Rapid Access Guide for Triage and Emergency Nurses

Chief Complaints With High Risk Presentations

Lynn Sayre Visser
Anna Sivo Montejano
Rapid Access Guide for
TRIAGE AND EMERGENCY NURSES
Lynn Sayre Visser, MSN, RN, PHN, CEN, CPEN, is a registered nurse with over two decades 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 on 911 and critical care transport ambulances, ICUs, postanesthesia care units, and as an organ procurement coordinator. Her passion for quality patient care led her to play instrumental roles in the implementation of a provider in triage, rapid triage assessment, and immediate bedding processes along with formalized triage education in multiple facilities. Ms. Visser is the author of Fast Facts for the Triage Nurse: An Orientation and Care Guide in a Nutshell, which won third place in the 2015 American Journal of Nursing Book of the Year awards in the critical care/emergency category. This book has since become available in the United Kingdom under the title Essentials for the Triage Nurse: An Orientation and Care Guide. Her author team donated hundreds of copies of the award-winning book to support fund-raising efforts for nursing scholarships, which they continue to do to this day. She is a graduate of the University of California-Davis, Samuel Merritt University, Walden University, and Semester at Sea. She holds a Master of Science degree in Nursing with an emphasis in education and a double Bachelor of Science degree in exercise physiology and nursing.

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Lynn Sayre Visser, MSN, RN, PHN, CEN, CPEN
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To the front-line healthcare provider who selflessly and fearlessly cares for patients during their most vulnerable moments

... and to every patient that we learned from and grew from, thank you.
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©Springer Publishing Company
The fear of every nurse is missing a life-threatening or high-risk patient presentation that deteriorates while awaiting care. This guide is designed to help any healthcare provider (ED/urgent care/clinic nurse, paramedic/EMT) faced with determining the urgency of a patient’s condition and prevent those misses or near misses.

This rapid access guide is the result of five decades of combined emergency nursing experience building upon what we called our pocket-sized “Book of Brains.” As colleagues and friends, together we focused on continually learning by enhancing our critical thinking skills, improving our decision-making, and being on a quest to acknowledge what we did not know yet needed to know as nurses in a busy urban ED.

Designed with the user in mind, there are screening tools and checklists along with space to customize the book with frequently and infrequently needed contact numbers. Also included are notes sections to write out or paste facility-specific policies and procedures along with quick reference tables and resources to help you efficiently identify and initiate care for the sickest patients.

Content includes waiting room and legal issues, medical conditions, behavioral health, trauma, active shooter/active violence, and emergency management of disasters, providing you with action steps to help in prioritization during crisis moments. Each body system covers the most common chief complaints and lists questions, assessments, and interventions that are of utmost priority in determining the patient’s level of urgency. Red flag findings throughout the sections bring attention to the most critical signs and symptoms and can be quickly located by the flag icon. Pediatric and older adult considerations, also identified by icons, are interwoven throughout the body system chapters.

Our sincere hope is that you utilize this guide in your daily practice, adding essential need-to-know content as new insights arise, and that soon you own a “Book of Brains” that is customized just for you.
From Us Both
To our editor, Elizabeth Nieginski: To be guided by you, in your infinite knowledge and experience, has been a true gift. Throughout this journey, you blessed us many times over with never-ending support, patience, and insightful thoughts. You never stopped believing in us, despite the many unexpected twists and turns. Thank you for taking the path less traveled, trusting that our vision would flourish into a useable guide, making a difference to both patients and healthcare providers in the years ahead. We cannot wait to see what the future holds.

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From Lynn Sayre Visser
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To my family and friends: Thank you for being with me on this wild journey called “life” and for supporting me along the way. Scott, Chase, Colton, and Brody, no day is dull with you in it! I love you!

From Anna Sivo Montejano

Lynn, how does one express the amazing friendship that began between us over 25 years ago? We started off as colleagues, became friends, and then our relationship blossomed professionally as we both shared the same goal, providing safer patient care. We both knew to grow professionally leaves no borders to what we can accomplish. Learning from and guiding each other has provided us with the knowledge and wisdom needed throughout our many ventures together, and for that I thank you.

