blood Pressure (SBP)	0	0	x 0.7326	_____
	1 to 49	1		
	50 to 75	2		
	76 to 89	3		
	>89	4		
Respiratory Rate (RR) in breaths per minute (BPM)	0	0	x 0.2908	_____
	1 to 5	1		
	6 to 9	2		
	>29	3		
	10 to 29	4		
Revised Trauma Score (add 3 adjusted scores):				_____

(f) TRIAGE DECISION TABLE FOR BURN VICTIMS

A burn score of "Low" or worse on this table is an exclusion criterion for hospital admission in the case of pandemic flu at triage levels 2 and 3.

Age (yrs)	Burn Size (% total body surface area)									
	0-10%	11-20%	21-30%	31-40%	41-50%	51-60%	61-70%	71-80%	81-90%	91%+
0-1.9	Very high	Very high	Very high	High	Medium	Medium	Medium	Low	Low	Low/expectant
2.0-4.9	Outpatient	Very high	Very high	High	High	High	Medium	Medium	Low	Low
5.0-19.9	Outpatient	Very high	Very high	High	High	High	Medium	Medium	Medium	Low
20.0-29.9	Outpatient	Very high	Very high	High	High	Medium	Medium	Medium	Low	Low
30.0-39.9	Outpatient	Very high	Very high	High	Medium	Medium	Medium	Medium	Low	Low
40.0-49.9	Outpatient	Very high	Very high	Medium	Medium	Medium	Medium	Low	Low	Low
50.0-59.9	Outpatient	Very high	Very high	Medium	Medium	Medium	Low	Low	Low/expectant	Low/expectant
60.0-69.9	Very high	Very high	Medium	Medium	Low	Low	Low	Low/expectant	Low/expectant	Low/expectant
70.0+	Very high	Medium	Medium	Low	Low	Low/expectant	Expectant	Expectant	Expectant	Expectant

Outpatient: Survival and good outcome expected, without requiring initial admission; **Very high:** Survival and good outcome expected with limited/short-term initial admission and resource allocation (straightforward resuscitation, LOS <14-21 days, 1-2 surgical procedures); **High:** Survival and good outcome expected (survival ≥90%) with aggressive and comprehensive resource allocation, including aggressive fluid resuscitation, admission ≥14-21 days, multiple surgeries, prolonged rehabilitation; **Medium:** Survival 50-90% and/or aggressive care and comprehensive resource allocation required, including aggressive resuscitation, initial admission ≥14-21 days, multiple surgeries and prolonged rehabilitation; **Low:** Survival <50% even with long-term aggressive treatment and resource allocation; **Expectant:** Predicted survival ≤10% even with unlimited aggressive treatment.

(g) NEW YORK HEART ASSOCIATION (NYHA) FUNCTIONAL CLASSIFICATION SYSTEM

The NYHA functional classification system relates symptoms to everyday activities and the patient's quality of life. NYHA Class III or IV heart failure are exclusion criteria for hospital admission in the case of pandemic flu at triage levels 2 and 3.

NYHA Classes	
Class	Patient Symptoms
Class I (Mild)	No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitations, or dyspnea.
Class II (Mild)	Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in fatigue, palpitations, or dyspnea.
Class III (Moderate)	Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes fatigue, palpitations, or dyspnea.
Class IV (Severe)	Unable to carry out physical activity without discomfort. Symptoms of cardiac insufficiency at rest. If any physical activity is undertaken, discomfort is increased.

Used with permission from www.abouthf.org.

(h) PUGH SCORE

A total PUGH SCORE >7 is an exclusion criterion for hospital admission in the case of pandemic flu at triage levels 2 and 3.

Scoring criteria			
Criteria	Value	Points	Total for criteria
Total Serum Bilirubin	<2 mg/dL	1	_____
	2-3 mg/dL	2	
	>3 mg/dL	3	
Serum Albumin	>3.5 g/dL	1	_____
	2.8 - 3.5 g/dL	2	
	<2.8 g/dL	3	
INR	<1.70	1	_____
	1.71-2.20	2	
	>2.20	3	
Ascites	None	1	_____
	Controlled medically	2	
	Poorly controlled	3	
Encephalopathy	None	1	_____
	Controlled medically	2	
	Poorly controlled	3	
Total Pugh Score			_____
Score interpretation			
Total PUGH SCORE	Class		
5-6	A	Life expectancy 15-20 years Abdominal surgery perioperative mortality 10%	
7 to 9	B	Liver transplant evaluation indicated Abdominal surgery perioperative mortality 30%	
10 to 15	C	Life expectancy 1-3 years Abdominal surgery perioperative mortality 82%	

DEFINITIONS USED IN THIS DOCUMENT

- **Emergency patients:** Those patients whose clinical conditions indicate that they require admission to the hospital and/or surgery within 24 hours.
- **Elective surgery:**
 - **Category 1:** Urgent patients who require surgery within 30 days.
 - **Category 2:** Semi-urgent patients who require surgery within 90 days.
 - **Category 3:** Non-urgent patients who need surgery at some time in the future.
- **Long-term Care Facility:** A residential program providing 24-hour care, to include: Nursing Homes, Skilled Nursing Facilities, Assisted Living 1 and 2, Residential Care Facilities, and Intermediate Care for the Mentally Retarded (ICFMR) facilities.
- **Palliative care:** To make a patient comfortable by treating symptoms from an illness and by addressing issues causing physical or emotional pain or suffering.

REFERENCES

This document was developed following review and partial adaptation of the following articles:

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Malpractice Liability: In the 2007 legislative session, SB 153 (Malpractice Liability During Pandemic Event) was passed and incorporated into law (53-13-2.6, Utah code annotated 1953). This bill protects healthcare providers, including facilities, from malpractice liability when they respond to a natural disaster, pandemic event, or bioterrorism. Activities that are protected include:

- Implementing measures to control the causes of epidemic, pandemic, communicable diseases, or other conditions significantly affecting public health as necessary to protect the public health;
- Investigating, controlling, and treating suspected bioterrorism or disease in accordance with Title 26, Chapter 23b; or
- Responding to the following: a national, state or local emergency; a public health emergency as defined in Title 26, Chapter 23b, 102; or a declaration of the President of the United States or other federal official requesting public health related activities.

