FEATURE ARTICLE
Continuing Education

Triaging

Common Complaints in the Workplace

by Polly Gerber Zimmermann, MS, MBA, RN, CEN
Section Editor: Joy E. Wachs, PhD, APRN, BC, FAAOHN

Employees frequently present to the occupational health clinic with common health complaints. Which of the following employees should be of the most concern to the nurse?

- Employee A has a history of diabetes. He was lifting 30 pound boxes approximately 3 hours ago. He is currently experiencing severe, nonradiating low back pain. He states he cannot bend at the waist and feels best when lying down (blood pressure [BP] 150/80, pulse [P] 96, respirations [R] 18).
- Employee B has a history of hypertension and peripheral vascular disease. He came in because he had a sudden onset of a severe "tearing" pain in his abdomen that is radiating to his back (BP 104/56, P 112, R 20).
- Employee C is a 30 year old complaining of having the "flu that is going around." He feels achy all over and has a headache (temperature [T] 100.4° F [38° C]; BP 138/88, P 92, R 18).
- Employee D is a 40 year old who has been vomiting (3 times) and denies recent travel, anyone else being sick who ate the same food, or dizziness (T 99° F [37.2° C]; lying BP 120/72, P 76, R 16; standing BP 128/74, P 84, R 16).

Employee B has a classic description of an expanding abdominal aortic aneurysm. However, even without recognizing that possible diagnosis, the ominous descriptive terms along with vital signs could indicate early shock are enough to initiate an emergent transfer. Most likely Client A has muscular strain and Client C has a viral influenza. Their higher vital signs could be from their discomfort. Client D probably has a viral gastroenteritis; there is no evidence of dehydration.

ABOUT THE AUTHOR
Ms. Zimmerman is Assistant Professor, Department of Nursing, Harry S. Truman College, and Contract Associate Nurse, American Airlines, Chicago O'Hare International Airport, Chicago, IL.
Dr. Wachs is Professor, East Tennessee State University, Johnson City, TN.

OCCUPATIONAL HEALTH TRIAGE

Occupational health nurses cannot allow the ordinary nature of employee complaints to lull them into complacency. These clients often need, and seek, knowledgeable advice about the complaint's seriousness. The nurse must discern, or triage, if this instance of an everyday complaint needs transfer, treatment, or teaching. To make proper decisions and provide meaningful advice, the occupational health nurse must rely on skillful history taking, physical assessment, and awareness of distinguishing signs and symptoms of potentially serious conditions.

Initial Intake

The process of assessing any complaint always begins by ensuring the physiological stability of the client, universally identified as the ABCDs (i.e., airway, breathing, circulation, disability). Assessing disability (or impairment) includes appropriately assessing the client' s mental status, neuromuscular function, and level of pain (initiating comfort measures according to protocol). Mental status includes being alert and oriented to the traditional time, place, person, and recent events (i.e., previous 5 days), which is indicative of frontal lobe function. Neuromuscular function includes extremity range of motion, movement, and strength. Pain includes a client rating on a scale of 1 to 10, with 10 as the most severe, and the client's account of the pain location, intensity, and quality. A frequent aid in obtaining a complete description is the mnemonic PQRST (see Table 1).

Cultural and ethnic differences can be variables in the client presentation or the nurse's interpretation of symp-

Table 1

Mnemonics

PQRST: Chief Complaint

P	**P**rovokes	What provokes the symptoms?
Q	**Q**uality	What makes it better/worse?
		What does it feel like?
R	**R**adiation	Where is it?
		Where does it radiate?
S	**S**everity	Rate on a scale of 1 to 10?
T	**T**ime	How long?
	Treatment	What has been done already?