To all of the people I have crossed paths with throughout my life in gatherings, conferences, schools, jobs, teaching, and so forth, I cannot thank you enough for the opportunity to have gotten to know you, for you have played a part in the person I am today. Phil, Zsuzsa, Michael, and Marcus, thank you for always supporting me in every new venture I undertake. The future holds so many possibilities.
### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
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<tbody>
<tr>
<td>A/O</td>
<td>alert and oriented</td>
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<tr>
<td>AAA</td>
<td>abdominal aortic aneurysm</td>
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<tr>
<td>A-B-C-D</td>
<td>airway; breathing; circulation; disability</td>
</tr>
<tr>
<td>ABG</td>
<td>arterial blood gas</td>
</tr>
<tr>
<td>abx</td>
<td>antibiotics</td>
</tr>
<tr>
<td>AC</td>
<td>alternating current</td>
</tr>
<tr>
<td>ACE</td>
<td>angiotensin-converting enzyme</td>
</tr>
<tr>
<td>ACS</td>
<td>acute coronary syndrome</td>
</tr>
<tr>
<td>ADLs</td>
<td>activities of daily living</td>
</tr>
<tr>
<td>a-fib</td>
<td>atrial fibrillation</td>
</tr>
<tr>
<td>AICD</td>
<td>automatic implantable cardiac defibrillator</td>
</tr>
<tr>
<td>ALTE</td>
<td>apparent life-threatening event</td>
</tr>
<tr>
<td>AMA</td>
<td>against medical advice</td>
</tr>
<tr>
<td>AMI</td>
<td>acute myocardial infarction</td>
</tr>
<tr>
<td>AMS</td>
<td>altered mental status</td>
</tr>
<tr>
<td>APR</td>
<td>air purifying respirator</td>
</tr>
<tr>
<td>ASAP</td>
<td>as soon as possible</td>
</tr>
<tr>
<td>ATP</td>
<td>advanced triage protocols</td>
</tr>
<tr>
<td>AVM</td>
<td>arteriovenous malformation</td>
</tr>
<tr>
<td>BC</td>
<td>blood culture</td>
</tr>
<tr>
<td>BiPAP</td>
<td>bi-level positive airway pressure</td>
</tr>
<tr>
<td>BLS</td>
<td>basic life support</td>
</tr>
<tr>
<td>BM</td>
<td>bowel movement</td>
</tr>
<tr>
<td>BMP</td>
<td>basic metabolic panel</td>
</tr>
<tr>
<td>BNP</td>
<td>brain natriuretic peptide</td>
</tr>
<tr>
<td>BP</td>
<td>blood pressure</td>
</tr>
<tr>
<td>BPH</td>
<td>benign prostate hyperplasia</td>
</tr>
<tr>
<td>BSA</td>
<td>body surface area</td>
</tr>
<tr>
<td>BVM</td>
<td>bag valve mask</td>
</tr>
<tr>
<td>CA</td>
<td>cancer</td>
</tr>
<tr>
<td>CAD</td>
<td>coronary artery disease</td>
</tr>
<tr>
<td>CAT</td>
<td>combat application tourniquet</td>
</tr>
<tr>
<td>CBC</td>
<td>complete blood count</td>
</tr>
<tr>
<td>CBRN</td>
<td>chemical, biological, radiological, nuclear, and explosive</td>
</tr>
<tr>
<td>c.-diff</td>
<td>Clostridium difficile</td>
</tr>
<tr>
<td>CHF</td>
<td>congestive heart failure</td>
</tr>
<tr>
<td>CMP</td>
<td>comprehensive metabolic panel</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
</tr>
<tr>
<td>CNS</td>
<td>central nervous system</td>
</tr>
<tr>
<td>c/o</td>
<td>cause of; complaining of</td>
</tr>
<tr>
<td>CO</td>
<td>carbon monoxide</td>
</tr>
<tr>
<td>COPD</td>
<td>chronic obstructive pulmonary disease</td>
</tr>
<tr>
<td>CP</td>
<td>chest pain</td>
</tr>
</tbody>
</table>
HR heart rate
HTN hypertension
hx history
IAP incident action plan
IBS irritable bowel syndrome
IC incident commander
ICB intracranial bleed
ICP intracranial pressure
IDLH immediately dangerous to life and health
IED improvised explosive device
IM intramuscular
INR international normalized ratio
IPV intimate partner violence
