THE STUDY VAULT

Clinical Chaos

Triage

SKILL SNAPSHOT

Purpose
- Rapidly prioritizes patients by urgency and resource need so the sickest receive timely evaluation and intervention.

When to use
- Every arrival to emergency/urgent care and with any change while waiting; uses the facility's validated acuity system.

Supplies needed
- Triage tool; vital-sign equipment; pulse oximeter; glucose/ECG resources; PPE; emergency call system.

PREP + PATIENT SETUP
- Perform quick visual assessment before lengthy registration.
- Use appropriate isolation/PPE and identify immediate threats.
- Know high-risk presentations and facility

VAULT TIP
- Ask: who can safely wait, who cannot, and what could deteriorate before the next reassessment?

STEP-BY-STEP
1. First look: assess appearance, airway, breathing, circulation, mental status, and uncontrolled bleeding on arrival.
2. If an immediate life threat exists, move directly to resuscitation and start interventions—do not delay for full triage.
3. Use two identifiers and obtain chief concern in patient's words plus onset, severity, associated symptoms, and mechanism.
4. Obtain focused history: allergies, medications, anticoagulants, pregnancy possibility, key conditions, recent procedures, and baseline.
5. Measure complete vital signs including SpO2, pain, and glucose/temperature when indicated.
6. Perform focused exam relevant to complaint and screen for time-sensitive syndromes: stroke, ACS, sepsis, ectopic pregnancy, anaphylaxis, trauma, behavioral emergency.
7. Assign acuity using validated facility scale based on threat, high-risk features, expected resources, and vital-sign danger zones.
8. Initiate nurse-driven protocols within scope: ECG, glucose, labs, isolation, analgesia, or other standing orders.
9. Communicate critical findings and use closed-loop handoff to receiving nurse/provider.
10. Reassess waiting patients at intervals appropriate to acuity and whenever symptoms change; document reassessment.
11. Upgrade acuity and move patient immediately if deterioration occurs. Never downgrade based only on a single normal vital sign.
12. Address safety, suicide/violence risk, falls, infection control, language/access needs, and return-to-desk instructions.

SAFETY REMINDERS
- Triage is dynamic, not a one-time score.
- Normal vitals do not exclude high-risk disease.
- Do not delay resuscitation for registration or full history.
- Use objective criteria and minimize bias.

COMMON MISTAKES
- Anchoring on chief complaint.
- No reassessment.
- Ignoring high-risk history.
- Under-triaging atypical symptoms.

DOCUMENTATION
- Chief concern and onset.
- Vitals/pain/focused findings.
- Acuity and rationale.
- Protocols/interventions.
- Reassessments, changes, handoff.