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Lynn Sayre Visser, MSN, RN, PHN, CEN, CPEN, is a registered nurse and award-winning author with over two decades of experience as a certified emergency nurse working in community and trauma hospitals across northern California. Her career has been complemented by experience working in prehospital care, ICUs, post-anesthesia care units and as an organ procurement coordinator. She held instrumental roles in teaching formalized triage education, orienting nurses to triage, and improving throughput processes with the implementation of a provider in triage, rapid triage assessment, and immediate bedding. She is the author of the pocket-sized chief complaint–based book titled Rapid Access Guide for Triage and Emergency Nurses: Chief Complaints With High Risk Presentations and Fast Facts for the Triage Nurse: An Orientation and Care Guide in a Nutshell that won third place in the 2015 American Journal of Nursing Book of the Year Awards in the critical care/emergency category. The Fast Facts book has since become available in the United Kingdom under the title Essentials for the Triage Nurse: An Orientation and Care Guide in a Nutshell. Her author team donated hundreds of copies of these book to support fund-raising efforts for nursing scholarships, which they continue to do to this day. Her honors with the Emergency Nurses Association include being the 2011 national conference blogger, a nominee for the Emergency Nurses Association Team Award for her triage work, an EMINENCE program mentee, a two-time academic scholarship recipient, and a conference poster presenter.

Anna Sivo Montejano, DNP, RN, PHN, CEN, has 32 years of experience in nursing with a specialty in emergency and triage education. She has taught nursing theory and aided the professional development of nurses as a preceptor, mentor, and clinical instructor. She has been a certified emergency nurse for more than 25 years. Her ED contributions include work as a staff nurse, primary preceptor, and assistant nurse manager as well as in educational development. Mrs. Montejano has worked to improve the quality and efficiency of patient care through projects such as the change process of rapid medical screenings and rapid triage assessments, as a project.

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FAST FACTS for
THE TRIAGE NURSE

An Orientation and Care Guide

Second Edition

Lynn Sayre Visser, MSN, RN, PHN, CEN, CPEN
Anna Sivo Montejano, DNP, RN, PHN, CEN

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To triage nurses everywhere.
Few people can understand what you encounter each shift—the overwhelming and unpredictable influx of patients, the sights and sounds of distress, the stories that simply do not make sense—yet you professionally balance the chaos with flawless precision, making split-second decisions in the best interest of each patient. Your selfless acts, gentle hands, and compassionate hearts touch the lives of many. Your commitment to excellence is deserving of a book dedicated to you.
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SECOND EDITION

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Foreword

In 2011, the American Nurses Association recognized emergency nursing as a specialty. Within that specialty, areas of focus have been developed to standardize the knowledge and practice base to enable a wide range of practitioners, from novice to expert, to provide excellent evidence-based clinical care across a wide spectrum of healthcare facilities—from small rural to large urban trauma centers. While standardization in some areas has been effected through courses such as the Trauma Nurse Core Course (TNCC), Emergency Nursing Pediatric Course (ENPC), and Advanced Cardiovascular Life Support (ACLS), the art and science of emergency nursing triage has had a longer period of development and standardization. Standardization in this field is critical because correct triage requires a broad knowledge base of all these areas as well as excellent decision-making skills and tools.

Lynn Sayre Visser has devoted her career to emergency nursing, believing each patient deserves unbiased care that is nothing short of excellent. She has a “can-do, never give up, reach for the stars” mind-set, which makes her an exemplary nursing role model. She has published in a variety of arenas, including emergency and radiology nursing, and was the 2011 Emergency Nurses Association conference blogger.

Anna Sivo Montejano has a passion for healthcare delivered in the emergency setting. Her intense desire for quality triage, paired with her compelling enthusiasm for the teaching of others, has allowed her to touch lives across the emergency nursing continuum. She is making a difference: from delivering the highest quality patient care, to teaching students, to writing for publication.

Both Lynn Sayre Visser and Anna Sivo Montejano have shown purposeful and energetic devotion to the development of the art and
science of emergency triage. Their enthusiasm and dedication to the holistic education of healthcare providers has my utmost admiration, and I consider them to be rising stars in this arena. Among the group of Triage First educators, they consistently stood out as having the most excellent evaluations and have proven themselves worthy of a following.

These authors/editors join together in leading a line of nursing authors, researchers, and teachers of triage to present essential information for the triage nurse to access quickly and repeatedly. *Fast Facts for the Triage Nurse* covers every area of triage in a concise and professional manner, starting with the essentials of triage orientation, preceptorship, competency, and self-care of the triage nurse, and including “Tips for Success at Triage,” a chapter created using helpful snippets of triage information from national emergency nursing experts. The book goes on to address point-of-entry processes, nursing essentials, and current trends that impact the initial patient–nurse encounter and are useful in settings from urgent care to the emergency department. Additional sections address “red flag” clinical presentations, special populations, and case studies to help the triage nurse understand these risky areas of triage nursing. The final sections focus on the triage nurse’s role if faced with any type of disaster including an active shooter either within or outside the triage area.