IV intravenous
JVD jugular vein distention
L&D labor and delivery
LFTs liver function tests
LLL left lower lobe
LLQ left lower quadrant
LMP last menstrual period
LOC level of consciousness
LOS length of stay
LP lumbar puncture
LPMSE left prior to the medical screening exam
LR lactated Ringers
LUQ left upper quadrant
LWBS left without being seen
LWT left without treatment
MAP mean arterial pressure
MASS move, assess, sort, send triage algorithm
MCI mass casualty incident
MI myocardial infarction
mo month
MOI mechanism of injury
MONA morphine, oxygen, nitroglycerin, aspirin
MRSA methicillin-resistant staphylococcus aureus
MERSA methicillin-resistant Staphylococcus aureus
MS multiple sclerosis
MSDS Material Safety Data Sheets
MSE medical screening exam
MVC motor vehicle crash
N/V nausea/vomiting
N/V/D nausea/vomiting/diarrhea
NGASR nurses’ global assessment of suicide risk
NHTRC National Human Trafficking Resource Center
NIHSS National Institutes of Health Stroke Scale
NP nurse practitioner
NPA nasopharyngeal airway
NPO nothing by mouth
NS normal saline
NSAID nonsteroidal anti-inflammatory drug
O2 oxygen
O2 sat oxygen saturation
OPA/NPA oropharyngeal/nasopharyngeal airway
ox oximetry
P & P policies and procedures
PA physician assistant
PA/Lat posterior-anterior/lateral
PAPR powered air purifying respirator
PCI percutaneous coronary intervention
PE pulmonary embolism
PEEP positive end expiratory pressure
PID pelvic inflammatory disease
PIO public information officer
PMH past medical history
POC point of care
PPE personal protective equipment
PPV positive pressure ventilation
PQRST provokes/palliates; quality; region/radiation; severity/associated symptoms; timing/temporal relations
PRO-BNP pro-brain natriuretic peptide
PT prothrombin time
PTA prior to arrival
PTT partial thromboplastin time
PUD peptic ulcer disease
r/o risk of; rule out
RA room air
RAM risk assessment matrix
RHCC Regional Hospital Coordination Center
RICE rest, ice, compression, elevation
RLL right lower lobe
RS respiratory syncytial
RLQ right lower quadrant
RR respiratory rate
RSQ risk of suicide questionnaire
RSV respiratory syncytial virus
r-tPA tissue plasminogen activator
RUQ right upper quadrant
s/sx signs/symptoms
SALT sort, assess, lifesaving interventions, treatment/transport triage algorithm
SANE sexual assault nurse examiner
SAR supplied air respirator
sat saturation
SBP systolic blood pressure
SCBA self-contained breathing apparatus
SCC squamous cell carcinoma
SCIWORA spinal cord injury without radiographic abnormality
SIQ suicidal ideation questionnaire
SIQ-Jr suicidal ideation questionnaire-junior
SIRS systemic inflammatory response syndrome
SOB shortness of breath
START simple triage and rapid treatment/transport triage algorithm
STEMI ST-elevation myocardial infarction
STI sexually transmitted infection
SWAT special weapons and tactics
TACO time of rupture, amount of fluid estimated, color of fluid, odor present
TBI traumatic brain injury
TCA tricyclic antidepressant
TEE transesophageal echocardiography
TIA transient ischemic attack
TKO to keep open
TSS toxic shock syndrome
Tx, tx treatment
UA urinalysis
URI upper respiratory infection
US ultrasound
UTD up to date
UTI urinary tract infection
VASA violence and suicide assessment form
VQ ventilation/perfusion
VS vital signs
VTE venous thromboembolism
WBC white blood cells
WMD weapons of mass destruction
yr year
yrs years
THE GOAL OF THIS GUIDE