EMTALA: EMTALA provisions may be waived by the Secretary of Health Human Services during a declared public emergency and under the Stafford act. The Secretary can issue the Section 1135 Waiver to waive sanctions for the "transfer of an individual who has not stabilized for both transfers and redirection for a medical screening examination. Waivers are generally limited to a 72-hour period beginning upon implementation of a hospital disaster protocol, unless the Waiver arises out of a public health emergency involving a pandemic. If related to a pandemic, the Waiver terminates upon the first to occur of either the termination of the underlying declaration of a public health emergency or 60 days after being first published. If the waiver terminates because of the latter, the Secretary may extend it for subsequent 60-day periods.

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for the Utah Department of Health

Version 4b, January 28, 2010

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These guidelines were developed by the Utah Hospitals and Health Systems Association (UHA) Triage Guidelines Workgroup in conjunction with Primary Children's Medical Center. The purpose is to guide the allocation of patient care resources during an influenza pandemic or other public health emergency, when demand for services dramatically exceeds supply. **Application of these guidelines will require physician judgment at the point of patient care.**

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- **The guidelines apply to all patients 13 years and younger.** Please see *Hospital and ICU Triage Guidelines for Adults* for patients 14 years and older.

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 - **Establish a peer-based structure** for the review of hospital admission, Intensive Care Unit (ICU) admission, and termination of life-sustaining treatment. Consider a team of at least 3 individuals, including an intensivist and 2 or more of the following: the hospital medical director, a nursing supervisor, a board member, an ethicist, a pastoral care representative, and one or more independent physicians.
 - **Institute an action team** to provide counseling and care coordination and to work with the families of loved ones who have been denied life-sustaining treatment.
- **Medical staff** should establish a method of providing peer support and expert consultation to physicians making these decisions.

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Malpractice Liability: In the 2007 legislative session, SB 153 (Malpractice Liability During Pandemic Event) was passed and incorporated into law (53-13-2.6, Utah code annotated 1953). This bill protects healthcare providers, including facilities, from malpractice liability when they respond to a natural disaster, pandemic event, or bioterrorism. Activities that are protected include:

- Implementing measures to control the causes of epidemic, pandemic, communicable diseases, or other conditions significantly affecting public health as necessary to protect the public health;
- Investigating, controlling, and treating suspected bioterrorism or disease in accordance with Title 26, Chapter 23b; or
- Responding to the following: a national, state or local emergency; a public health emergency as defined in Title 26, Chapter 23b, 102; or a declaration of the President of the United States or other federal official requesting public health related activities.

EMTALA: EMTALA provisions may be waived by the Secretary of Health Human Services during a declared public emergency and under the Stafford act. The Secretary can issue the Section 1135 Waiver to waive sanctions for the "transfer of an individual who has not stabilized for both transfers and redirection for a medical screening examination. Waivers are generally limited to a 72-hour period beginning upon implementation of a hospital disaster protocol, unless the Waiver arises out of a public health emergency involving a pandemic. If related to a pandemic, the Waiver terminates upon the first to occur of either the termination of the underlying declaration of a public health emergency or 60 days after being first published. If the waiver terminates because of the latter, the Secretary may extend it for subsequent 60-day periods.



OVERVIEW OF PANDEMIC TRIAGE LEVELS

Triage Level 1 Early in the pandemic

- Hospitals recognize the need to surge bed capacities.
- Emergency departments are experiencing increased numbers.
- Note: In the event of a severe and rapidly progressing pandemic, start with Triage Level 2.

Triage Level 2 Worsening pandemic

- Hospitals have surged to maximum bed capacity, and emergency departments are overwhelmed.
- There are not enough beds to accommodate all patients needing hospital admission, and not enough ventilators to accommodate all patients with respiratory failure.
- Hospital staff absenteeism is 20% to 30%.

Triage Level 3 Worst-case scenario

- Hospitals have already implemented altered standards of care regarding nurse/patient ratios and have already expanded capacity by adding patients to already occupied hospital rooms.
- Hospital staff absenteeism is 30% to 40%.

PRE-HOSPITAL SETTINGS

Initial Triage

Applies to: Patients who appear for care in physician offices or clinics, or in pre-evaluation spaces for emergency departments;

Implemented by: Physicians, clinic staff, pre-screening staff

Other uses: Publish in newspapers, place in websites, etc. for self-use by public.

ALL Triage Levels: Use **INITIAL TRIAGE TOOL** (*Appendix A*) to provide initial triage screening, as well as instructions and directions for patients who need additional care or medical screening.

EMS, Physician Offices, and Clinics

Applies to: Patients who present for care or call for guidance for where to go or how to care for ill family members;

Implemented by: Primary care staff, hospital help lines, community help lines, and health department help lines

Triage Level 1:

- Use **INITIAL TRIAGE TOOL** (*Appendix A*) to evaluate patients before sending to hospital emergency department or treating in an outpatient facility.

Triage Levels 2 and 3:

- Continue to use **INITIAL TRIAGE TOOL** (*Appendix A*).
- Initiate **EXCLUSION CRITERIA for Hospital Admission** (page 5) to evaluate patients. Do not send patients meeting **EXCLUSION CRITERIA** to the hospital for treatment. Send home with care instructions (*Appendices pending*).

Home Care, Long-term Care Facilities, and Other Institutional Facilities (e.g., mental health, correctional, handicapped)

Applies to: Patients in institutional facilities

Implemented by: Institutional facility staff

ALL Triage Levels:

- Ensure that all liquid oxygen tanks are full.
- Limit visitation to control infection.

Triage Levels 2 and 3:

- Use **EXCLUSION CRITERIA for Hospital Admission** (page 5) to evaluate patients. Do not transfer patients meeting exclusion criteria to the hospital for treatment.
- Give palliative and supportive care in place.