The first edition of this book was certainly deserving of its third-place honor in the 2015 *American Journal of Nursing* Book of the Year Awards in the critical care/emergency category. The second edition offers an even greater opportunity to examine and discuss every aspect of triage nursing concepts and skills, including some uncomfortable yet very necessary topics. “Fast Facts” located throughout the book highlight critical information for easy reference. Without hesitation this book will be valuable for anyone practicing triage.

Rebecca S. McNair, RN, CEN
President/Founder, Triage First, Inc.
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Preface

The purpose of this book is to provide new and seasoned nurses, preceptors, educators, and management teams with foundational skills that can be used throughout the triage orientation process as well as when practicing as an experienced triage nurse. Highlighted concepts include building confidence in the triage role, accurately assessing patient presentations, reducing personnel and hospital liability, increasing patient and staff satisfaction, and, ultimately, delivering quality patient care that supports best outcomes.

Triage is one of the toughest jobs in healthcare. Patients rarely present to triage with a diagnosis, but rather they convey what is often a multitude of complaints, signs, and symptoms that must be weeded through to effectively determine how sick they really are. The authors of this book have years of experience practicing, teaching, and writing about triage to support the reader in the journey toward enhancing triage knowledge.

The main themes and objectives focus on numerous aspects of triage, from front-end processes and orientation to clinical practice and nursing essentials. The diverse factors of patient populations—age, gender, ethnicity, socioeconomic status, and so on—all impact the care a patient receives. A patient may present with a simple laceration, but a self-inflicted wound and a history of mental illness may lead to safety issues for the patient and the individuals in his or her immediate environment. Patient care must be individualized to each patient for each visit. This book details the many aspects of triage in an organized manner using real-life examples to harden the facts.

The book is divided into parts to help organize the flow of information. The establishment of orientation and self-care early on sets the stage for a nurse to be successful in the triage setting. The sections cover workflow and “red flag” presentations, introduced in an
organized manner with easy-to-find information. Each chapter contains a brief introduction as well as objectives, followed by “just the facts” information. Content that should not be missed is highlighted in the “Fast Facts” boxes throughout the book. The term provider is threaded throughout the content and represents a medical doctor (MD), doctor of osteopathy (DO), nurse practitioner (NP), or physician assistant (PA). Treatment interventions are covered in various sections. However, each member of the healthcare team should only act within his or her scope of practice and follow facility policies and procedures.

The three authors of the first edition brought more than 80 years of combined nursing experience together with their shared common passion for the topic of triage to create a needed resource for healthcare teams. The first edition won third place in the 2015 American Journal of Nursing Book of the Year Awards in the critical care/emergency category. The authors reached out to other professionals around the country, who contributed and reviewed chapters, in their quest to bring this book to the highest possible level of functionality for the frontline triage nurse and others practicing triage.

The second edition doubled the number of content reviewers, strengthening the team with leaders from within the Emergency Nurses Association and further expanding the review team to include international reviewers. No other source is available on this topic that brings together the expertise of so many valuable professionals. Some readers may want to read this book cover to cover, while others may stick it in their lab coat pocket and pull it out for use as a quick resource to answer a clinical question. Perhaps it will be most helpful to novice readers, who will benefit from the concise expertise contained in this book before “learning it the hard way,” one patient at a time.

Lynn Sayre Visser
Anna Sivo Montejano
~A Heartfelt Thank-You~

Valerie Aarne Grossman was the third author for the first edition of *Fast Facts for the Triage Nurse: An Orientation and Care Guide in a Nutshell*. The expertise Valerie brought to the book was pivotal to the overall layout, quality, and award-winning success of the first edition. She selflessly devoted countless hours of time to mentor two new authors eager to make a dream become a reality. Valerie made the difficult decision to step back from the second edition of this book to give her attention to other life commitments.

Valerie,

Your presence during the development of the second edition was surely missed, but we sincerely hope we’ve made you proud. As Flavia once said, “Some people come into our lives and quickly go. Some stay for a while and leave footprints on our hearts. And we are never ever the same.” Thank you for touching the depths of our hearts and for giving us the wings to fly.