The goal of this rapid access guide is to help the healthcare provider quickly identify high-risk patient presentations. Many of these patients high-risk will be identified during the rapid triage assessment through brief questioning and/or identification of a Red Flag Finding. However, sometimes a comprehensive triage assessment may be needed (when feasible) to identify the patient as high risk. Although clinical diagnoses are mentioned throughout the guide to assist with critical thinking and consideration of the worst case scenario, the nurse’s role is not to diagnose.

The content in this book will help any healthcare provider in the field or in the ED (EMS, triage, emergency, and/or urgent care nurse, etc.) who encounters a patient with a clinical complaint. Determination of the risk of an emergent condition is always the priority. Consider the rapid triage assessment to be the primary survey and the comprehensive triage assessment the secondary survey. In the ED, the assessment is often complaint specific and focused, while in other settings a more extensive assessment may be required.
CHAPTER LAYOUT (FOR CHIEF COMPLAINT CHAPTERS 8 TO 25)

Aside from the content provided in Chapters 1–7, this clinical guide is set up in a body systems format. Common, everyday chief complaints that have the potential to be of high concern are covered. Most sections include tables or other quick resource information to help the user. Some complaints and tables were purposely repeated in more than one chapter to help the user get to the right information as quickly as possible.

Each chapter is formatted as follows:

**Chief Complaints:** Each chapter begins with a list of chief complaints presented in alphabetical order.

**Red Flag Findings:** These findings likely indicate a high-risk presentation requiring immediate or rapid intervention. Of course, clinical correlation with the finding is always a priority. The red flag findings are also listed in alphabetical order.

**Key Tips:** This content may help you think about core measures, worst-case scenarios, and clinical information. Other chapters to consider and orders to (potentially) anticipate are covered.
RAPID TRIAGE ASSESSMENT (takes <60–90 seconds)

| QUESTIONS | • Listed here are questions you may ask to **quickly** determine if a high-risk presentation exists. You may ask fewer questions or ask additional questions to make a final triage determination. *Use critical thinking!* |
| ASSESSMENT | • A–B–C–D–E assessment  
• Think abnormal VS  
• Additional complaint-specific assessment needs will be listed.  
**You may simultaneously palpate a pulse or observe the respiratory rate, but quick simultaneous multitasking is key.** |
| INTERVENTIONS | • If any alteration in A–B–C–D–E, intervene immediately!  
• Additional interventions required for the specific complaint will be listed. |

*Note:* Once the patient is identified as needing life-saving intervention or to have a high-risk injury or illness, triage is over. The patient should be placed in a treatment area that has the staff and resources to assume care.
COMPREHENSIVE TRIAGE ASSESSMENT (takes 2–5 minutes)

QUESTIONS
• Additional complaint-specific questions help to identify if the patient is a high-risk presentation.
• Tx PTA *PQRST (pain) *PMH *Drug & Alcohol Use *Meds *Allergies?

ASSESSMENT
• The complaint-specific assessment may be more involved than in the rapid triage assessment.
• Full set of VS per discretion/policies. A full set of VS including temperature, HR, RR, BP, pulse oximetry, and pain scale may or may not be needed. What, if any, VS should be obtained at this point is based on your critical thinking, facility P & P.

INTERVENTIONS
• Check glucose if indicated *Initiate Advanced Triage Protocols (ATPs) per policies

** If the patient was not identified as a high-risk presentation during the rapid triage assessment, the additional information obtained in the comprehensive triage assessment may help determine if the patient should be high-risk (though it may also confirm your suspicion that the patient is low-risk). Simultaneously asking questions while assessing and performing tasks (VS, glucose testing) is critical at triage.

TIP
• Additional information that may assist in your triage decision-making is covered here.
WHAT THIS GUIDE IS

This guide is . . .

■ Intended to help you identify life-threatening and high-risk patient presentations.
■ A quick access resource to help prompt you in questioning and facilitate rapid decision-making.
■ Jam packed with many common chief complaints you may encounter on a regular basis.
■ A mobile “book of brains” created to be customized to fit your needs.
■ A tool to use during crisis moments such as an active shooter or disaster event.

PEDIATRIC

OLDER ADULT

Some sections also include unique pediatric and/or older adult-specific information. If a chapter does not include this content, few differences were identified between the pediatric and older adult patient as compared to adults (other than normal physiological differences). Some of those physiological differences are covered in Chapter 4, Pediatric Considerations and Chapter 5, Older Adult Considerations.

