SUBJECT: **TRIAGING OF CLIENTS**
APPROVED BY: VP Acute Care _____
EFFECTIVE DATE: September 2012
REVIEW/REVISED DATE:

Purpose:

To provide guidelines for registered nurses when providing initial and ongoing assessment of emergencies.

Policy/Standard:

Registered nurses must complete a triage assessment, a detailed primary assessment and ongoing assessment on all patients who present as an emergency to the Community Clinic. Registered nurses will document the findings on the outpatient register form. Triage is not a static process because client conditions change therefore it is imperative that the registered nurse continually reassesses the client.

Materials Required:

Los Angeles Prehospital Stroke Screen (Appendix B).

Related Policies:

Not applicable.

Procedure:

Triage and Initial Assessment

In urgent or emergent situations the registered nurse will perform an initial assessment within ten minutes of arrival to the Community Clinic to determine the acuity of the client. This assessment will include the documentation of subjective and objective data. If a comprehensive triage assessment is not possible within ten minutes, a “quick look” scan may be appropriate until a comprehensive assessment can take place.

1. Prior to the nurse/physician's assessment, obtain consent , either from the client or the next of kin, and provide instructions when undressing clients for examination (when appropriate).

2. Complete a general objective physical assessment following the priorities of emergency care and including the following:

a.) Primary Assessment (ABCDE)

- **A**irway (Appraise airway patency with simultaneous cervical spine protection for trauma patients and document abnormalities);
- **B**reathing (Assess presence and effectiveness and document abnormalities);
- **C**irculation (Assess presence and effectiveness including pulse, skin color/ temperature, presence of diaphoresis, capillary refill and document abnormalities);
- **D**isability (Complete a brief neurological assessment, for example AVPU, GCS, LAPSS- see definitions);
- **E**xposure/**E**nvironmental control (Remove patient clothing when appropriate and after consent has been provided;

b.) Secondary Assessment

- **F**ull set of vital signs (Measure the patient's B/P, HR, RR, T, O2 sat and document);
- Implement ongoing cardiac and oxygen saturation monitoring as indicated by patient condition;
- If indicated (trauma) establish 2 large bore IVs;
- Foley catheter and gastric tube if there are no contraindications as per medical consultation;
- Blood work may also be drawn at this time as per medical consultation;

- **G**ive comfort measures and assess pain (PQRST- see definitions eg, cover open wound with dressing or apply ice);

- **H**istory (SAMPLE and/or MIVT- see definition) and **H**ead-to-toe assessment (Appendix C) (Complete a head-to-toe assessment is necessary for all critically ill or injured patients. For patients presenting with minor illness or injury or symptoms isolated to one body system, the registered nurse may rapidly and systematically complete the various components of the head-to-toe evaluation, then focus the assessment on the specific problem) [Kunz Howard, &Steinmann, 2010];

- **I**nspect posterior surfaces;

3. Initiate or maintain spinal precautions for patients presenting with spinal injury or potential spinal injury.

4. **Weigh all pediatric patients.** Weigh adult patients if requested by physician.

5. Document the date of last normal menstrual period(LNMP) for females of childbearing age.

6. Document the date of last Tetanus Immunization for all patients with impaired skin/eye integrity.

7. Document assessment findings on outpatient register record.

8. Initiate medical directives as indicated.

9. Facilitate family presence and involvement in care where appropriate.

10. Provide emotional support to patient and/or family.

Definitions & Acronyms

AVPU	A rapid screening tool for assessment of level of consciousness. A = alert, V = verbal (patient responds to voice), P = pain (patient responds to painful stimulus only), U = unresponsive.
GCS(Appendix A)	Glasgow Coma Scale
LAPSS (Appendix B)	Los Angeles Prehospital Stroke Scale (An abbreviated out-of-hospital neurologic evaluation tool).
B/P, HR, RR, T, O2 sat	B/P = Blood Pressure, HR = Heart Rate, RR = Respiratory Rate, T = Temperature, O2 sat = Oxygen Saturation
PQRST	A mnemonic used to characterize pain: P =Provoking Factors, Q = Quality, R = Radiation, S =Severity and T = Time of onset and duration.
SAMPLE	A mnemonic for collecting pertinent historical data: S= Symptoms, A = Allergies, M = Medications, P = Past Health History, L = Last Oral Intake, E = Events leading to illness/ injury.
MIVT	In trauma patients information from pre-hospital staff can be obtained using M= Mechanism of Injury, I = Injuries Sustained, V= Vital Signs, T= Treatment.
CVA/TIA	Cerebral Vascular Accident/ Transient Ischemic Attack