*Much Love and Gratitude, Lynn and Anna*
Valerie Aarne Grossman, MALS, BSN, NE-BC, is a registered nurse with over 36 years of heterogeneous nursing experience in direct patient care, hospital leadership, and professional service and as a nurse author. Her areas of practice expertise have included emergency nursing, nursing leadership, telephone triage nursing, and radiology nursing. She has been an active volunteer with nursing organizations, including Emergency Nurses Association, Association for Radiologic and Imaging Nursing, and RAD-AID.org, as well as serving on boards of directors, including the New York State Board for Nursing and the University of Rochester’s Research Subjects Review Board, and numerous editorial boards (American Journal of Interventional Radiology, Journal of Radiology Nursing, SCOREBoard: Stakeholders for Care in Oncology & Research for the Elderly, and the International Advisory Board for Nurse Education Today). She has authored (or coauthored) numerous peer-reviewed publications, including six book titles (10 editions), six book chapters, and 29 articles. She is the recipient of numerous awards, including the American Nurses Association’s Honorary Nursing Practice Award, the Association of Radiologic and Imaging Nursing’s Nurse of the Year Award, and Cortland Senior High School’s Wall of Fame. Her advocacy for the bedside nurse drives her passion for professional involvement and dedication to creating tools that will be most helpful to them. She believes it is an honor to take care of each patient she encounters during their most vulnerable times in their health crisis or journey.
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To our superstar editor, Elizabeth Nieginski, and her supportive assistant, Rachel Landes, thank you for your endless positive energy, never-ending encouragement, and for always being quick to reply as questions came up. Grateful for you both for making this project easy and enjoyable to tackle.

To our contributors who have been on this journey with us, we are eternally grateful for each of you. Your knowledge, expertise, and evidence-based research created not only interesting reading but a strong foundation for both those seeking to understand the triage role for the very first time and those who have been in the triage role for years.

To our reviewers, thank you for stepping up to the plate time and time again and for sharing your expertise from all areas of the globe. From the Netherlands to Australia, to the East and West Coasts of the United States, and many areas in-between, you provided a glimpse into the delivery of emergency care in rural and urban environments as well as on military bases. You all rock!

Many thanks to the Emergency Nurses Association (ENA). Our affiliation with this great organization has opened so many doors for our team and has provided us with unlimited resources, networking opportunities, and professional growth. In fact, our ENA connection is how we met many of the individuals associated with this book. This team of authors, contributors, and reviewers brings a combined total of over 675 years of nursing experience, more than 475 years of membership with ENA, nearly 400 years as Certified Emergency Nurses, and decades of other experience as Certified Pediatric Emergency Nurses, Certified Flight Registered Nurses, Trauma Certified Registered Nurses, and Certified Critical-Care Nurses. In addition, this team has contributed countless volunteer hours holding board
and committee member positions, serving at the local, national, and international level.

Lynn Sayre Visser: To my husband, Scott, and the other rocks in my life, thank you for your endless love and support. To my three teenage boys, Chase, Colton, and Brody, the world is full of opportunities; don’t let them pass you by. Always remember there is no such thing as failure; rather learn from each experience, no matter what it looks like, and enjoy the ride! To the many patients, colleagues, and friends I have crossed paths with, I feel so blessed to have had the honor to be there during some of your most intimate and vulnerable moments. Some of you have said I touched your lives and for that I am grateful, but truly I feel most fortunate to have had the depths of my heart touched by you. Lastly, Anna, you are a bright spot in my life day in and day out; never lose your radiance as your steady glow continually sparks my desire to be the best I can be. Thank you for the years of friendship, learning, and laughs.

Anna Sivo Montejano: Thank you again Phil for supporting me with the second edition of *Fast Facts for the Triage Nurse*. I cannot tell you what it means to me to have you by my side every day as I grow professionally in a career I love so much. To my three grown children, Zsuzsa, Michael, and Marcus, don’t ever stay stagnant. Seek out your dreams, grab hold of them, and don’t let go. Determination, focus, and drive will get you to where you want to be. Never give up and remember “Stay shredded!”

Finally, to my good friend Lynn, thank you for your friendship and encouragement. We have achieved so many things together that I never dreamed of and it is because of you! You amaze me every day with your ability to persevere when life throws you curve balls. Thank you for your amazing friendship.
Abdominal Emergencies
Polly Gerber Zimmermann and Lynn Sayre Visser

The abdomen contains many organs, both solid and hollow, that can manifest a wide range of possible abnormal findings. Utilizing key questions helps differentiate the patient with “gas” from one with a life-threatening perforation. When triaging patients, it is important to consider the worst-case scenarios and to identify not only patients who are obviously seriously ill but also those who might be. This chapter provides a foundation for potential high-acuity abdominal presentations that the triage nurse may encounter. See Chapter 21 for other presentations not addressed in this chapter.

Upon conclusion of this chapter, you will be able to:

1. State three worst-case scenarios of abdominal presentation.
2. List three triage questions related to an abdominal emergency.
3. List three “red flag” findings of abdominal emergencies.