HOSPITAL SETTINGS

Hospital Administrative Roles - General (refer to page 8 for definitions of elective surgery categories)

Triage Level 1:

1) Preserve bed capacity by:

- Canceling all category 2 and 3 elective surgeries, and advising all category 1 elective surgery patients of the risk of infection.
- Canceling any elective surgery that would require postoperative hospitalization.

Note: Use standard operation and triage decision for admission to ICU since there are still adequate resources to accommodate the most critically ill patients.

2) Preserve oxygen capacity by:

- Phasing out all hyperbaric medicine treatments.
- Ensuring that all liquid oxygen tanks are full.

3) Improve patient care capacity

by transitioning space in ICUs to accommodate more patients with respiratory failure.

4) Control infection by limiting visitation (follow hospital infection control plan).

Triage Level 2:

1) Preserve bed capacity by:

- Canceling all elective surgeries unless necessary to facilitate hospital discharge.
- Evaluating hospitalized category 1 elective surgery patients for discharge using same criteria as medical patients.

2) Preserve oxygen capacity by stopping all hyperbaric treatments.

3) Improve patient care capacity by implementing altered standards of care regarding nurse/patient ratios and expanding capacity by adding patients to already occupied hospital rooms.

4) Provide emotional support by initiating pre-established action team to provide counseling and care coordination and to work with the families of loved ones who have been denied life-sustaining treatment.

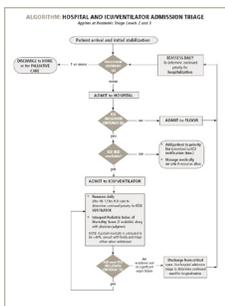
Triage Level 3:

1) Preserve bed capacity by limiting surgeries to patients whose clinical conditions are a serious threat to life or limb, or to patients for whom surgery may be needed to facilitate discharge from the hospital.

Emergency Department, Hospital, and ICU - Clinical Triage

Use **HOSPITAL AND ICU/VENTILATOR ADMISSION TRIAGE** algorithm and tools (pages 4 and 5) to determine which patients to send home for palliative care or medical management and which patients to admit or keep in hospital or ICU. Note that the *lowest* priority for admission is given to patients with the lowest chance of survival with *or* without treatment, and to patients with the highest chance of survival *without* treatment.

Physician judgment should be used in applying these guidelines.



See pages 4 and 5 for triage algorithm and supporting tools.

Triage Level 2:

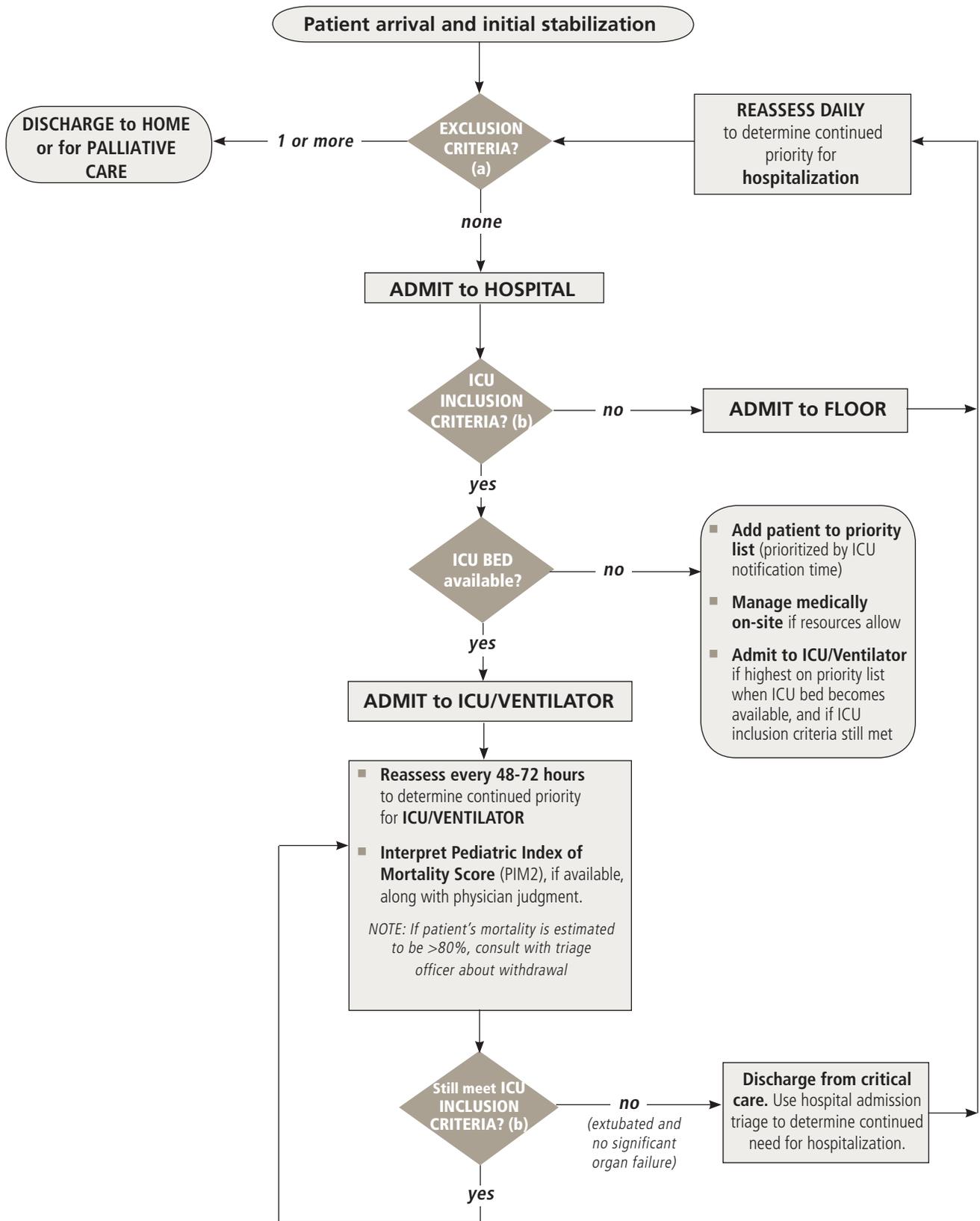
- Initiate **HOSPITAL AND ICU/ VENTILATOR ADMISSION TRIAGE** algorithm (page 4) to determine priority for ICU admission, intubation, and/or mechanical ventilation.
- Reassess need for ICU/ventilator treatment daily after 48-72 hours of ICU care.

