Triage Tribulations and Pitfalls
Warning Signs!

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Disclaimer

- No conflicts of interest
- Interactive discussion
Objectives

- Review the purpose of triage including the challenges posed on the nurse
- Discuss useful tips when interviewing the patient
- Review the ABCs, and the physiological parameters as they pertain to acuity scores
- Examine some paediatric and geriatric considerations
- Provide some triage case reviews – subtle symptoms may indicate warning signs of deterioration
Triage is a sorting process that involves a rapid assessment to prioritize level of urgency for patients arriving to the Emergency Department (NENA, 2014).

- Complete the “critical look” for those who are seriously ill or injured – directing them to a treatment area immediately.
- For those that are less critical, a rapid assessment of the presenting complaint and completing vital signs assists the nurse in determining the CTAS score.
- Directs patients to the appropriate treatment area and determines resource requirements to best meet the needs of the patient – all while managing line-ups at triage and overcrowding.
Remember the goal of triage is to obtain enough information to determine any life threatening conditions, assign a CTAS score and determine their disposition of care following triage.

In addition there have been many Lean methodologies implemented in the ED to assist in managing the overcrowding in ED - examples.
* Triage is a fundamental aspect of emergency departments
* The triage nurse is a registered nurse who requires in-depth knowledge, strong critical thinking skills and have the ability to make rapid, accurate decisions
* Role of triage is to assess, intervene, communicate effectively and establish an initial rapport with patients and their families – all in a matter of a few minutes!

ENA, position statement, 2011
Many chief complaints may have different levels of severity (CTAS score), such as head injury, respiratory complaints, chest pain, etc.

A rapid assessment of the presenting complaint, past medical history, vital signs, associated symptoms and potential risk factors are determined and the level of acuity (CTAS score) is assigned.

Triage nurse also determines the need for any immediate interventions and the need for any reassessment for those waiting to be assigned to a treatment area.
The triage nurse needs to use all their senses while completing their assessment – sight, hearing, touch, smell,

- Look – colour, laboured breathing, indrawing
- Listen – audible breath sounds, cough, stridor, wheezing
- Touch – skin temperature/moisture, pulse – regularity
- Smell – odours such as alcohol, infection, or fruity breath

Caution to the combative or intoxicated patient – do not pre-judge!
# Physiological Parameters

## First order Modifiers

<table>
<thead>
<tr>
<th>Modifier</th>
<th>CTAS 1</th>
<th>CTAS 2</th>
<th>CTAS 3</th>
<th>CTAS 4</th>
<th>CTAS 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Airway &amp; Breathing</td>
<td>Severe resp. distress, unable to speak, airway obstruction SpO2 &lt;90%</td>
<td>Moderate resp. distress, clipped sentences, stridor, but airway protected SpO2 &lt;92%</td>
<td>Mild resp. distress, SOBOE, tachypnea, SpO2 &lt;94%</td>
<td>Normal</td>
<td>Normal</td>
</tr>
<tr>
<td>(Respiratory Distress)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Circulation (Hemodynamic stability)</td>
<td>Shock symptoms hypotension, significant tachycardia or bradycardia</td>
<td>Unexplained tachycardia, suspected hypotension</td>
<td>Vital signs are at the borderline of normal for patient</td>
<td>Normal vital signs</td>
<td>Normal vital signs</td>
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High Risk Predictors

- Age – extremes of age (infants and the elderly)
- Co-morbidities
- Chronic illnesses - immunocompromised
- Severe pain
- Temperature instability (hypo/hyperthermia)
- Cognitive impairments
- Return visit to ED due to worsening symptoms
* Mechanism of injury (MOI) – Motor Vehicle Collision
  * Speed of vehicle – higher speed increases acuity
  * Death of an occupant in the vehicle
  * Vehicle roll over / Compartment Intrusion
  * Lack of seat belt use
  * Ejection from vehicle
  * Use of Rescue Tools / Extrication time > 20 min
* Falls (especially elderly) ask about anticoagulant use
* Pedestrian/Bicyclist struck or Motor Cycle Collision
Paediatric Considerations

- Use of the Paediatric Assessment Triangle (PAT) and CIAMPEDS to assist the nurse in determining acuity
- Physiologic parameter tables should be utilized to provide guidance for the nurse to interpret normal respiratory and pulse rates and standard deviations
- Look for red flags – inclusive of any alterations in PAT
### Paediatric Red Flags