RED FLAG FINDINGS

■ Bloody or black stools
■ Boardlike or rigid abdomen (from muscle contraction)
■ Coffee-ground or bloody emesis
■ Acute colicky pain
■ Pain severe in nature that awakens a person from sleep
■ Pulsating abdominal mass
Rebound tenderness present
- Shoulder tip pain accompanied by abdominal pain (indicates free air from perforation rising and irritating the phrenic nerve)
- Sudden-onset, severe abdominal pain

**WORST-CASE SCENARIOS**

Abdominal aortic aneurysm, appendicitis, cholecystitis or cholelithiasis, diverticulitis, gastrointestinal (GI) bleeding (upper and lower)/esophageal varices, incarcerated hernia, intestinal obstruction (large and small intestine), lacerated liver, pancreatitis, peptic ulcer disease, perforated bowel, splenic rupture, testicular torsion.

**ESSENTIAL TRIAGE QUESTIONS, ASSESSMENT, AND INTERVENTIONS**

Chapter 16 is a crucial foundation for the content that follows.

**Generic Questions**

- Time of onset (acute versus gradual)?
- Vomiting (often seen in infectious processes)?
- Frequency and characteristics (e.g., color, food contents, bile appearance) of vomiting?
- Is anyone else sick in the household? Anyone sick who ate the same food?
- Emesis related to pain?
  - Pain preceding vomiting suggests a potential surgical abdomen, whereas vomiting before pain is more typical of a nonsurgical condition.
  - Nausea and vomiting occurring simultaneously with the onset of pain is associated with torsion, ectopic pregnancy, ureteral colic, or bowel obstruction.
  - Epigastric pain relieved by vomiting is more likely to be caused by an intragastric problem.
- Last bowel movement (BM)?
  - Frequency of BMs, characteristics, and normal patterns for patient?
  - Presence of dark tarry or bloody stool?
  - Guidelines for “frequent” diarrhea includes occurrence every 30 to 60 minutes for more than 6 hours, five or more episodes in the previous 24 hours, or diarrhea daily for more than 5 days.
- Passing flatus?
- Recent travel (e.g., different country or region)?
- Urine frequency (especially with children or elderly who are more prone to dehydration) and characteristics (e.g., color, odor)?
- First day of last menstrual period (if premenopausal)?
• Pain worse with movement?
• Positional pain?
  • Patients often appear rigid when flat and, if ambulating, walk gingerly to avoid moving peritoneal area; this is often referred to as the pelvic inflammatory disease (PID) shuffle.
• Previous history of the same or similar condition; does this feel the same as it did before?
• Lower chest trauma? (Remember: The liver and spleen are protected by the lower rib cage but are still vulnerable to injury.)
• Recent hospitalization, surgery, and antibiotics (within 8 weeks) with foul “horse barn odor”?
  • Rule out *Clostridium difficile* (C-Diff).

**Fast Facts**

• Remember that the bismuth from Pepto-Bismol and ferrous sulfate (iron) turn stools black. Stool with “digested” blood is stickier and has a foul odor.
• Atypical presentations can be “typical” in the elderly patient. Do not make assumptions regarding the origin of pain. Consider an atypical cardiac presentation in the elderly patient presenting with upper abdominal pain or nausea and vomiting. Look for the subtle clues. Approximately one third of patients older than 65 who are admitted with abdominal pain need surgery.

**Generic Assessment**

**Vital Signs**

• Abdominal pain with abnormal vital signs is usually more serious
• Signs of dehydration
  • Heart rate is more sensitive than blood pressure (healthy adults must lose 1,500 mL of fluid before exhibiting hypotension).
  • A pulse of 120 bpm or higher is highly indicative of dehydration or other serious illness; tachycardia is an early sign.

**Skin Assessment**

• Assess skin turgor on sternum or forehead where alteration in skin elasticity is less marked with aging.

**Abdominal Assessment**

• Palpate the abdomen (consider peritoneal signs).
• Assess bowel sounds; initially bowel sounds can be hyperactive before the presence of hypoactive bowel sounds or the absence of bowel sounds with an obstruction.
Generic Interventions

- Anticipate the need for analgesics since early pain relief in stable patients with nontraumatic acute abdominal pain is recommended.
- Anticipate the need to collect urine in premenopausal women and in menstruating preadolescents/adolescents for pregnancy testing even if the patients state they are not pregnant or sexually active.
- Consider whether an ECG within 10 minutes is indicated, especially for patients with diabetes.

**Fast Facts**

- Severe pain that is a 7 or greater on a 0-to-10 scale and lasts 6 or more hours is a potentially serious condition.
- Writhing or restlessness is often indicative of a colicky pain from stones.
- In the elderly patient, pain out of proportion to the exam should raise concern for the potentially life-threatening diagnosis of mesenteric ischemia.
- “Frequent” vomiting is considered to be 10 or more episodes in the previous 24 hours.
- An early sign of dehydration is a decreased ability to focus.
- Areas of the body to assess for dehydration include mucous membranes, tongue, or teeth (dry). Skin can be assessed for poor turgor.