Triage Level 3:

- Continue to use **HOSPITAL AND ICU/ VENTILATOR ADMISSION TRIAGE** algorithm (page 4) to determine priority for ICU, intubation, and/or mechanical ventilation.

ALGORITHM: HOSPITAL AND ICU/VENTILATOR ADMISSION TRIAGE

Applies at Pandemic Triage Levels 2 and 3



TRiage TOOLS AND TABLES

(a) EXCLUSION CRITERIA for Hospital Admission:

The patient is excluded from hospital admission or transfer to critical care if ANY of the following is present:

- (1) **Known “Do Not Resuscitate” (DNR) status.**
- (2) **Persistent coma or vegetative state.**
- (3) **Severe acute trauma with a REVISED TRAUMA SCORE <2 (see (d) and (e) on following pages).**
GCS: ____ SBP: ____ RR: ____
Revised trauma score: ____
- (4) **Severe burns with <50% anticipated survival** (patients identified as “Low” or worse on the TRIAGE DECISION TABLE FOR BURN VICTIMS (f)). Burns not requiring critical care resources may be cared for at the local facility (e.g., burns that might have been transferred to the University of Utah Medical Center Burn Center under normal circumstances).
- (5) **Cardiac arrest not responsive to PALS interventions within 20-30 minutes.**
- (6) **Short anticipated duration of benefit, e.g.,** underlying condition with >80% mortality rate at 18-24 months:
 - a) Known chromosomal abnormalities such as Trisomy 13 or 18
 - b) Known metabolic diseases such as Zellweger syndrome
 - c) Spinal muscular atrophy (SMA) type 1
 - d) Progressive neuromuscular disorder, e.g., muscular dystrophy and myopathy, with inability to sit unaided or ambulate when such abilities would be developmentally appropriate based on age
 - e) Cystic fibrosis with post-bronchodilator FEV₁ <30% or baseline PaO₂ <55 mm Hg
 - f) Severe end-stage pulmonary hypertension

OTHER CONSIDERATIONS:

- Resuscitation of extremely premature infants with anticipated mortality rates greater than 80% should not be offered. See http://www.nichd.nih.gov/about/org/cdbpm/pp/prog_epbo/
- The use of ECMO will be decided on an individual basis by the Chief Medical Officer (with input from attending physician, nursing supervisor, and ECMO representative) based on prognosis, suspected duration of ECMO run, and availability of personnel and other resources. Patients should have an estimated survival of >70% with an estimated ECMO run of <7-10 days.

(b) ICU/Ventilator INCLUSION CRITERIA

- Applies to all patients except those infants not yet discharged from the NICU
- Patients must have NO EXCLUSION CRITERIA (a) and at least one of the following INCLUSION CRITERIA:

(1) Requirement for invasive ventilatory support

- Refractory hypoxemia (SpO₂ < 90% on non-rebreather mask or FIO₂ > 0.85)
- Respiratory acidosis (pH < 7.2)
- Clinical evidence of impending respiratory failure
- Inability to protect or maintain airway

(2) Hypotension* with clinical evidence of shock** refractory to volume resuscitation, and requiring vasopressor or inotrope support that cannot be managed in a ward setting

- * **Hypotension** = Systolic BP < 90 mm Hg for patients age > 10 years old, < 70 + (2 x age in years) for patients ages 1 to 10, < 60 for infants < 1 year old, or relative hypotension
- ** **Clinical evidence of shock** = altered level of consciousness, decreased urine output, or other evidence of end-stage organ failure

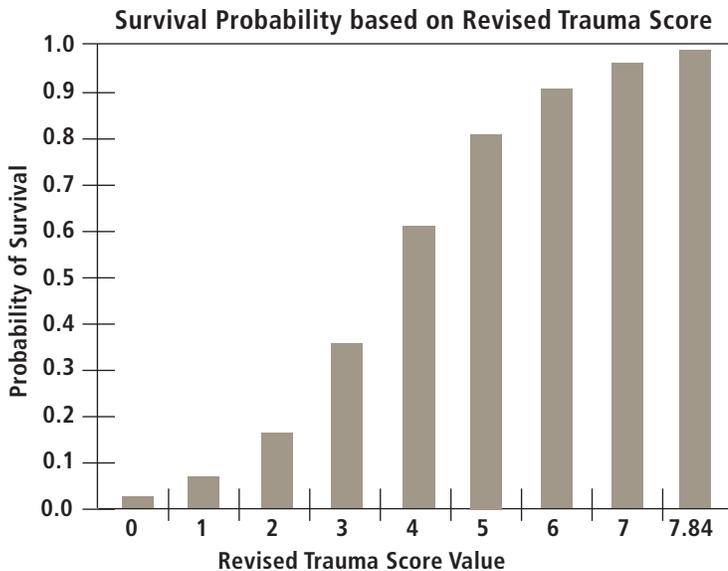
(c) GLASGOW COMA SCORE (GCS)

The GCS is used as part of the REVISED TRAUMA SCORE (RTS) in determining exclusion criteria for hospital admission in the case of pandemic flu at triage levels 2 and 3.