OLD CART: Chief Complaint*

O **O**nset of symptoms
L **L**ocation of problem
D **D**uration of symptoms
C **C**haracteristics of the symptoms described
A **A**ggravating factors
R **R**elieving factors
T **T**reatment administered before arrival

POSHPATE: Chief Complaint†

P **P**roblem
O **O**nset
S Associated **s**ymptoms
H Previous **h**istory
P **P**recipitating factors
A **A**lleviating/**a**ggravating factors
T **T**iming
E **E**tiology

TICOSMO: Have I overlooked anything?†

T **T**rauma
I **I**nfection
C **C**hemical
O **O**rgans
S **S**tress
M **M**usculoskeletal
O **O**ther

**(Tipsord-Klinkhammer, 1998).*
†(Rutenberg, 2000).

toms. Sometimes the client rates the pain a "10," but appears comfortable or has only a minor complaint, such as a sore throat. The first time an individual experinces a new type of pain, they are likely to rate it as the "worst ever" or a "10." The nurse should then ask the client about the worst pain ever experienced. If the client compares the current pain to an incident such as childbirth, renal colic, or a fracture, the nurse knows the client's pain truly is severe, regardless of the outward manifestations (Canadian Association of Emergency Physicians [CAEP], 1999).

Pain of the most concern begins abruptly (recall the exact time it began), has a maximum severity at onset (within 1 minute), and is associated with vital sign abnormality. Generally, pain is less serious if it is crampy, intermittent, or sharp without vital sign abnormalities. More concern is warranted if there is constant visceral pain (e.g., ache, pressure, burn, squeeze), with associated signs or symptoms and vital sign abnormalities (CAEP, 1999).

A way for nurses to perform a rapid assessment of client stability is to remember the phrase, "30, 2, CAN DO." Clients are likely stable, with adequate perfusion, if their respirations are fewer than 30, they have orientation to person and situation (the "2"), and they obey verbal commands (the "can do").

History

After establishing the client's physiological stability, the nurse should obtain a history. This includes medical history, current medications, allergies, immunizations, and last menstrual period and sexual activity (when applicable).

Thoroughness is an asset. It is often said that 90% of the information needed for diagnosis is in a client' s history. Using established mnemonics, such as OLD CART, helps occupational health nurses remember important areas, such as onset of the complaint (Zimmermann, 2001) (see Table 1). For example, an employee had participated in company paid physical therapy before it was recognized that the muscular back strain was from an off duty activity.

Certain generic client indicators can translate into a more serious condition. These include age, comorbidity, immunosuppression, related significant history, or recent medication change or hospitalization (see Table 2). For instance, one employee complained of dizziness and had severe bradycardia. He had mistakenly taken his new prescriptions as one nitroglycerin every morning and digoxin (Lanoxin) as needed.

Universal indicators related to the complaint can signal a more serious condition. These include (see Table 3):

- Acuteness
- Rapid
- Abrupt onset
- Trends, severity
- Comparison to the client's normal state.

For example, there is more concern for a client who states, "This headache is different than any other headache I have experienced" than one who indicates "I get this heartburn every time I eat tacos."

Finally, other influential demographics may include job related issues. Length of time in the current job, work performance, recent use of sick time or disciplinary action, and difficulties with department manager or coworkers can be enlightening. One employee began coming to the clinic regularly, stating he was "too ill to be safe on the job." Eventually, it was correlated that these "symptoms" began after a new supervisor reassigned the employee to undesirable duties.

Difficulty in Pinpointing the Problem

Sometimes the chief complaint is only a rambling, vague recounting of multiple problems. One client actually started with "Well, ever since I was born..." The nurse can focus the client by asking "What is different today that made you come in."

Table 2

Client Indicators Signaling a More Serious Condition

Client Indicators	*Rationale*
Older client	Aging depresses the immune system
Co-morbidity	The client's physiologic capacity to adapt is already strained by the multiple health conditions.
Immunosuppression	Conditions ● Splenectomy ● Leukemia ● Human immunodeficiency virus ● Organ transplant Medications ● Systemic steroids ● Chemotherapy
Related significant history	● Recent (past 3 months) foreign travel ● Previous serious etiology for same physical complaint
Recent medication change or hospitalization	Period of risk for error is highest after a treatment variation is made.