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■ A tool to use during crisis moments such as an active shooter or disaster event.

If you are looking for additional triage and/or emergency nursing content, check out our award-winning book Fast Facts for the Triage Nurse available at www.springerpub.com/fast-facts-for-the-triage-nurse.html
18 EAR, NOSE, AND THROAT EMERGENCIES

COMPLAINTS

- Dysphagia
- Facial/head trauma
- Facial swelling (including eyes/mouth)
- Foreign body—throat
- Sore throat (severe, rapid onset)
- Tooth avulsion/dental pain
- Vocal change, new onset

RED FLAG FINDINGS

- Airway compromise post-ENT injury
- Battle’s sign
- Drooling, new onset
- Foreign body in throat
- Halo sign indicative of CSF fluid leaking from ear/nose post injury (halo sign also noted as a “double ring sign”)
- Lateral gaze palsy
- Muffled voice
- Nasal bleeding, uncontrolled (even with pressure) or taking a blood thinner
- Secretions difficult to control, airway compromise
- Severe sore throat, rapid onset
- Swelling to floor of mouth
- Tooth avulsed with root intact
- Tripod position
- Upward gaze limited
KEY TIPS FOR ENT EMERGENCIES

- Think airway, airway, airway!
- Screen for sepsis and think Sepsis Alert if applicable.
- Do not assume what appears to be a simple ENT complaint is actually low-risk until proven so!
- ENT complaints can turn into pneumonia or sepsis.
- Evaluate change in mentation. Perform a quick neuro exam.
- Consider Other Chapters: Neurological, trauma, infectious, toxicology.
- Anticipate Orders: Labs (CBC, CMP, Rapid Strep, mono); diagnostics (CT, facial/soft tissue neck x-rays, MRI, US); meds (glucocorticoids for allergic reaction, Racemic Epi for epiglottitis, Epi for anaphylaxis, diphenhydramine for angioedema hives, analgesics for pain).
# Dysphagia

## Rapid Triage Assessment (takes <60–90 seconds)

| Questions                                      |  
|-----------------------------------------------|---
| Onset (sudden or gradual) and duration?       |  
| Anything put into the mouth (food or other object)? |  
| Fever?                                        |  

| Assessment                                   |  
|----------------------------------------------|---
| A–B–C–D–E                                    |  
| Stridor or tripod positioning                |  
| Number of words patient can speak            |  
| Visualize oral cavity (swollen tongue, kissing tonsils) |  
| Check pulse oximetry if result will help determine if patient is high-risk |  
| Screen for SIRS criteria                     |  

| Interventions                                |  
|----------------------------------------------|---
| If any alteration in A–B–C–D–E, intervene immediately! |  
| Prepare for intubation if airway is compromised |  

## Comprehensive Triage Assessment (takes 2–5 minutes)

| Questions                                      |  
|-----------------------------------------------|---
| SOB?                                          |  
| Tonsils still present?                        |  
| Tx PTA *PQRST *PMH *Drug & Alcohol Use *Meds *Allergies? |  

| Assessment                                   |  
|----------------------------------------------|---
| Full set of VS per discretion/policies       |  

| Interventions                                |  
|----------------------------------------------|---
| Glucose POC if indicated *Initiate ATPs per policy |  

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TIPS

- Think CVA/TIA, anaphylaxis, Ludwig’s angina, foreign body, epiglottitis, among others.
- Risk of choking and aspiration with potential for pneumonia if patient aspirates.

PEDIATRIC:

- If a child is drooling or unable to control their airway, do not stick anything in the mouth, support the airway and seek expert consultation.
- Minimize stimulation to allow the child to maintain a position of comfort as long as they are maintaining their airway. If airway is remotely compromised, think potential life-threatening situation.
- Possible causes of dysphagia in children that may be highly concerning include epiglottitis and tonsillitis.
- Strep throat can cause abdominal pain so check both the abdomen and throat.