Glasgow Coma Scoring Criteria				
Criteria	Adults and Children	Infants and Young Toddlers	Score	Criteria Score
Best Eye Response (4 possible points)	No eye opening	No eye opening	1	_____
	Eye opens to pain	Eye opens to pain	2	
	Eye opens to verbal command	Eye opens to speech	3	
	Eyes open spontaneously	Eyes open spontaneously	4	
Best Verbal Response (5 possible points)	No verbal response	No verbal response	1	_____
	Incomprehensible sounds	Infant moans to pain	2	
	Inappropriate words	Infant cries to pain	3	
	Confused	Infant is irritable and continually cries	4	
	Oriented	Infant coos or babbles (normal activity)	5	
Best Motor Response (6 possible points)	No motor response	No motor response	1	_____
	Extension to pain	Extension to pain	2	
	Flexion to pain	Abnormal flexion to pain	3	
	Withdraws from pain	Withdraws from pain	4	
	Localizes to pain	Withdraws from touch	5	
	Obeys commands	Moves spontaneously or purposefully	6	
Total Score (add 3 subscores; range 3 to 15):				_____

(d) REVISED TRAUMA SCORE (RTS)

Values for the REVISED TRAUMA SCORE (RTS) range from 0 to 7.8408. The RTS is heavily weighted towards the GLASGOW COMA SCORE (GCS) to compensate for major head injury without multisystem injury or major physiological changes. The RTS correlates well with the probability of survival. A Revised Trauma Score of <2 is an exclusion criterion for hospital admission during a pandemic flu at triage levels 2 and 3.



Revised Trauma Score Calculation				
Criteria	Score	Coded value	Weighting	Adjusted Score
Glasgow Coma Score	3	0	x 0.9368	_____
	4 to 5	1		
	6 to 8	2		
	9 to 12	3		
	13 to 16	4		
Systolic Blood Pressure (SBP)	0	0	x 0.7326	_____
	1 to 49	1		
	50 to 75	2		
	76 to 89	3		
	>89	4		
Respiratory Rate (RR) in breaths per minute (BPM)	0	0	x 0.2908	_____
	1 to 5	1		
	6 to 9	2		
	>29	3		
	10 to 29	4		
Revised Trauma Score (add 3 adjusted scores):				_____

(e) TRIAGE DECISION TABLE FOR BURN VICTIMS

A burn score of “Low” or worse on this table is an exclusion criterion for hospital admission in the case of pandemic flu at triage levels 2 and 3.

Age (yrs)	Burn Size (% total body surface area)									
	0-10%	11-20%	21-30%	31-40%	41-50%	51-60%	61-70%	71-80%	81-90%	91%+
0-1.9	Very high	Very high	Very high	High	Medium	Medium	Medium	Low	Low	Low/expectant
2.0-4.9	Outpatient	Very high	Very high	High	High	High	Medium	Medium	Low	Low
5.0-19.9	Outpatient	Very high	Very high	High	High	High	Medium	Medium	Medium	Low
20.0-29.9	Outpatient	Very high	Very high	High	High	Medium	Medium	Medium	Low	Low
30.0-39.9	Outpatient	Very high	Very high	High	Medium	Medium	Medium	Medium	Low	Low
40.0-49.9	Outpatient	Very high	Very high	Medium	Medium	Medium	Medium	Low	Low	Low
50.0-59.9	Outpatient	Very high	Very high	Medium	Medium	Medium	Low	Low	Low/expectant	Low/expectant
60.0-69.9	Very high	Very high	Medium	Medium	Low	Low	Low	Low/expectant	Low/expectant	Low/expectant
70.0+	Very high	Medium	Medium	Low	Low	Low/expectant	Expectant	Expectant	Expectant	Expectant

Outpatient: Survival and good outcome expected, without requiring initial admission; **Very high:** Survival and good outcome expected with limited/short-term initial admission and resource allocation (straightforward resuscitation, LOS <14-21 days, 1-2 surgical procedures); **High:** Survival and good outcome expected (survival ≥90%) with aggressive and comprehensive resource allocation, including aggressive fluid resuscitation, admission ≥14-21 days, multiple surgeries, prolonged rehabilitation; **Medium:** Survival 50-90% and/or aggressive care and comprehensive resource allocation required, including aggressive resuscitation, initial admission ≥14-21 days, multiple surgeries and prolonged rehabilitation; **Low:** Survival <50% even with long-term aggressive treatment and resource allocation; **Expectant:** Predicted survival ≤10% even with unlimited aggressive treatment.

DEFINITIONS USED IN THIS DOCUMENT

- **Emergency patients:** Those patients whose clinical conditions indicate that they require admission to the hospital and/or surgery within 24 hours.
- **Elective surgery:**
 - **Category 1:** Urgent patients who require surgery within 30 days.
 - **Category 2:** Semi-urgent patients who require surgery within 90 days.
 - **Category 3:** Non-urgent patients who need surgery at some time in the future.
- **Long-term Care Facility:** A residential program providing 24-hour care, to include: Nursing Homes, Skilled Nursing Facilities, Assisted Living 1 and 2, Residential Care Facilities, and Intermediate Care for the Mentally Retarded (ICFMR) facilities.
- **Palliative care:** To make a patient comfortable by treating symptoms from an illness and by addressing issues causing physical or emotional pain or suffering.

REFERENCES

This document was developed following review and partial adaptation of the following articles:

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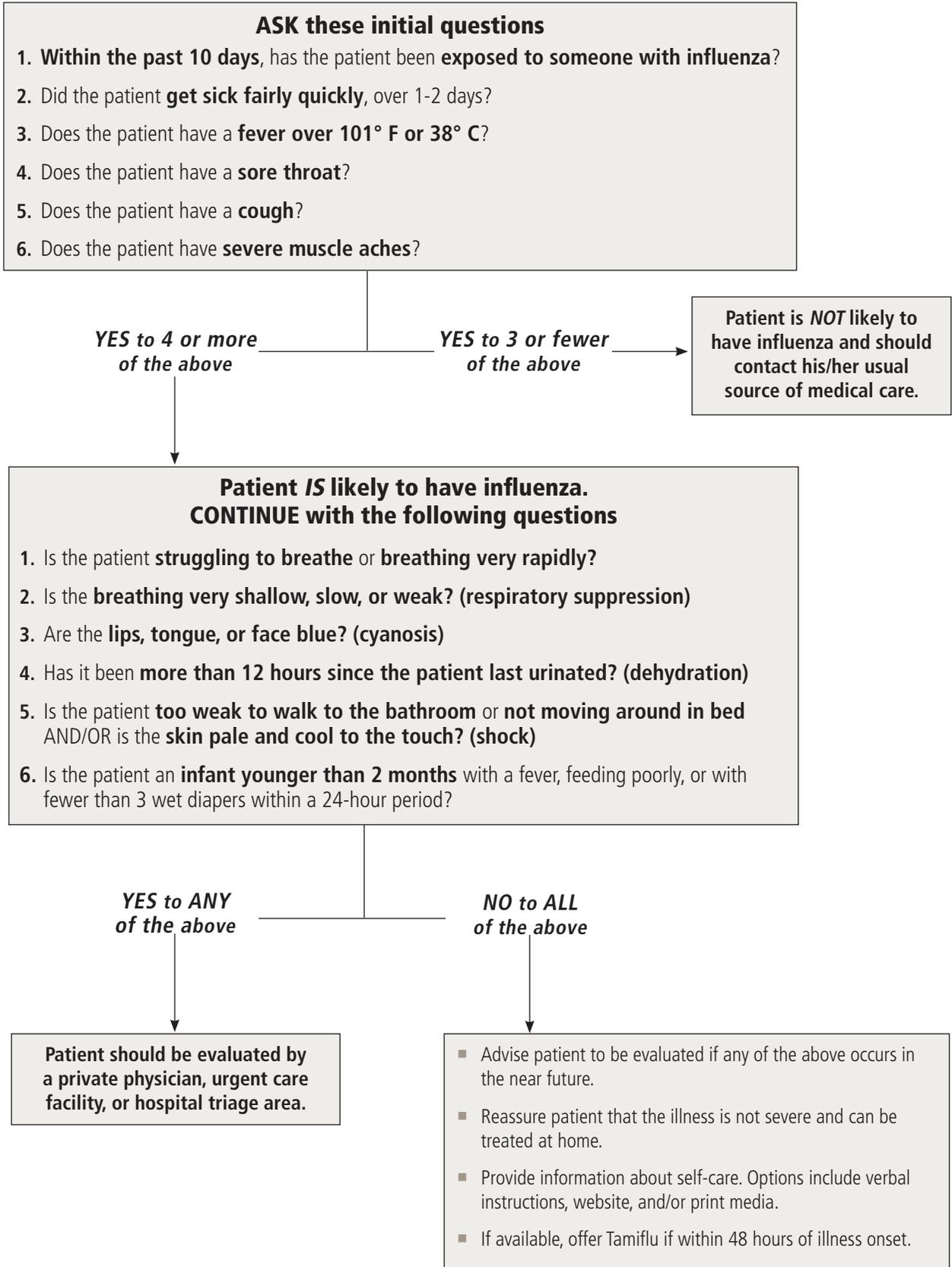
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 - Ethics Committee, Primary Children’s Medical Center
 - Family Advisory Committee, Primary Children’s Medical Center

Appendix A. INITIAL TRIAGE for Pandemic Influenza

Purpose: Initial triage is intended to help patients who are concerned about influenza determine whether or not they should seek medical help.



Appendix B1. ADULT PATIENT WORKSHEET for Pandemic Influenza Triage

STEP 1: If any of the following are present, DO NOT ADMIT. Transfer to palliative care.

The patient is excluded from hospital admission or transfer to critical care if ANY of the following is present:

- (1) **Known "Do Not Resuscitate" (DNR) status.**
- (2) **Severe and irreversible chronic neurologic condition** with persistent coma or vegetative state
- (3) **Acute severe neurologic event with minimal chance of functional neurologic recovery (physician judgment).** Includes traumatic brain injury, severe hemorrhagic stroke, and intracranial hemorrhage.
- (4) **Severe acute trauma with a REVISED TRAUMA SCORE <2** (see (d) and (e))
 GCS: ____ SBP: ____ RR: ____
 Revised trauma score: ____
- (5) **Severe burns with <50% anticipated survival** (patients identified as "Low" or worse on the **TRIAGE DECISION TABLE FOR BURN VICTIMS (f)**). Burns not requiring critical care resources may be cared for at the local facility (e.g., burns that might have been transferred to the University of Utah Medical Center Burn Center under normal circumstances). **Score: ____**
- (6) **Cardiac arrest not responsive to ACLS interventions within 20-30 minutes.**
- (7) **Known severe dementia** medically treated and requiring assistance with activities of daily living.
- (8) **Advanced untreatable neuromuscular disease** (such as ALS or end-stage MS) requiring assistance with activities of daily living or requiring chronic ventilatory support.
- (9) **Incurable metastatic malignant disease.**
- (10) **End-stage organ failure** meeting the following criteria:
 - Heart: NEW YORK HEART ASSOCIATION (NYHA) FUNCTIONAL CLASSIFICATION SYSTEM Class III or IV (g).** **Class: ____**
 - Lung** (any of the following):
 - Chronic Obstructive Pulmonary Disease (COPD) with Forced Expiratory Volume in one second (FEV₁) < 25% predicted baseline, PaO₂ <55 mm Hg, or severe secondary pulmonary hypertension.
 - Cystic fibrosis with post-bronchodilator FEV₁ <30% or baseline PaO₂ <55 mm Hg.
 - Pulmonary fibrosis with VC or TLC < 60% predicted, baseline PaO₂ <55 mm Hg, or severe secondary pulmonary hypertension.
 - Primary pulmonary hypertension with NYHA class III or IV heart failure (g), right atrial pressure >10 mm Hg, or mean pulmonary arterial pressure >50 mm Hg.
 - Liver: PUGH SCORE >7 (h)**, when available. Includes bili, albumin, INR, ascites, encephalopathy.
Total score: ____
- (11) **Age:**
 - Triage Level 1: >95 years
 - Triage Level 2: >90 years
 - Triage Level 3: >85 years

STEP 2: Modified Sequential Organ Failure Assessment (MSOFA)

The MSOFA requires only one lab value, which can be obtain using bedside point-of-care testing (creatinine obtained through ISTAT).