(Canadian Association of Emergency Physicians, 1999; Mackway-Jones, 1997; Zimmermann, 2002a).

Sometimes it helps to specifically ask, "Is there anything else going on in your life that you think could be contributing to this problem?" Often clients provide an insightful answer about their life stressors, such as a recent divorce or the anniversary of the spouse's death (Zimmermann, 2002a).

On the other hand, occasionally the client gives an emphatic yes answer to every single question asked, even if it does not seem congruent with the current presentation. The nurse needs to discriminate whether these answers are accurate by asking, "Do your toenails itch?" because it is not possible for nails to have that sensation. A yes answer can help confirm something else is probably involved; a response of no makes all the previous multiple yes answers more believable and concerning (Zimmermann, 2002a).

SPECIFIC CHIEF COMPLAINTS

Beyond the general initial interview and assessment, the nurse must also evaluate key related historical and physical findings that traditionally signal an ominous warning for this complaint. "When you hear hoof beats, think horses, not zebras" is the familiar adage emphasizing the need to first consider the most common etiologies. However, a few "zebras" exist. Knowing important differential indicators helps to discern the less frequent, but higher risk, presentations.

Table 3

Complaint Indicators Signaling a More Serious Condition

Client Indicators	*Rationale*
Acute condition	Acute, versus chronic, conditions have the potential of a more lethal cause.
Rapid, abrupt onset	● The exact time of onset is remembered. ● Maximum intensity is reached within 1 minute.
Trends	● Steady progressive decline in general condition. ● Minor symptoms that recur repeatedly. ● Minor symptoms that increase in severity.
Severity	● Pain at 8 to 10 on a 1 to 10 rating scale. ● Pain described with foreboding words, such as "excruciating" or "unbearable." ● Pain requiring stopping all function.
Comparison to normal state	● Recognition of previously experienced symptoms of a serious condition. ● Recognition of a new distinction.

(Canadian Association of Emergency Physicians, 1999; Mackway-Jones, 1997; Zimmermann, 2002a).

Chief Complaint: Influenza

The self diagnosis of "flu" is the layman's term for a host of minor, usually self limiting, illnesses, including most colds. General symptoms, such as fever, fatigue, and pain, account for 15.6% of the visits to United States emergency departments (McCaig, 2002).

True influenza is a viral infection of the respiratory tract causing fever, chills, headache, muscle ache, fatigue, and weakness. In comparison, the common head cold is a viral infection of the mucous membranes inside the nose and throat, causing a stuffy, runny nose, sneezing, sore throat, and headache. The old adage about the flu is "it takes a week to get better if you treat it, 7 days if you don't." Knowing this does not stop many people from asking for, and hoping the nurse has, a miracle cure.

Treatment consists of the familiar advice of rest, (warm) fluids, and over the counter medications for symptom relief. Nurses should reinforce that antibiotics do not cure viral infections. Nurses also should remind clients about the importance of a yearly immunization.

Concern is warranted when the condition lingers beyond 7 to 10 days or is accompanied by other significant symptoms. A secondary bacterial infection (indicated by yellow or green discharge or phlegm), an exacerbation of an existing chronic condition (e.g., asthma), or spreading involvement (e.g., otitis media, sinusitis) requires referral to an appropriate health care provider. Amantadine, which can reduce the severity of an influenza episode if given within 24 hours of onset of the symptoms, may be given to older clients with chronic illnesses. Bacterial infections may require antibiotics.

Differential Diagnosis: Rule Out Hepatitis. The classic prodromal phase for all types of hepatitis mimics a viral syndrome. It is a result of circulating immune antibodies that activate the complement system and inflammatory response. During this stage, fever (70% to 94%) and nausea and vomiting (31% to 69%) predominate (Salk, 1999). It is usually possible to palpate an enlarged liver and the client may describe "heaviness" in the upper right quadrant.