**SPECIFIC CONDITIONS**

The questions, assessment, and interventions that follow are *not* intended to be comprehensive in nature but will help guide the triage nurse through the nursing process.

**Abdominal Aortic Aneurysm**

1. **Questions:** Abdominal or back pain, or both; sudden, severe tearing pain with radiation to groin; syncopal episode; male, history of smoking, or high blood pressure (increased risk)?
2. **Assessment:** Palpate abdomen for pulsating abdominal mass or rigidity; clammy skin
3. **Interventions:** Anticipate the need for rapid surgical intervention

**Appendicitis**

1. **Questions:** Pain starts around umbilicus and slowly moves to right lower quadrant (McBurney’s point) over 48 hours?
2. **Assessment**: Anorexia; gait with limp; rebound tenderness with abdominal assessment; age considerations (most commonly occurs in those aged 11–35 years)

3. **Interventions**: Anticipate the need for surgical intervention

### Fast Facts

Patients with acute appendicitis may experience delays in diagnosis or a missed diagnosis often due to vague initial symptoms, including periumbilical and epigastric pain preceding right lower quadrant pain. Appendicitis does not only occur on the right side. The triage nurse should be aware that left-sided appendicitis may occur in patients who have an elongated appendix, situs inversus, or congenital midgut malrotation (Yang, Liu, Lin, & Lin, 2012). In pediatrics, atypical is typical.

### Cholecystitis or Cholelithiasis

1. **Questions**: Time of last meal; history of recent fat intake; history of cholelithiasis; shoulder tip and acute colicky pain; presence of the six Fs (fat, female, forty, fertile, fair, flatulent)?

2. **Assessment**: Refer to Generic Assessment discussed earlier

3. **Interventions**: Give nothing by mouth (NPO) and anticipate the need for antiemetics

### Diverticulitis

1. **Questions**: Constant persistent pain (sometimes for several days); nausea, vomiting, and/or constipation; fever?

2. **Assessment**: Abdominal assessment reveals left-sided pain similar to an “appendicitis”; age considerations (symptoms typically after age 50 years)

3. **Interventions**: Refer to Generic Interventions discussed earlier

### Fast Facts

Patients with duodenal ulcers have reduced pain after eating while those with gastric ulcers tend to have more pain following a meal.

### Incarcerated Hernia

1. **Questions**: History of intermittent “abdominal mass”; sudden pain with rapid increase in intensity; pain with bending over, lifting, and/or coughing?
2. Assessment: Palpate abdomen for “mass” that is now tender and tense

3. Interventions: Anticipate the need for surgical intervention

**Intestinal Obstruction (Large Intestine)**

1. Questions: Obstipation (feels the need to pass gas but is unable)?

2. Assessment: High-pitched “tinkling” bowel sounds

3. Interventions: Refer to Generic Interventions discussed earlier

**Intestinal Obstruction (Small Intestine)**

1. Questions: Vomiting (gastric contents, then bilious, then brown fecal material); symptoms worse after eating; history of abdominal surgery (present in 50%–70% of patients)?

2. Assessment: Refer to Generic Assessment discussed earlier

3. Interventions: Refer to Generic Interventions discussed earlier

**GI Bleeding (Lower)**

1. Questions: History of GI bleed (upper gastrointestinal [UGI] is more common than lower gastrointestinal [LGI]), melena? Perirectal disease, diverticulosis, cancer, or inflammatory disease (most common sources of LGI bleed)?

2. Assessment: Refer to Generic Assessment discussed earlier

3. Interventions: Anticipate the need for nasogastric (NG) tube, labs including hemoglobin (Hgb)/hematocrit (Hct), type and crossmatch, intravenous (IV) with fluids, possible blood transfusion

**GI Bleeding (Upper)**

1. Questions: Abdominal pain? GI bleed in the last 48 to 72 hours? Dizziness or syncope? History of alcoholism or nonsteroidal anti-inflammatory drug (NSAID) use? Hematemesis? History of duodenal or gastric ulcers, Mallory-Weiss tears, or esophagitis?

2. Assessment: Confusion, ascites, jaundice; nausea/vomiting, melena, and/or hematochezia; hypovolemia?

3. Interventions: Refer to Generic Interventions discussed earlier; anticipate the need for fluid replacement, labs including Hct/Hgb, type and crossmatch, blood products, endoscopy team, potential surgical intervention

**Pancreatitis**

1. Questions: History of alcoholism or cholelithiasis; sudden knife-like pain in left upper quadrant, midgastric, or back (related to retroperitoneal location); is the pain worse with eating or lying flat?
2. **Assessment:** Check pulse oximetry (latent hypoxia is a major complication); signs of dehydration; hypovolemia (major complication)

3. **Interventions:** Anticipate the need for antiemetics and pain control

### Peptic Ulcer Disease

1. **Questions:** Smoking history; generous use of NSAIDs or acetylsalicylic acid (ASA); gnawing or burning sensation intermittently?