MSOFA scoring guidelines						
Variable	Score 0	Score 1	Score 2	Score 3	Score 4	Score for each row
SpO₂/FIO₂ ratio* <i>or</i> nasal cannula or mask O ₂ required to keep SpO ₂ >90%	SpO ₂ /FIO ₂ >400 <i>or</i> room air SpO ₂ >90%	SpO ₂ /FIO ₂ 316-400 <i>or</i> SpO ₂ >90% at 1-3 L/min	SpO ₂ /FIO ₂ 231-315 <i>or</i> SpO ₂ >90% at 4-6 L/min	SpO ₂ /FIO ₂ 151-230 <i>or</i> SpO ₂ >90% at 7-10 L/min	SpO ₂ /FIO ₂ ≤150 <i>or</i> SpO ₂ >90% at >10 L/min	_____
Jaundice	no scleral icterus			clinical jaundice/ scleral icterus		_____
Hypotension†	None	MABP <70	dop <5	dop 5-15 <i>or</i> epi ≤0.1 <i>or</i> norepi ≤0.1	dop >15 <i>or</i> epi >0.1 <i>or</i> norepi >0.1	_____
Glasgow Coma Score	15	13-14	10-12	6-9	<6	_____
Creatinine level, mg/dL (use ISTAT)	<1.2	1.2-1.9	2.0-3.4	3.5-4.9 <i>or</i> urine output <500 mL in 24 hours	>5 <i>or</i> urine output <200 mL in 24 hours	_____
MSOFA score = total scores from all rows:						_____

* SpO₂/FIO₂ ratio:
 SpO₂ = Percent saturation of hemoglobin with oxygen as measured by a pulse oximeter and expressed as % (e.g., 95%); FIO₂ = Fraction of inspired oxygen; e.g., ambient air is 0.21
 Example: if SpO₂=95% and FIO₂=0.21, the SpO₂/FIO₂ ratio is calculated as 95/0.21=452
 † Hypotension:
 MABP = mean arterial blood pressure in mm Hg (diastolic + 1/3(systolic - diastolic))
 dop = dopamine in micrograms/kg/min
 epi = epinephrine in micrograms/kg/min
 norepi = norepinephrine in micrograms/kg/min

STEP 3: Determine admission priority based on MSOFA

- Score >11:** Unlikely to survive. Discharge to palliative care.
- Score 8-11:** Intermediate priority for hospital admission.
- Score 1-8:** Highest priority for hospital admission.
- Score 0:** Lowest priority for hospital admission. Likely to survive without treatment. Discharge to home

STEP 4: Record disposition

Disposition: _____
Signature: _____
Date and time: _____

Appendix B2. PEDIATRIC PATIENT WORKSHEET for Pandemic Influenza Triage

STEP 1: If any of the following are present, DO NOT ADMIT. Transfer to palliative care.

The patient is excluded from hospital admission or transfer to critical care if ANY of the following is present:

- (1) Known "Do Not Resuscitate" (DNR) status.
- (2) Persistent coma or vegetative state.
- (3) Severe acute trauma with a REVISED TRAUMA SCORE <2 (see (d) and (e) on following pages).
GCS: _____ SBP: _____ RR: _____
Revised trauma score: _____
- (4) Severe burns with <50% anticipated survival (patients identified as "Low" or worse on the TRIAGE DECISION TABLE FOR BURN VICTIMS (f)). Burns not requiring critical care resources may be cared for at the local facility (e.g., burns that might have been transferred to the University of Utah Medical Center Burn Center under normal circumstances).
- (5) Cardiac arrest not responsive to PALS interventions within 20-30 minutes.
- (6) Short anticipated duration of benefit, e.g., underlying condition with >80% mortality rate at 18-24 months:
 - a) Known chromosomal abnormalities such as Trisomy 13 or 18
 - b) Known metabolic diseases such as Zellweger syndrome
 - c) Spinal muscular atrophy (SMA) type 1
 - d) Progressive neuromuscular disorder, e.g., muscular dystrophy and myopathy, with inability to sit unaided or ambulate when such abilities would be developmentally appropriate based on age
 - e) Cystic fibrosis with post-bronchodilator FEV₁ <30% or baseline PaO₂ <55 mm Hg
 - f) Severe end-stage pulmonary hypertension

OTHER CONSIDERATIONS:

- Resuscitation of extremely premature infants with anticipated mortality rates greater than 80% should not be offered. See http://www.nichd.nih.gov/about/org/cdbpm/pp/prog_epbo/
- The use of ECMO will be decided on an individual basis by the Chief Medical Officer (with input from attending physician, nursing supervisor, and ECMO representative) based on prognosis, suspected duration of ECMO run, and availability of personnel and other resources. Patients should have an estimated survival of >70% with an estimated ECMO run of <7-10 days.

STEP 2: Determine if patient meets ICU/Ventilator INCLUSION CRITERIA.

Patients must have NO EXCLUSION CRITERIA (1) and at least one of the following INCLUSION CRITERIA:

- (1) Requirement for invasive ventilatory support
 - Refractory hypoxemia (SpO₂ < 90% on non-rebreather mask or FIO₂ > 0.85)
 - Respiratory acidosis (pH < 7.2)
 - Clinical evidence of impending respiratory failure
 - Inability to protect or maintain airway
- (2) Hypotension* with clinical evidence of shock** refractory to volume resuscitation, and requiring vasopressor or inotrope support that cannot be managed in a ward setting
 - * Hypotension = Systolic BP < 90 mm Hg for patients age > 10 years old, < 70 + (2 x age in years) for patients ages 1 to 10, < 60 for infants < 1 year old, or relative hypotension
 - ** Clinical evidence of shock = altered level of consciousness, decreased urine output, or other evidence of end-stage organ failure

STEP 3: Determine admission priority.

- Unlikely to survive. Discharge to palliative care.
- Hospital treatment is likely to be life-saving.
 - Admit to Floor
 - Admit to ICU if room available
- Lowest priority for hospital admission. Likely to survive without treatment. Discharge to home.