References:

EMT Resource :
http://www.emtresource.com/resources/scales/182-los-angeles-prehospital-stroke-screen-lapss

Kunz Howard, P., & Steinmann, R. (2010). Sheehy's emergency nursing principles and practice. (6th ed.). St. Louis (MO): Mosby

Appendix A

Glasgow Coma Scale and Score

Feature	Scale Responses	Score Notation
Eye Opening	Spontaneous To speech To pain None	4 3 2 1
Verbal Response	Orientated Confused conversation Words(inappropriate) Sounds(incomprehensible) None	5 4 3 2 1
Best motor response	Obey commands Localize pain Flexion-Normal Abnormal Extend None	6 5 4 3 2 1
Total Coma Score		3/15 - 15/15

The scale comprises three tests: eye, verbal and motor responses. The three values separately as well as their sum are considered. You use the best response for the client to score.

Severe Head Injury:
GCS score of 8 or less Moderate Head Injury----
GCS score of 9 to 12 Mild Head Injury----
GCS score of 13 to 15
(Adapted from: Advanced Trauma Life Support: Course for Physicians, American College of Surgeons 1993)

Appendix B

Los Angeles Prehospital Stroke Screen (LAPSS)
(Positive if all five criteria present)

Patient Name_____
Assessor's Name_____
Date_____

Criteria	Yes	No	Unknown
Age greater than 45 years	__	__	__
No history of seizures or epilepsy	__	__	__
Onset of symptoms is less than 24 hours	__	__	__
Patient was ambulatory prior to onset of symptoms	__	__	__
Blood glucose between 3.9 and 5.5 mmol/l	__	__	__

Physical Exam	Equal	Right	Left
Facial smile	__	__ Droop	__ Droop
Grip strength	__	__ Weak __ No grip	__ Weak __ No grip
Arm strength	__	__ Drifts down __ Falls rapidly	__ Drifts down __ Falls rapidly

Alert referral centre of possible CVA client.

Appendix C
Head- to – Toe Assessment

General appearance: Note the patient's body position, posture, stiffness, rigidity or flaccidity of muscles. Note any unusual odors.

Head and Face: Inspect for any contusions, abrasions, lacerations, avulsions, puncture wounds, impaled objects, ecchymosis, edema, exposed bone, loose teeth, compromised airway.
Inspect eyes, ears, nose and throat. Note any drainage from ears, eyes and nose. Note Battle signs or Raccoon eyes. Note pupil size and reactivity.
Palpate face and skull for any bony deformities, areas of tenderness, depressions or subcutaneous emphysema.

Neck: Inspect for contusions, abrasions, lacerations, avulsions, penetrating injuries, impaled objects, ecchymosis and edema. Note the position of the trachea and the appearance of the external jugular veins.

Palpate for tracheal position, areas of tenderness and subcutaneous emphysema.

Chest: Inspect for breathing, rate, depth and degree of effort required for breathing.
Note any paradoxical chest wall movement. Inspect for lacerations, abrasions, contusions, ecchymosis, swelling, impaled objects and deformities.

Auscultate lung sounds for any adventitious sounds (crackles, wheezes).

Auscultate heart sounds for the presence of muffled heart sounds.
Palpate for crepitus, deformities, subcutaneous emphysema and tenderness.

Abdomen/Flanks: Inspect for lacerations, contusions, abrasions, puncture wounds, impaled objects, scars, ecchymosis, distention, evisceration and edema.

Auscultate for the presence or absence of bowel sounds. (Auscultate before palpating)

Palpate all 4 quadrants of the abdomen. Note any rigidity, guarding, masses and areas of tenderness.

Pelvis/Perineum: Inspect for lacerations, abrasions, contusions, avulsions, puncture wounds, impaled objects, ecchymosis, edema and scars. Note any exposed bone or deformities. Note any blood at the urethral meatus, vagina or rectum. Note the presence of priapism. Note pain and/or the urge, but inability to void.

Palpate the pelvis for instability and tenderness over the iliac crests / symphysis pubis.

DO NOT ROCK THE PELVIS

Extremities: Inspect any previously applied splints, color, temperature, presence of moisture, bleeding, lacerations, abrasions, contusions, avulsions, puncture wounds, deformity. Note any spontaneous movement, ROM and sensation.

Palpate for pulses, tenderness and muscle strength. All four extremities must be assessed (if present).

Inspect posterior Surfaces: Maintain C-spine precautions and inspect posterior surfaces for lacerations, abrasions, contusions, deformity, puncture wounds, impaled objects.

Palpate for the vertebral column noting any deformity, step offs or areas of tenderness