2. **Assessment:** Vomitus for presence of blood (red or coffee-ground hematemesis); age (more common in older adults)

3. **Interventions:** Refer to Generic Interventions discussed earlier

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**Fast Facts**

The volume of hematemesis is a poor guide for estimating volume loss. Tachycardia is an earlier sign followed by hypotension after 1,500 mL blood loss.

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### Testicular Torsion

1. **Questions:** Sudden pain (often described as “twisting” after sports activities)?

2. **Assessment:** “Saddle” (bow-leg) walk; unilateral, affected testis is usually firm, and tender; intense pain or minimal pain relief when the testicle is elevated; age considerations (most common in adolescent years)

3. **Interventions:** Anticipate the need for surgical intervention

## Reference


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Upon conclusion of this chapter, you will be able to:

1. State three special populations seen by triage nurses.
2. List two suggestions to improve communication with developmentally delayed patients.
3. List three suggestions for recognizing a victim of sex trafficking (ST).

**HEARING-IMPAIRED PATIENTS**

When patients with a hearing impairment arrive at a healthcare facility, we need to do our best to complete an accurate assessment. Simultaneously, we need to provide an environment in which
patients feel their impairment is not affecting their ability to express their concerns and one in which our ability to understand them is not hindered.

Suggestions to Assist the Hearing Impaired

- Offer a certified sign language interpreter.
- If the patient has arrived with a person to “interpret or be their eyes,” allow this person to accompany them as much as possible.
- Use a paper and pen.
- Have patients lip-read if they state that is acceptable to them.
- Pay close attention to nonverbal communication.
- If hearing aid(s) are being worn, ensure proper placement and function.
- Use a text-telephone device (TTD) or telecommunication device for the deaf (TDD).

VISUALLY IMPAIRED PATIENTS

A patient who is visually impaired requires the triage nurse to adapt the triage processes. Nurses may think they need to talk loudly so the patient can hear them. The patient is not deaf, so speaking in a normal tone when communicating is appreciated. Making patients feel comfortable when they cannot see their surroundings is an important part of reducing patients’ anxiety in an unfamiliar environment.

Suggestions to Assist the Visually Impaired

- Introduce yourself and let the patient know everything you are doing; for example, “I am going to get a urine specimen cup for you.”
- Ask patients if they need help before assuming they do.
- Ask if the patient uses any visual aid, such as a cane or service animal (if not present with them).
- Guide patients to where you need them to go by letting them hold onto your arm.
- Let patients know how they can find you for any questions or concerns (e.g., if they are sitting in the waiting room, walk them to the front desk so they know where to find assistance).
- Update the patient verbally since the visual clues are not available.
- Introduce every new individual involved in the patient’s care; remember that he or she cannot see who enters the room.
- If you leave the room, verbally tell the patient.
- Ask patients where they would like their belongings so they know where to find them if an item is needed,
- Make sure all their questions are answered and needs are met.
PATIENTS WITH A LANGUAGE BARRIER

Many languages are spoken in the United States today. With patients and visitors originating from all areas of the world, ensuring effective communication is vital. Treating each person as a unique individual and being respectful of differing beliefs can aid in recovery.

Suggestions to Assist Patients With a Language Barrier
- Ensure that a certified interpreter is provided.
- Some facilities have in-house translation services.
- Use a phone with two handsets so the patient and healthcare provider can be on the phone at the same time as the interpreter.
- Utilize picture boards.

Although convenient, avoid having family members act as interpreters. They may not accurately relay questions to the patient or convey all the information you provide, information may be of a personal nature, or maltreatment may be a possibility.

PATIENTS WHO ARE DEVELOPMENTALLY DELAYED, AUTISTIC, OR THE LIKE

When a patient who is developmentally delayed or autistic arrives at your facility, how do you ascertain his or her level of knowledge? Where do you begin? How do you elicit the true story of the patient’s visit? Healthcare providers are sometimes uncomfortable interviewing patients who are developmentally delayed, autistic, or the like. They may worry that important information may be missed, resulting in a detrimental outcome. In such situations, nurses must be careful not to make assumptions. Family members, caretakers, and others who know the patient can help the nurse understand the patient’s baseline function, assisting the nurse in performing an accurate triage assessment. The individuals who spend time with these patients know them best.

Suggestions to Assist the Developmentally Delayed, Autistic, or the Like
- Ask the accompanying person about the patient’s baseline function.
- Inquire about any changes the caretaker is concerned about.
- Ask simple questions and move slowly.
- Explain to the patient what you are doing.
- Pay very close attention to nonverbal signs.
- Always be cognizant of the possibility of maltreatment.