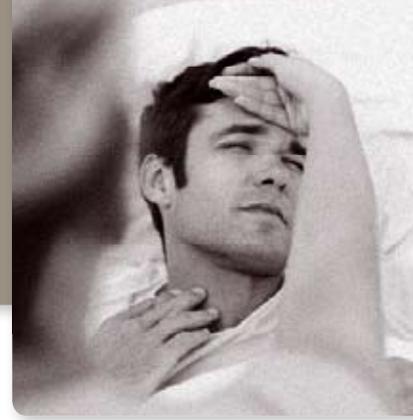
STEP 4: Record disposition

Disposition: _____

Signature: _____

Date and time: _____

Caring for Someone with Influenza at Home



During this influenza (“flu”) outbreak, some people will need care at a hospital. **But many influenza patients must be cared for at home.** This handout will help you care for an influenza patient — a friend or family member — at home. Follow these instructions carefully, as well as any others the doctor gives you.

Protect yourself and prevent the spread of flu.

- Wash your hands often — especially after touching things that have been used or touched by the patient.
- Wear a mask when you’re with the patient.
- Cover your coughs and sneezes with your elbow.
- **Keep a trashcan near the patient’s bed, and line it with a plastic bag.** Toss every used tissue, straw, etc. Seal the plastic bag before emptying it into the garbage.
- Take care of yourself. Get plenty of rest and exercise, and make healthy food choices.

Keep the patient comfortable.

- Let the patient sleep or rest as much as they like. This will help the patient recover.
- Treat aches and fever with medication (see below). Sponging the patient’s body with lukewarm (wrist-temperature) water may lower the patient’s temperature, but only for a brief time. Do not sponge with alcohol.

Give medication as directed.

- For pain and fever, give ibuprofen (Advil or Motrin) or acetaminophen (Tylenol) regularly, as instructed on the bottle or box. Do not give aspirin to children or teenagers because it can cause Reye’s syndrome, a life-threatening illness.
- For flu or any other medical condition the patient has, follow the doctor’s advice carefully. If you have any questions about medication, contact the patient’s doctor.

Prevent dehydration.

Our bodies need fluids to function well. But sickness can lead to dehydration (lack of fluid in the body). To prevent this, do the following:

- Unless the patient is vomiting (throwing up), offer small amounts of liquids frequently throughout the day. Do this even if the patient doesn’t feel thirsty and especially if the patient has a fever. (A person with a fever needs more fluids than usual.) Here are some targets for patients of different ages:

- For young children, give 1½ ounces of liquid per pound of body weight every day (multiply 1.5 times the weight of the child). For example, a toddler weighing 30 pounds needs 45 ounces of liquid a day (30 x 1.5 = 45).
- For older children and adults, give at least 1½ to 2½ quarts of liquid per day — 3 to 5 eight-ounce cups or 2 to 3 twelve-ounce cans or bottles.
- If the patient isn’t eating solid foods, offer liquids that contain sugars and salts. For example, offer broth or soups, sports drinks like Gatorade® mixed with water (aim for half water, half sports drink), Pedialyte® or Lytren® drinks, and any soda that is NOT diet and does NOT have a lot of caffeine.
- Pay attention to how much the patient urinates (pees). (Dehydration causes people to urinate less often and the urine to have a dark yellow color.) An infant should have at least 3 wet diapers in 24 hours. An adult should urinate at least every 8 to 12 hours. If the patient is not meeting these targets, offer frequent sips and spoonfuls of liquids for a 4-hour period, and watch for signs of dehydration (see “Call the doctor” at the end of this handout).

Limit food and drink to a patient who is vomiting (throwing up). Follow this procedure:

- For 1 hour after a patient vomits, don’t give any liquid or food. Let the stomach rest.
- Next, offer a very small amount of clear liquid such as water, weak tea, ginger ale, or broth. Start with 1 to 3 teaspoons of clear liquid every 10 minutes (or give the patient an ice cube to suck on). If the person vomits, let the stomach rest for an hour, then try again with small, frequent amounts of clear liquid.
- When there is no vomiting, gradually increase the amount of liquid offered, and add liquids that contain sugars and salts. After 6 to 8 hours of a liquid diet without vomiting, add foods that are easy to digest, such as saltine crackers, dry toast, mashed potatoes or rice. Gradually, return to a regular diet.

Note: Continue to breastfeed a baby who is vomiting. Let the baby nurse more often — for 4 to 5 minutes every 30 to 45 minutes or so. You can also give the baby small amounts (½ ounce or less) of Pedialyte or Lytren every 10 minutes in a bottle.

Keep a daily record of symptoms

If the patient should need further medical attention, detailed information will be helpful to the doctor. Write down the following information every day:

- **Temperature.** Using an oral or ear thermometer, take the patient's temperature at least once a day (more often if symptoms change). Write down the reading along with the date and time.
- **Skin condition.** Once a day — more often if symptoms change — note the patient's skin color (pink, pale or bluish) or whether there is a rash.
- **How much liquid the patient drinks.** Write down the approximate number of ounces taken in during the day and through the night.
- **Urination.** Record how many times the patient goes to the bathroom each day and the color of the urine (clear to light yellow, dark yellow, orange, brown, or red).
- **Medications given.** For every medication you give the patient, write down what you gave, how much you gave, and the time you gave it.
- **Symptoms.** Write down any changes in these common flu symptoms:
 - Fever (often high — should go away as the patient gets better)
 - Headache
 - Tiredness (can be extreme)
 - Cough
 - Sore throat
 - Runny or stuffy nose
 - Body aches
 - Nausea and vomiting
 - Diarrhea (more common in children than adults)

Call the doctor if you notice any of the following:

- **Signs of dehydration that continue** even after 4 hours of increased liquids as described in the “Prevent dehydration” section. Signs of dehydration include:
 - Weakness or unresponsiveness
 - Dry mouth and tongue, decreased saliva (spit)
 - Dry eyes (and no tears if crying)
 - Sunken eyes
 - Urinating less than 3 times in 24 hours
- **Worsening symptoms** (especially if the patient seems worse after appearing to improve)
- **An infant younger than 2 months old** has a fever, is **feeding poorly**, or has **fewer than 3 wet diapers in a 24 hour period.**

Call 911 or take the patient to the hospital emergency room if you notice any of these complications:

- **Difficulty breathing, fast breathing, or bluish color to the skin or lips**
- **Coughing up blood**
- **Difficulty responding or communicating, confusion**
- **Convulsions (seizures)**