Another possible etiology of liver symptoms is excess acetaminophen consumption. Studies indicate 35% to 38% of hospitalized clients with severe liver injury were associated with excessive acetaminophen use (i.e., usually two to three times the maximum dose of four grams per day). Individuals who abuse alcohol are particularly susceptible because alcohol impairs the liver's ability to clear toxins (Smith, 2001).

Chief Complaint: Nausea and Vomiting

Nausea and vomiting are non-specific symptoms from many causes, not diseases in and of themselves. Yet, many lay people believe the act of vomiting requires a health care professional's immediate attention. Digestive symptoms are the reason for 12.4% of emergency department visits in the United States (McCaig, 2002).

Nausea and vomiting are probably related to ordinary viral gastroenteritis if associated with watery diarrhea, low grade fever, myalgias, and crampy abdominal pain that improves with defecation (Jenkins, 2000). Recent food intake, whether others who ate the same food are also sick (rule out "food poisoning"), and recent (i.e., within the past 3 months) travel in developing countries are essential assessment questions (Mackway-Jones, 1997). One recent study indicated that tabletop sauces stored and served at room temperature in restaurants located in Mexico grew E. coli up to 44% of the time (Adachi, 2002).

Treatment usually involves resting the gastrointestinal (GI) system while it heals itself. Diet, removal of irritants, and reassurance are key aspects. The client is instructed to consume a clear liquid and advance as tolerated to a BRAT (bananas, rice, applesauce, dry toast) and then soft, bland diet.

Differential Diagnosis: Bacterial Etiology. A more serious cause is suggested for GI symptoms if the client has concurrent constant or severe pain (Jenkins, 2000). Clients with bacterial gastroenteritis (20% incidence), such as *Shigella* or *Salmonella*, tend to have a more toxic appearance, a fever (100.4° F, 38° C), and frequent, bloody stool (10 stools per 14 hours) (MacCormack, 1999). If the nurse suspects this, the client should be referred to an appropriate health care provider because antibiotics are sometimes needed.

Differential Diagnosis: Rule Out Dehydration. The nurse needs to consider the possibility of dehydration resulting from frequent vomiting or diarrhea. The standardized Canadian Triage and Acuity Scale (CTAS) defines "frequent vomiting and stools" as either 10 or more episodes of vomiting in the previous 24 hours or five or more bowel movements per day for 2 or more days (CAEP, 1999).

Tachycardia, not blood pressure, is the most sensitive vital sign for dehydration. The adult must have a fluid volume deficit of 1,500 cc before exhibiting hypotension (Matheny, 2000). Tachycardia is frequently defined as a heart rate 20 or more beats per minute beyond the client' s normal rate or more than 120 beats per minute. An increased pulse (i.e., more than 30 beats) is a very specific indication of dehydration (Greenberg, 1999).

Orthostatic vital signs (e.g., rise of 10 or more in pulse and a drop of 10 or more in systolic blood pressure with position change) can be considered. However, the sensitivity and specificity are poor. A blood pressure drop of 20 mmHg has only 29% sensitivity and 81% specificity for 5% or greater fluid deficit (Young, 1999).

Abnormal findings occur from factors other than volume depletion, such as medications. Medications more likely to cause problems are antihypertensives (e.g., alpha adrenergic blockers, beta blockers, calcium channel blockers), aminoglycosides, anticonvulsants, tranquilizers, and vasodilators (Bodenhamer, 1999; Hayes, 2001).

Other causes for abnormal orthostatic findings include age related physiologic changes or autonomic insufficiency (Savitsky, 1999). Hydrated clients 65 or older have a false positive for dehydration more than 25% of the time (Young, 1999).