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Fast Facts

Patience is essential when meeting the needs of unique groups of people. Patients may not always understand what is going on in their immediate surroundings. Your patience and kindness can go a long way in facilitating the patient–provider encounter.

ILLITERATE PATIENTS

An illiterate patient does not have the ability to read or write, which may not be evident initially at triage. However, paying close attention to nonverbal signs may provide clues. As triage nurses, we must clarify with patients, in a nondemeaning way, whether they can read and write. Not following through when there is a suspicion of illiteracy can have detrimental implications because the patient cannot understand written instructions.

Suggestions to Assist the Illiterate Population

■ Have the patient give you a return demonstration or verbalize key elements of discharge instructions.
■ Draw pictures to help with explanations or instructions.
■ Use pictures and pain scales (e.g., Wong–Baker) with assessments.

MILITARY PERSONNEL

Being culturally competent in nursing has been a necessary ingredient to better understand the needs and values of patients of different ethnicities, socioeconomic status, religions, and so on, but we must not overlook another special population—our military personnel. The military culture focuses on loyalty, selflessness, and following moral codes. Nurses must be aware of the risk factors that military men and women are prone to so interventions can be timely and accurate.

Most Common Chief Complaints

■ Musculoskeletal conditions (most common are back, ankle/knee, and shoulder pain)
■ Postsurgical complications
■ Behavioral health issues (e.g., depression, post-traumatic stress disorder, suicide)

The heightened awareness can assist nurses in asking appropriate questions and being aware of signs that might otherwise go
unnoticed. The nurse may wonder, “Why does not the patient just tell me the real reason for the visit?” From a military perspective, a potential behavioral health problem may serve as a major barrier to obtaining care.

When it comes to amputations, direct communication about their loss of limb is appropriate. They are aware the limb is gone. These individuals have already undergone surgery, physical and occupational rehabilitation, as well as psychological therapy. Providers who have little experience in providing care to these individuals find direct communication difficult. It is common for the veteran to comment or make jokes about the limb. For example, one veteran, having lost three limbs and multiple abdominal surgeries, wore a T-shirt to the emergency room (ER) saying “combat veteran, some assembly required.”

**Indications of Military Personnel (Former or Current)**

- Tattoo of an anchor, eagle, or globe
- Tattoo around the wrist (like a bracelet), on the deltoid(s) forearm, or chest signifies a fallen comrade(s)
- Addressing others as “sir” or “ma’am”
- Clothing
- Body language
- They have direct eye contact

When triaging a military member, active or retired, who presents with a behavioral health complaint, the healthcare provider needs to maintain situational awareness. Active or veteran military members commonly carry sidearms (weapons) in public. Part of the triage assessment is to ask the patient and/or family if the individual is carrying a weapon. Do not attempt to take the weapon from the individual but rather contact security or your local police department for assistance.

**Fast Facts**

Do not hesitate to ask patients if they have been or are associated with the military. Such a simple question may make a difference in getting a patient the care he or she truly needs.

**INTIMATE PARTNER VIOLENCE**

Intimate partner violence (IPV), sometimes referred to as domestic violence, is an act in which the victim is assaulted by his or her intimate partner. The assaulitive act may come in many forms, and you may encounter a combination of these forms together.
Recognition seems like it would be easy when one out of every three women have experienced physical violence from their intimate partners in their lifetime (National Intimate Partner and Sexual Violence Survey, 2010). The National Coalition Against Domestic Violence (n.d.) reports that in the United States, on an average close to 20 persons per minute are physically abused by their intimate partner. Abuse affects not only women but also teenagers, men, partners in same-sex relationships, and bisexual and transgender couples. Recognition is the first step in helping victims of IPV.

Every patient needs to be screened appropriately since IPV is found in all of the following groups:

- Ethnicity
- Religious
- Economic
- Age
- Educational

The triage nurse must ask questions regarding the potential victim’s safety, but the key is making these inquiries privately. If questions are asked in a safe environment and in a nonjudgmental fashion, the victim is more likely to be forthcoming about the history of the violence.

Sometimes the aggressor partner will not leave the victim’s side, making it challenging to screen the victim. Explain to the patient that a urine specimen is needed, or an x-ray, thus separating the potential victim from the partner, in a location where the partner may not follow. This is your opportunity to ask the victim if he or she feels safe. Once IPV is identified, take action and adhere to your facility policies. Remember you can make a difference in saving the life of a victim, but you must first ask the question.