<table>
<thead>
<tr>
<th>Triage Red Flags</th>
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</thead>
<tbody>
<tr>
<td>Apnea</td>
<td>Diaphoresis</td>
<td>Pain</td>
</tr>
<tr>
<td>Choking</td>
<td>Tachycardia</td>
<td>Decreased tearing</td>
</tr>
<tr>
<td>Drooling</td>
<td>Hypotension</td>
<td>Sunken or bulging fontanelles</td>
</tr>
<tr>
<td>Stridor</td>
<td>Bradycardia</td>
<td>History of chronic illness</td>
</tr>
<tr>
<td>Grunting</td>
<td>Petechia</td>
<td>Child who acts as a surrogate parent</td>
</tr>
<tr>
<td>Sternal retractions</td>
<td>Purpura</td>
<td>History of family crisis</td>
</tr>
<tr>
<td>Irregular respiratory patterns</td>
<td>Hypothermia</td>
<td>Signs and symptoms of maltreatment</td>
</tr>
<tr>
<td>Absence of breath sounds</td>
<td>Fever in infant under 3 months of age &gt; 38 °C or temperature &gt; 40 °C</td>
<td>Return ED visit within 24 hours</td>
</tr>
<tr>
<td>Cyanosis</td>
<td>Floppy child</td>
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</table>

- Return ED visit within 24 hours
Geriatric Considerations

* Frail elderly patient without specific complaints
  * Cognitively impaired – acute vs. chronic
  * Vague symptoms – ask about co-morbidities
  * Past medical history – medication lists provides valuable information
  * Functional decline – “inability to manage at home”
* Risk of under triaging this patient group due to poor recognition of neurological symptoms, atypical presentations with underlying conditions that may imply a medical emergency
  * Examples – infection, falls, delirium, cardiovascular problems (CHF, MI, arrhythmias), stroke, COPD, etc.
42-year-old male patient presents altered LOC – breath smells of ETOH

Patient rouses to tactile stimuli

Speech is slurred, slightly confused, poor historian

Vitals – T – 36.7, HR 104, RR 10, BP – 108/82

What further assessment would you conduct?

* Check blood glucose level
* Co-morbidities
* Consider co-ingestions (toxins)
24 year old, epigastric pain x 2 days radiating to back, presenting for ultrasound follow up

Vital signs – T – 36.8, HR 92, RR – 20, BP 88/64 (patient states BP normally low), SpO2 – 98% on R/A

Appearance – pale, cachectic, states has had recent weight loss after discontinuation of anabolic steroids

What further assessment would you conduct at triage?

- BP check for both arms for any chest/abdominal pain to assess for variation between arms
- Complete ECG at triage to identify any ischemia and rule out myocardial infarction
72 year old female, from nursing home, with 1 day history of fever, and increased confusion this morning, she also fell out of bed this AM

Vital signs – T – 38.4, HR 94, RR – 24, BP – 90/60, SpO2 – 93% on R/A

On exam, bruising to forehead noted

PMHx – diabetes, hypertension and CAD, atria fibrillation

What additional information would you require?
- Anticoagulation use & check blood sugar
- Risk of sepsis – SIRS criteria, suspected infection
36 year old female presents via ambulance with SOB since this morning

Vital signs – T – 37.8, HR 104, RR – 28, BP – 128/82 SpO2 – 91% on R/A; chest has no adventitious breath sounds

PMHx – 6 weeks post partum, recent travel to Florida, returned yesterday

Patient has a feeling of impending doom

What is concerning about this patient’s presentation?

* History of pregnancy and recent travel – increases risk of VTE
* Within 15 minutes, patient becomes apneic and has a cardiac arrest
Case #5

- 6 year old male, presents with vomiting x3 days, fever and abdominal pain, no diarrhea
- PMHx – none, immunizations up to date, seen by FMD yesterday, still not feeling well

- What concerns do you have about his presentation?
  - Risk of dehydration (tachycardia, tachypnea, low BP)
  - Remember, vomiting alone is NOT gastroenteritis, needs to be investigated
Final Thoughts

* eCTAS will be implemented in the next year – will assist the nurse in determining CTAS score, however, the nurse still needs to use critical thinking and putting the pieces together to determine if there are any warning signs that requires immediate attention

* If in doubt, consider up-triaging the patient
Vision is the art of seeing the invisible... Triage

http://www.triagehospitality.com/home_creation.html