Nurses should consider hypovolemia, even in the presence of normal orthostatic vital signs, if the client has a related history with other accompanying symptoms. These symptoms can include a sensation of thirst, dizziness (especially immediately after a position change), and parched mucous membranes (Greenberg, 1999; Savitsky,

Table 4

Differentiating Between Gastritis and Peptic Ulcer Disease (PUD)

	Gastritis	*Peptic Ulcer Disease (PUD)*
Relationship to irritants	Relates history of exposure	No direct correlation
Severity	Mild Often only with palpation	More severe Constant, repetitive pain
Pain relationship to eating	Not relieved	Relieved
Duration	Self limiting, especially with diet changes	Not self limiting

1999). The mucous membranes can be assessed by looking where the cheek and gums meet or for tongue furrows because those assessments are not affected by mouth breathing. Skin turgor assessment can be used, but individuals older than 55 normally have less turgor because of age related skin elasticity loss. For a more accurate turgor assessment, the nurse can pinch the skin over the sternum, inner or medial aspects of the thigh, forehead, or abdominal area (Matheny, 2000). Using a dipstick to test the urine for ketones can also be an effective general screening aid. A mild dehydration, without current vomiting, can be treated with oral electrolyte fluid. More severe dehydration requires intravenous replacement.

Chief Complaint: Upset Stomach

With a complaint of upset stomach, a key determination is whether the client is experiencing a common, relatively benign erosive gastritis or a more serious gastrointestinal ulcer. Erosive gastritis is a temporary condition usually related to intake or lifestyle. Although there is often no clear etiology, common causes include use of salicylates, nonsteroidal antiinflammatory drugs (NSAIDs), alcohol, overindulgence of food, or stress. The typical symptoms are a "burning" stomach pain, with a mild epigastric discomfort upon palpation. Usually, several days of clear liquids followed by bland foods resolves the problem (Jenkins, 2000).

Differential Diagnosis: Peptic Ulcer Disease. Peptic ulcer disease (PUD), on the other hand, is more serious erosions or ulcers in the stomach's mucosa and needs referral to an appropriate health care provider. This disease is the cause of 10% of all emergency department visits with abdominal pain, and 10% of clients with PUD eventually have a perforation (Henneman,1999; Jenkins, 2000). The causes are many, and range from *Helicobacter pylori* (*H. pylori*) to smoking. There is a 2% to 4% incidence in anyone consuming aspirin or NSAIDs for more than 1 year (Heitkemper, 2000). Peptic ulcers are not related to consuming spicy foods as laypeople commonly assume.

Often this condition is "silent" (31% to 69% of the time), and clients show no signs or symptoms except for hematemesis or melena. The most common presentation has three notable characteristics: localization to the epigastrium, relationship to food, and episodic occurrence—probably from the acid coming into contact with the ulcer (Williams, 2000). The discomfort is a gnawing, burning mid-epigastric discomfort that can radiate to the back after eating (1 to 2 hours later for gastric ulcers, 2 to 4 hours later for duodenal ulcers). The pain is usually relieved by eating—resulting in a recent weight gain. Forty percent of those who have PUD have nausea with occasional vomiting (Henneman, 1999, McCullough,1999). These clients need referral to an appropriate health care provider for diagnostic evaluation and treatment.

Considerations for differentiating between the two conditions are listed in Table 4. However, either condition warrants an urgent physician referral for any evidence of bleeding.

Differential Diagnosis: Alcoholic Gastritis. For a client with recurrent gastritis, especially after days off or weekends, the nurse needs to consider the possibility of excessive alcohol consumption. The National Center on Addiction and Substance Abuse at Columbia University found binge drinking (i.e., four drinks in one sitting three times in the previous 2 weeks) starts as early as 9th grade for both women and men (Morse, 2002).

It is sometimes difficult to obtain accurate answers when questioning clients about alcohol consumption because employees know the "acceptable" answer. The nurse can phrase questions so a quantitative answer is expected. Rather than asking "Do you drink?" the nurse may find the following questions to be more effective:

- "What do you normally drink?"
- "How much do you normally drink?"
- "When did you last take a drink?"

The nurse might also try overestimating. "Do you drink two cases of beer during a weekend?" Clients are more likely to be honest as they "correct" the misperception. For example, the client may answer, "Oh, no. I only drink a six pack every night." Another approach is feigning surprise if a doubtful answer is given. The nurse may say, "Really? Is that all?" Sometimes the individual "corrects" the answer. The key is to remain nonchalant during the interaction.

