

## Clinical Protocol Training

### Lesson 3: Protocols- Step 1 and 2

The first two steps a nurse performs when taking a triage call are \_\_\_\_\_  
and \_\_\_\_\_.

The Goal of Triage is to always get the patients to the  
\_\_\_\_\_ at the right \_\_\_\_\_.

#### **Navigating through a Protocol:**

1. Have a general sense of where you are going and how you will get there.
2. Navigation devices, like protocols, guide you step by step so you don't have to remember every turn along the way.
3. First, you must determine your patient's \_\_\_\_\_.
4. Then your initial assessment helps you to lead your patient to the right destination.

#### **Protocols should never be a replacement for nursing judgment or critical thinking:**

1. Protocols should enhance your nursing skills and fine-tune your decision-making.
2. Protocols provide a \_\_\_\_\_ approach to each call and act as a reminder of \_\_\_\_\_ that could be overlooked.

#### **Initial Assessment:**

1. To get a general sense of the appropriate level of care for your patient, you should first check your \_\_\_\_\_'s and rule out any life threatening emergencies.

#### **Asking Questions of the Patient:**

1. After obtaining a brief medical history and present symptoms, find out which symptoms are most bothersome to the patient.
2. Asking questions that are specific and purposeful, such as, when the symptoms started and about their severity will help in narrowing down the protocol choice to the one with the \_\_\_\_\_.
3. When triaging a female, asking about her last \_\_\_\_\_ can be an additional factor in which protocol to choose.
4. Ask about Medications including OTC.
5. Ask about recent Hospitalizations, Surgeries, and if the patient has any Allergies.

### **Mental Questions for the Nurse:**

1. Is there anything in the past medical history that makes this patient high risk?
2. Does the airway, breathing and circulation assessment indicate shock, respiratory distress or \_\_\_\_\_?
3. Does anything in their story make you feel that they are sick or need urgent evaluation?

### **Determine the Disposition:**

1. All of these questions help determine if this is a 911 situation, or an Evaluate Today, or an Evaluate Next Day, or Routine Follow-up.

### **Communicating with your patient to avoid roadblocks:**

1. Be proactive, Patients do not know what information is relevant and what information is not.
2. Be \_\_\_\_\_ly listening and alert, one piece of information may change the entire direction.
3. Conveying the sense that you are Qualified, Confident and Self Assured builds \_\_\_\_\_ and helps in \_\_\_\_\_ your patient.

### **Never Assume:**

1. It is the nurse's responsibility to \_\_\_\_\_ and \_\_\_\_\_.
2. Always ask if anything unusual about their voice is normal for them, such as soft or hoarseness, mumbling, slurred speech, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ or \_\_\_\_\_.
3. When patients are scared, anxious, frustrated or in pain they may not tell you everything, show empathy to gain trust and provide reassurance.