OLDER ADULT:

- Older adults can have osteoporotic changes so maintaining the airway in a “neutral” position is important.
# FACIAL/HEAD TRAUMA

## RAPID TRIAGE ASSESSMENT (takes <60–90 seconds)

| QUESTIONS | Time injury sustained? MOI? Object involved? If “yes” what object?  
|           | Taking blood thinners?  
|           | Loss of consciousness or loss of vision? |
| ASSESSMENT | A–B–C–D–E  
|           | Facial asymmetry or blood/fluid from nose/ears  
|           | Bruising around eyes (raccoon eyes) or behind ears (Battle’s sign)  |
| INTERVENTIONS | If any alteration in A–B–C–D–E, intervene immediately!  
|              | Initiate c-spine immobilization if patient was struck in head with significant force |

## COMPREHENSIVE TRIAGE ASSESSMENT (takes 2–5 minutes)

| QUESTIONS | Current eye doctor?  
|           | Tx PTA *PQRST *PMH *Drug & Alcohol Use *Meds *Allergies? |
| ASSESSMENT | Neurologic assessment (quick and basic—FAST assessment)  
|           | Able to open mouth  
|           | Evaluate for nystagmus or ocular neglect (upward gaze limited; lateral gaze palsy)  
|           | Perform halo test  
|           | Full set of VS per discretion/policies |
| INTERVENTIONS | Glucose POC if indicated *Initiate ATPs per policy |

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TIPS

• MOI typically requires great impact and force to break the facial bones which can be highly concerning especially with any airway compromise and/or potential cervical injury.

• For significant head trauma (e.g., raccoon eyes and Battle’s sign), think serious MOI and the potential for other injuries. Refer to Chapter 22: Trauma Emergencies.

• To perform a halo test, allow liquid from nose or ears to drain onto gauze, and evaluate if a halo sign is present.

PEDIATRIC:

• Anticipate airway compromise with facial and nasal fractures.
• Increased irritability or difficulty in arousal can signify head trauma.
• Maintain a heightened awareness/suspicion for child maltreatment.

OLDER ADULT:

• Look for asymmetry of facial features to help identify facial trauma.
• Maintain a heightened awareness/suspicion for elder maltreatment.
# FACIAL SWELLING (INCLUDING EYES/MOUTH)

## RAPID TRIAGE ASSESSMENT (takes <60–90 seconds)

<table>
<thead>
<tr>
<th>QUESTIONS</th>
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</thead>
<tbody>
<tr>
<td>• Onset of symptoms (sudden or gradual) and duration?</td>
<td></td>
</tr>
<tr>
<td>• Trauma (think trauma criteria)?</td>
<td></td>
</tr>
<tr>
<td>• SOB, dysphagia, or fever?</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>ASSESSMENT</th>
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</thead>
<tbody>
<tr>
<td>• A–B–C–D–E</td>
<td></td>
</tr>
<tr>
<td>• Number of words patient can speak</td>
<td></td>
</tr>
<tr>
<td>• Visualize oral cavity (swollen tongue, kissing tonsils); presence of drooling</td>
<td></td>
</tr>
<tr>
<td>• Screen for SIRS criteria</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>INTERVENTIONS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• If any alteration in A–B–C–D–E, intervene immediately!</td>
<td></td>
</tr>
</tbody>
</table>

## COMPREHENSIVE TRIAGE ASSESSMENT (takes 2–5 minutes)

<table>
<thead>
<tr>
<th>QUESTIONS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Fever, chills, pain, change in vision?</td>
<td></td>
</tr>
<tr>
<td>• Routine dental visits?</td>
<td></td>
</tr>
<tr>
<td>• Tx PTA *PQRST *PMH *Drug &amp; Alcohol Use *Meds *Allergies?</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>ASSESSMENT</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Visualize pupils, oral cavity (assess hygiene), neck for swelling</td>
<td></td>
</tr>
<tr>
<td>• Full set of VS per discretion/policies (including pulse oximetry)</td>
<td></td>
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</table>

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<thead>
<tr>
<th>INTERVENTIONS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Snellen chart (vision test) if indicated</td>
<td></td>
</tr>
<tr>
<td>• Anticipate eye exam and possible ophthalmology consult</td>
<td></td>
</tr>
<tr>
<td>• Glucose POC if indicated *Initiate ATPs per policy</td>
<td></td>
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</tbody>
</table>
**TIPS**

- Think **Ludwig’s angina** if the swelling is specific to the mouth; think potential for airway obstruction.
- **Angioedema** can be caused by angiotensin-converting enzyme (ACE) inhibitors such as lisinopril or a possible allergic reaction.
- Potential or actual loss of vision is concerning (may occur from an infection, trauma or other causes). Refer to Chapter 17, Ocular Emergencies for additional information.