Differential Diagnosis: Rule Out Cardiac Origin. Acute myocardial infarction and ischemia can be accompanied by indigestion-like pain (6% to 30% of the time) and nausea (31% to 69% of the time) (Louden, 1999). The nurse should have an increased concern for this etiology if the client's history includes indications of acute coronary syndrome. These include (CAEP, 1999; Granger, 2001):

- Nontraumatic visceral pain continuous for 2 to 5 minutes.

- Other associated symptoms, such as shortness of breath.
- A history of any previous myocardial infarction, coronary artery disease, angina (especially related to exertion), cardiac surgery, or use of nitroglycerin for chest pain.
- Presence of risk factors such as smoking, hyperlipidemia, hypertension, family history, diabetes mellitus, or recent cocaine use.

Differential Diagnosis: Digoxin (Lanoxin) Toxicity. If appropriate to the client, the nurse should consider digoxin (Lanoxin) toxicity. It is more likely in an elderly client because the glomerular filtration rate decreases as much as 50% through the life span. The incidence increases if the client is taking concurrent cardiac drugs or diuretics (Jenkins, 2000).

Early signs of digoxin toxicity include anorexia, nausea and vomiting, and general weakness. Bradycardia and visual disturbances, the signs classically associated with toxicity, occur later (House-Fancher, 2000).

Differential Diagnosis: Psychological Stress. Abdominal discomfort from psychological stress is also always a possibility. The nurse can ask the client to point to the location of the pain. If the finger goes to a fixed point (other than the navel), there is likelihood it has a physical significance. If the client points to the navel, and seems generally well, the nurse should consider a psychogenic cause (Potter, 1998).

Chief Complaint: Low Back Pain

Approximately 80% of American adults have low back pain at least once in their lifetime because of the inherent structural weakness of the lumbar area. The assessment should focus on differentiating muscular origin from a significant disc involvement. Clients whose pain is from a disc most often relate a history of experiencing immediate pain at its maximum intensity (CAEP, 1999). The well localized pain is described as sharp and frequently radiates distally to the knee (Hockberger, 1999).

Muscular pain, in comparison, tends to increase gradually over time. In addition, there is often a recent history of performing an activity known to cause muscular strain. These activities include continued bending at the waist, lifting below the knuckles, lifting above the shoulders, and twisting at the waist while lifting (Edlich, 2001).

Concern is warranted if a history of trauma exists (e.g., direct blows to the back or falls in which the client lands on the feet as the shock is absorbed up the spine), or heavy lifting with a history of osteoporosis (Sorrentino, 2001; Weitz, 1999). "Red flags" include an inability to walk (versus difficulty walking because of the pain) or new or evolving neurologic symptoms (Hockberger, 1999; Mackway-Jones, 1997; Weitz, 1999). The classic neurologic constellation for concern is cauda equina syndrome (i.e., central herniation of the disc), which includes motor weakness and numbness, loss of bowel or bladder control, and "saddle anesthesia" (i.e., buttock numbness) (Weitz, 1999).

The nurse should have the client perform the straight leg raising test (Bates, 2002; Hockberger, 1999; Potter, 1998; Seidel, 1999). In the supine position, the client raises one relaxed leg with the knee extended until back pain occurs. The client then dorsiflexes that foot. A normal finding is no pain or only mild back pain. It is not significant if there is a mild discomfort behind the knee from a tight hamstring muscle.

A positive test result (i.e., abnormal finding), which pinpoints a nerve root irritation, is the inability to raise the leg more than 30 to 60 degrees without pain or radiculopathy pain that radiates down the involved leg with dorsiflexion. It pinpoints nerve root irritation because these actions cause a pressure on the lumbosacral nerve root (Bates, 2002).

A positive crossed straight leg raising test occurs when the elevation of the uninvolved leg causes pain to radiate down the involved leg. It is a sensitive, specific sign for disc herniation.

It is generally accepted that 50% to 70% of clients with back pain recover in 1 week; and 90% recover by 1 to 2 months, even if there is a disc protrusion. Most practitioners recommend trying conservative measures first. This includes no heavy lifting (20 pounds or more), proper body mechanics, sleeping on the back with a pillow underneath the bent knees or on the side with a pillow between the knees (never on the stomach), and initially cold compress application. A referral for additional health care provider treatment is usually made only after a lack of improvement for a week or more (Hockberger, 1999; Weitz, 1999; Zimmermann, 2002b).

Differential Diagnosis: Tumor or Infection. Atypical causes of back pain are tumors or infections. This pain is more likely to be severe at night or when the client is supine (normal muscular pain improves with rest) and has not improved despite more than a month of NSAIDs. These etiologies are more likely in an older client (i.e., age 50 and older) with a history of intravenous drug abuse, cancer, back surgery, unexplained weight loss, recent fever and chills, and immunosuppression (Hockberger, 1999; Sorrentino, 2001).

Differential Diagnosis: Evolving Abdominal Aortic Aneurysm. Mid or low back pain can be a sign of an expanding, rupturing, or leaking abdominal aortic aneurysm (AAA). The typical candidate is an elderly man with a history of hypertension and atherosclerosis (Drake, 1999). This dilation of the aorta, secondary to weakening of all of the layers of the aortic wall, often causes an intense, severe, "ripping" or "tearing" pain (70% to 94%). The pain can be located in the abdomen, flank, or back, with radiation to the groin or legs. It can mimic renal colic pain, which results in blood in the urine because of moving kidney calculi.

There can be a pulsatile abdominal mass present (70% to 94%), with systemic circulation signs later on, such as hypotension (31% to 69%) or peripheral embolization ("purple toes") and unequal extremity pulses (5%) (Char, 1999; Jenkins, 2000). This is an emergency situation in which the client needs to be sent to the hospital immediately.

SUMMARY

Occupational health nurses regularly encounter clients with benign, common complaints. However, the mundane nature should not detract from the need for careful evalua-

tion and guidance. Obtaining a comprehensive history and making key assessments help guide the occupational health nurse to properly manage the client's complaint.

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IN SUMMARY

Triaging

Common Complaints in the Workplace

Zimmermann, P.G.

AAOHN Journal 2003; 51(6), 267-273

1. Thorough history taking, skillful physical assessments, and awareness of potential serious conditions are instrumental in determining whether the presenting client needs teaching, treatment, or transfer to a higher level of care. The nurse needs to consider both client and complaint related indicators and characteristics.

2. The most concerning characteristics for any pain complaint are an abrupt onset, maximum severity at onset, visceral quality, and accompanying abnormal vital signs.

3. The occupational health nurse should first evaluate the client for the most common etiology of a "common" complaint. However, the possibility of less frequent, but higher risk, conditions must be ruled out.

Triaging: Common Complaints in the Workplace

This issue of the AAOHN JOURNAL contains a Continuing Education Module on "Triaging: Common Complaints in the Workplace." 1.0 contact hours of continuing education credit will be awarded by AAOHN upon successful completion of the posttest and evaluation.

A certificate will be awarded and the scored test will be returned when the following requirements are met by the participant: 1) The completed answer sheet is received at AAOHN on or before May 31, 2004; (2) A score of 70% (7 correct answers) is achieved by the participant; (3) The answer sheet is accompanied by a $10.00 processing fee. Expect up to 6 weeks for delivery of the certificate.

Upon completion of this lesson, the occupational health nurse will be able to:

1. Describe the essential characteristics of an initial intake and history for occupational health triage.
2. List the specific chief complaints for influenza, nausea and vomiting, upset stomach, and low back pain.
3. Identify differential diagnoses which may indicate the need for emergent care.

AAOHN is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation. AAOHN is additionally approved as a provider by the California Board of Registered Nursing (#CEP9283) and the Louisiana State Board of Nursing (#LSBN3).

Contact hour credits received for successful completion of the posttest and evaluation may be used for relicensure, certification, or re-certification.

Directions: Circle the letter of the best answer on the answer sheet provided. (Note: You may submit a photocopy for processing.)

1. Using the mnemonic PQRST, the occupational health nurse asks this question to assess for the P:
A. "What is the problem?"
B. "What provokes the symptoms?"
C. "What is the location of the problem?"
D. "What are the precipitating factors?"

2. When taking a client's history, the occupational health nurse uses the "OLD CART" mnemonic. The T stands for:
A. Trauma.
B. Timing.
C. Treatment administered.
D. Trends.

3. The occupational health nurse considers that a complaint indicator signaling a more serious condition is a:
A. Chronic condition.
B. Related significant history.
C. Recent medication change.
D. Comparison to normal state.

4. Referral of an employee with a viral influenza is indicated in all of the following situations except:
A. Condition continuous for 5 days.
B. Exacerbation of an existing chronic condition.
C. Secondary bacterial infection.
D. Spreading involvement.

5. Which of the following indicates an eitology for gastroenteritis?
A. Watery diarrhea.
B. Myalgias.
C. Severe pain.
D. Low grade fever.

6. The occupational health nurse uses this as the most sensitive sign of dehydration:
A. Tachycardia.
B. Blood pressure.
C. Orthostatic vital signs.
D. Dizziness.

7. The occupational health nurse recognizes that all of the following are characteristic of peptic ulcer disease except:
A. Localization of the epigastrium.
B. Episodic occurrence.
C. Pain not relieved by eating.
D. Not self-limiting.

8. A later sign of digoxin toxicity is:
A. Anorexia.
B. Bradycardia.
C. Nausea and vomiting.
D. General weakness.

9. The occupational health nurse differentiates between back pain of muscular origin and disk involvement. A characteristic of disk involvement is:
A. Motor weakness and numbness.
B. Pain gradually increasing over time.
C. A negative crossed straight leg raising test.
D. Severe pain at nighttime.

10. An employee comes to the occupational health service complaining of a severe "tearing" pain. On assessment, the employee is found to have hypotension, peripheral embolization, and unequal extremity pulses. The occupational health nurse recognizes this is most probably an emergent situation caused by:
A. Myocardial infarction.
B. Abdominal aortic aneurysm.
C. Peptic ulcer disease.
D. Disk protrusion.

ANSWER SHEET
Continuing Education Module

Triaging:
Common Complaints in the Workplace

June 2003

(Goal: To gain ideas and strategies to enhance personal and professional growth in occupational health nursing.)

Mark one answer only!
(You may submit a photocopy of the answer sheet for processing.)

1.	A	B	C	D
2.	A	B	C	D
3.	A	B	C	D
4.	A	B	C	D
5.	A	B	C	D
6.	A	B	C	D
7.	A	B	C	D
8.	A	B	C	D
9.	A	B	C	D
10.	A	B	C	D

EVALUATION (must be completed to obtain credit)

Please use the scale below to evaluate this continuing education module.

	4 - To a great extent	3 - To some extent	2 - To little extent	1 - To no extent
1. As a result of completing this module, I am able to:				
A. Describe the essential characteristics of an initial intake and history for occupational health triage.	4	3	2	1
B. List the specific chief complaints for influenza, nausea and vomiting, upset stomach, and low back pain.	4	3	2	1
C. Identify differential diagnoses which may indicate the need for emergent care.	4	3	2	1
2. The objectives were relevant to the overall goal of this independent study module.	4	3	2	1
3. The teaching/learning resources were effective for the content.	4	3	2	1
4. How much time (in minutes) was required to read this module and take the test?	50	60	70	80

Please print or type: (this information will be used to prepare your certificate of completion for the module).
DEADLINE: MAY 31, 2004. Allow up to 4 weeks for processing.

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