**HUMAN TRAFFICKING**

Although human trafficking is not an activity one would expect to encounter in the United States, sadly this problem is becoming more common. The term *human trafficking* can refer to ST, commercial sexual exploitation (CSE), or child sex trafficking (CST). The vulnerability of children puts them at particular risk for this type of abuse. Victims are exposed to oppressive exploitation and physical and mental harm. Providing their “service” up to 12 hours a day results in
physical injuries, sexually transmitted diseases (STDs), malnutrition, isolation, and psychological trauma. What can a triage nurse do to stop this horrific abuse? Recognize that this exists, intervene appropriately, and refer (Miller, 2013).

Suggestions for Recognizing the Victim

- Individual is accompanied by a person who stays close and speaks for him or her
- Individual lies about his or her age
- May have multiple differing forms of identification
- Inconsistencies or denial of injuries and illnesses, patient/keeper often changing stories
- Individual does not have possession of his or her own documents (e.g., passport, birth certificate)
- Presence of STDs, yeast or bacterial infections, particularly in underage patients
- Highly anxious or obedient demeanor (Miller, 2013)
- Trafficker is often the same nationality as the victim
- Presence of tattoo that may be a number, a symbol, or the trafficker's initials (shows ownership)
- Bald patches (e.g., hair being pulled out)
- Presence of a global positioning system (GPS) tracking bracelet (Peters, 2013)

One must be sensitive to what the victim is enduring on a day-to-day basis in a world with no hope of escape. Victims are often told by their traffickers that no one is there for them and they are alone. Consequently, they may have a distrust of others that incapacitates them. Victims may exhibit:

- Fear and distrust related to possible imprisonment or deportation
- Shame
- Lack of emotion or, conversely, intense anger
- A strong attachment to the trafficker
- Anger toward the nurse or other healthcare professionals (e.g., the victim may fear that questions will upset the trafficker)
- Limited communication ability as they may not speak English
-Feelings of depression or possible suicidal ideation (Peters, 2013)

Tips for the Nurse

- Recognize behaviors that are characteristic of victims.
- Talk to the victim alone.
- Keep the victim and staff safe; interfering with the trafficker’s “property” can result in an unsafe situation.
- Notify security, local police, or both.
A triage nurse’s awareness is our first line of defense. With this knowledge and the passion to help the victims of this unimaginable slavery, we can make a difference in the lives of those who may not have come to the attention of victim advocates or child protective services in our communities. Do not think this issue exists only in faraway places. These individuals can be living in your community at this very moment.

Fast Facts

- Be mindful that a relative of the victim may be the trafficker. Trust your instincts!
- The triage nurse must look beneath the surface. Every minute, every day, every patient could be a victim of ST (Peters, 2013).

LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUESTIONING/QUEER (LGBTQ)

The transgender population often delays seeking treatment due to their past experience with healthcare providers often described as unprofessional, biased, negative, harassing, and unwelcoming. Sadly the patient’s delay in treatment can lead to a worsening of their illness (Grossman, 2016).

Suggestions when assessing a LGBTQ patient include:

- Stay focused on the reason for the patient’s visit.
- Be nonjudgmental.
- Listen to how the patient self-identifies themselves (pay attention to the pronoun being used).
- If something is said incorrectly, do not overapologize.
- If you are unsure regarding how to address your patient, be respectful and just ask them what they prefer.

As healthcare providers, we must be caring and compassionate to all patients we encounter in our line of work. Being respectful and compassionate goes a long way in the care of patients.

PATIENTS WITH A LEFT VENTRICULAR ASSIST DEVICE

Healthcare providers are encountering left ventricular assist devices (LVADs) more often among patients with heart failure who are awaiting a heart transplant or other cardiac conditions. Years ago these patients needed to remain hospitalized, but now these devices use battery packs that allow the patients to remain mobile. As triage nurses, we need to be familiar with the potential complications of these devices.

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Complications in LVAD Patients
- Infection
- Thromboemboli
- Device malfunction
- Right-sided heart failure
- Hemolysis

Although knowing the potential complications is important, having a basic knowledge of the normal findings for an LVAD patient is also vital when completing an assessment.

Normal Findings in LVAD Patients
- Pulses are usually absent
- Systolic blood pressure (SBP) range of 70 to 90 mmHg via Doppler reading
- Ventricular assist devices (VADs) may “hum” loudly
- Be aware that these patients are on anticoagulation therapy

The nurse must be familiar with the LVAD and understand the resources available to troubleshoot the device, such as the phone number to call.

Suggestions to Assist LVAD Patients
- When assessing the patient, if there is concern about the device malfunctioning, contact the LVAD center listed on the patient’s VAD card (carried by the patient at all times).
- If you hear beeps or alarms, refer to the symbols displayed and call the number on the patient’s VAD card.
- If you need to assist with defibrillation or cardioversion, place the external patches, one anteriorly and one posteriorly.
- Cardiopulmonary resuscitation (CPR) should be performed only upon confirming LVAD malfunction.

References

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