**PEDIATRIC:**

- Consider allergic reaction as a cause of swelling. Observe carefully as kids can decompensate fast.

**OLDER ADULT:**

- Consider shingles for swelling to one side of the face.
FOREIGN BODY: THROAT

### RAPID TRIAGE ASSESSMENT (takes <60–90 seconds)

<table>
<thead>
<tr>
<th>QUESTIONS</th>
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<tbody>
<tr>
<td></td>
<td>• Able to speak?</td>
</tr>
<tr>
<td></td>
<td>• What object was swallowed?</td>
</tr>
<tr>
<td>ASSESSMENT</td>
<td>• A–B–C–D–E</td>
</tr>
<tr>
<td></td>
<td>• Stridor with variation in tone</td>
</tr>
<tr>
<td>INTERVENTIONS</td>
<td>• If any alteration in A–B–C–D–E, intervene immediately!</td>
</tr>
<tr>
<td></td>
<td>• Abdominal thrusts if patient is unable to speak or swallow and appears to be choking</td>
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<tr>
<td></td>
<td>• If patient does not have complete airway obstruction, encourage patient to cough</td>
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<td></td>
<td>• Maintain NPO status</td>
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</tbody>
</table>

### COMPREHENSIVE TRIAGE ASSESSMENT (takes 2–5 minutes)

<table>
<thead>
<tr>
<th>QUESTIONS</th>
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<tbody>
<tr>
<td></td>
<td>• Time of sx onset?</td>
</tr>
<tr>
<td></td>
<td>• Retching, gagging, and vomiting?</td>
</tr>
<tr>
<td></td>
<td>• Tx PTA *PQRST (when able)*PMH *Drug &amp; Alcohol Use *Meds *Allergies?</td>
</tr>
<tr>
<td>ASSESSMENT</td>
<td>• Full set of VS per discretion/policies (including pulse oximetry)</td>
</tr>
<tr>
<td>INTERVENTIONS</td>
<td>• Glucose POC as indicated *Initiate ATPs per policy</td>
</tr>
</tbody>
</table>
**TIPS**

- **Small batteries** from a hearing aid or other items can cause a burn through the esophagus resulting in mediastinitis.
- Objects made out of lead (painted toy) can release the substance into the body. Think potential for toxic poisoning.

**PEDIATRIC:**
- Avoid blind finger sweep for foreign object/choking.
- Stridor with variation is suggestive of a foreign body especially for children ages 1 to 3 yrs.

**OLDER ADULT:**
- Keep patient calm as anxiety can worsen symptoms.

**NOTES:**

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**SORE THROAT (SEVERE, RAPID ONSET)**

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<thead>
<tr>
<th>RAPID TRIAGE ASSESSMENT (takes &lt;60–90 seconds)</th>
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<tbody>
<tr>
<td><strong>QUESTIONS</strong></td>
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<tr>
<td><strong>INTERVENTIONS</strong></td>
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</tbody>
</table>
SORE THROAT (SEVERE, RAPID ONSET) (Continued)

COMPREHENSIVE TRIAGE ASSESSMENT (takes 2–5 minutes)

| QUESTIONS | • High fever?  
|• Painful to swallow (odynophagia)? Able to eat and drink (keep fluids in)?  
|• Tx PTA *PQRST *PMH *Drug & Alcohol Use *Meds *Allergies? |

| ASSESSMENT | • Visible exudate, erythema to throat  
|• Hydration status (signs and symptoms of dehydration)  
|• Full set of VS per discretion/policies (including pulse oximetry) |

| INTERVENTIONS | • Anticipate rapid strep test if infectious process  
|• Glucose POC as indicated *Initiate ATPs per policy |

TIPS

• Referred pain from a sore throat can be from angina!  
• A sore throat can be caused by an infectious process (e.g., abscess—think sepsis), allergic reaction, ACE inhibitor.  
• An untreated group A strep can develop into rheumatic fever, which may progress into rheumatic heart disease.
**SORE THROAT (SEVERE, RAPID ONSET) (Continued)**

**PEDIATRIC:**
- Assess for s/sx of dehydration including sunken fontanelle, sunken eyes, dry diapers, or no tears when crying.
- Untreated alpha strep can lead to rheumatic fever.

