

Triage Assessment Protocols

- ◆ Cardiovascular
- ◆ Respiratory
- ◆ Ears / Hearing
- ◆ Neurological

Performing a detailed and accurate triage assessment is a vital part of the role of the Emergency Department nurse. Using the established guidelines at your facility, follow these assessment charts to obtain the information necessary to assign an appropriate triage level to your patient. Remember, when triaging a patient, you are relying on both the patient's verbal complaint **as well as** your physical assessment.

Cardiovascular Assessment

Does the Patient Complain of:

- Chest pain
- Shortness of breath
- Cough
- Fatigue
- Swelling of extremities
- Past history of heart problems
- Family history of heart problems

Evaluation of the Patient Through:

- **Inspection**
 - Level of consciousness
 - Vital signs: blood pressure, pulse (rate & rhythm), & respirations
 - Cyanosis or pallor
- **Auscultation**
 - Note rate & rhythm
 - Listen for extra heart sounds
 - Listen for murmurs (timing, loudness, pitch, pattern, quality, location, radiation)

Respiratory Assessment

Does the patient tell you he has....

- A cough that may or may not be productive
- Shortness of breath
- Pain with breathing
- Recent cold-like symptoms
- May include other respiratory complaints

Evaluation of patient through

- **Inspection**
 - Level of consciousness
 - Vital signs: blood pressure, pulse, respiration (rate & rhythm)
 - Skin color and condition
 - Body posture
 - Facial expression
- **Auscultation**
 - Lung fields

Ears - Hearing Assessment

Does the Patient Complain of....

- Earaches
- Recent infections
- Drainage from ear(s)
- Hearing loss
- Ringing in ear(s)
- Dizziness

Inspection

- **Inspection Without Otoscope**
 - Size & shape
 - Skin condition
 - Tenderness
 - External auditory meatus
- **Inspection With Otoscope**
 - External canal
 - Tympanic membrane (color & characteristics)
 - Position
- **Hearing Acuity**
 - Voice test
 - Tuning fork tests

Neurological Assessment

Does the patient complain of:

- Headache
- Lightheadedness or dizziness/vertigo
- Weakness
- Problems with balance/incoordination
- Numbness or tingling
- Difficulty swallowing
- Difficulty speaking
- Tremors
- Seizures
- Significant past history of:
 - High blood pressure
 - Stroke
 - Head injury
 - Spinal cord injury
 - Meningitis
 - Encephalitis
 - Congenital defect
 - Alcoholism

Assessment of the patient through:

- Level of Consciousness: Conscious and
 - Oriented
 - Disoriented
 - Restless
 - Combative
- Vital Signs
 - Blood Pressure
 - Temperature
 - Pulse (rate & rhythm)
 - Respirations
- Speech
 - Clear
 - Rambling
 - Garbled
 - None
- Will awaken to:
 - Name
 - Shaking
 - Light pain
 - Strong pain
- Non-verbal reaction to pain
 - Appropriate
 - Inappropriate
 - "Decerebrate" (rigidity or flaccid)
 - None
- Pupils
 - Dilated pupils
 - Ptosis
 - Eye turns out and slight down
 - Fails to move eye up, in, down
- Ability to move
 - Right arm
 - Left arm
 - Right leg
 - Left leg