**OLDER ADULT:**
- Sore throat as evidenced by hoarseness can also be a symptom of a thoracic aneurysm. Less serious, but it can also be a symptom of sinusitis. Stay alert for atypical presentations.

**NOTES:**
**TOOTH AVULSION/DENTAL PAIN**

### RAPID TRIAGE ASSESSMENT (takes <60–90 seconds)

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>• Time of onset?</td>
<td></td>
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<tr>
<td>• MOI? Trauma or loss of consciousness (think trauma criteria)?</td>
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<tr>
<td>• Location of the tooth?</td>
<td></td>
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<tr>
<td>• Type of care rendered for the dislodged tooth PTA (time is tooth for permanent ones)?</td>
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<tbody>
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<td>• A–B–C–D–E</td>
<td></td>
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<tr>
<td>• Amount of bleeding/blood loss</td>
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<tr>
<td>• Evaluate patient’s tooth if present and visualize oral airway</td>
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<tr>
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<tbody>
<tr>
<td>• If any alteration in A–B–C–D–E, intervene immediately!</td>
<td></td>
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<tr>
<td>• Place tooth in whole milk, tooth preservative (Save-A-Tooth), or patient’s tooth socket if able. Handle by the crown only; <strong>DO NOT TOUCH THE ROOT</strong></td>
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### COMPREHENSIVE TRIAGE ASSESSMENT (takes 2–5 minutes)

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<tr>
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<td>• Tx PTA *PQRST *PMH *Drug &amp; Alcohol Use *Meds *Allergies?</td>
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</table>

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TIPS

- Anticipate the need to consult dentistry.
- If the tooth has debris, irrigate with normal saline using an 18 gauge angiocath.
- If the tooth is placed in the socket, the patient can bite down on gauze placed over the tooth to properly seat it.
- Refer to sore throat in this section if suspicious of an infectious process (fever, pain, and/or swelling).

PEDiatric:

- Avulsed primary teeth are usually not reimplanted due to unnecessary risk to a permanent tooth. Permanent teeth should be reimplanted ASAP for best outcomes.

OLDER ADULT:

- Use a multidisciplinary approach for older adults to achieve best possible outcomes in the case of dental injury/avulsion. Dentition is important to help maintain nutritional status in older adults.
**VOCAL CHANGE, NEW ONSET**

### RAPID TRIAGE ASSESSMENT (takes <60–90 seconds)

| QUESTIONS | • Onset of sx (sudden or gradual)? Circumstances?  
| | • Able to speak? SOB?  
| | • Swallowing difficulties?  
| | • Recent trauma to neck? If so, when and MOI? |
| ASSESSMENT | • A–B–C–D–E  
| | • Drooling or stridor  
| | • Soot in nares or mouth  
| | • Number of words patient can speak |
| INTERVENTIONS | • If any alteration in A–B–C–D–E, intervene immediately! |

### COMPREHENSIVE TRIAGE ASSESSMENT (takes 2–5 minutes)

| QUESTIONS | • Tx PTA *PQRST *PMH *Drug & Alcohol Use *Meds *Allergies? |
| ASSESSMENT | • Full set of VS per discretion/policies (including pulse oximetry) |
| INTERVENTIONS | • Glucose POC if indicated *Initiate ATPs per policy |

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TIP

• Voice muffled or sudden change can be the result of exposure to fire or smoke (inhalation burns), laryngeal fracture, bee/wasp sting, and so on. Airway compromise can occur rapidly.

PEDIATRIC:

• Airway compromise can happen quickly—hoarseness can be a sign of impending airway collapse.

OLDER ADULT:

• Hoarseness can be a sign of thoracic aneurysm or TIA/CVA.

NOTES: