## Objective

- To provide the **health care professional** with direction and expectations for the initial assessment and ongoing reassessment of patients in an Emergency Department or an Urgent Care Centre.

## Applicability

This practice support document applies to Covenant Health Emergency Departments, their staff, members of the medical staff, students and any other persons acting on behalf of Covenant Health.

## Elements

**Note:** All assessment and reassessment shall be documented in the patient's health record per Covenant Health Policy #III-120, *Clinical Documentation*.

1. **Personnel**

   1.1 The initial assessment and ongoing reassessment(s) of patients is restricted to health care professionals who, within their professional scope of practice, demonstrate the competency of comprehensive systems assessments after receiving the appropriate didactic and clinical education and training.

2. **Triage Assessment**

   2.1 All patients presenting to the Emergency Department and Urgent Care Centre, including patients arriving for scheduled/planned visits and those arriving by Emergency Medical Services (EMS), shall be assessed during the triage process. The Canadian Triage and Acuity Scale (CTAS) shall be used to assign an acuity score based on the patient's presenting complaint, triage assessment and vital signs.

   2.2 Vital signs measures may be deferred if the patient is being transferred to a treatment area for timely and/or emergency/urgent assessment. The triage assessment and initial bedside assessment may be completed concurrently if the patient is being transferred to a treatment area.
2.3 Complete vital signs measures shall include:

a) temperature;

b) heart rate (HR) / pulse;

c) blood pressure (BP);

d) respiratory rate (RR);

e) oxygen saturation (O₂ sat); and

f) pain scale score or the absence of pain as applicable.

2.4 For pediatric patients, pulse/HR, RR, O₂ sat and temperature shall be measured as part of triage assessment. Blood pressures shall be measured on CTAS 1, 2 or 3.

a) For pediatric patients who are difficult to get a blood pressure assessment on, it is acceptable to allow the BP measure to be deferred until the patient is taken into the treatment area.

b) Obtain a weight for pediatric patients. It is acceptable to defer measurement of the weight until the patient is taken into a treatment area. A length-based resuscitation tape (i.e. Broselow Pediatric Emergency Tape) may be used for higher acuity presentations (i.e. CTAS 1 or 2).

2.5 Neurological vital signs measures, including Glasgow Coma Scale (GCS), pupil size and reaction, motor power and sensation assessment to all four extremities, shall be assessed based on patient presentation (e.g. altered level of consciousness, suspected cerebral vascular accident, seizures, suspected head injury, or fall with suspected head impact).

3. Triage Reassessments

3.1 Covenant Health recognizes that timely access to appropriate interventions relies on accurate and timely reassessment of a patient’s condition, and makes all efforts to comply with the CTAS Reassessment Guidelines (Appendix A). Covenant Health also recognizes that there may be times of extreme acuity and/or volume that prohibit meeting the identified reassessment guidelines, and therefore has modified the minimal reassessment guidelines.

3.2 Recommended triage reassessments and vital signs measures frequency to be completed on all patients awaiting initial physician or physician/NP directed care are based on the following guidelines, Table 1:
**TABLE 1: Frequency of Post-Triage Reassessments and/or Vital Signs**

<table>
<thead>
<tr>
<th>CTAS Level</th>
<th>Reassessment with / without Vital Signs</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>CTAS 1</td>
<td>Ongoing</td>
<td>Patients shall be taken to the appropriate treatment area for immediate assessment and bedside registration.</td>
</tr>
<tr>
<td>CTAS 2</td>
<td>Reassessment and written documentation every 15*-60 minutes or more frequently based on clinical judgement.</td>
<td>Patients shall be taken to an appropriate treatment area upon arrival for immediate assessment (may include bedside registration). If no treatment space is available, all CTAS Level 2 patients shall be located within visual range of the triaging health care professional at all times.</td>
</tr>
<tr>
<td>CTAS 3</td>
<td>Reassessment and written documentation is to occur every 30*-120 minutes or more frequently based on clinical judgement.</td>
<td></td>
</tr>
<tr>
<td>CTAS 4</td>
<td>Reassessment and written documentation is to occur every 60*-120 minutes based on clinical judgement.</td>
<td></td>
</tr>
<tr>
<td>CTAS 5</td>
<td>Reassessment and written documentation is to occur every 120* minutes or more frequently based on clinical judgement.</td>
<td></td>
</tr>
</tbody>
</table>

* CTAS Guidelines

3.3 If there is a marked change in the patient's condition, a complete set of vital signs measures shall be repeated.

a) Priority for care may be adjusted with acuity change, however the initial CTAS score does not change.

b) Document acuity level changes and change priority accordingly. This would include patients returning for routine tests or procedures who shall receive an initial assessment at triage, including complete vital signs measures and further assessment only if condition changes.
3.4 The triage health care professional shall:

a) Inform all patients to return immediately to the triage desk if they feel their condition is worsening; and

b) Inform all patients to tell the health care professional if leaving the Emergency Department prior to formal discharge.

4. Ongoing Assessment and Reassessment

4.1 Initial Assessment

a) Patients shall undergo an initial assessment by the receiving health care professional which shall include:

i. complete vital signs measures;

ii. a focused assessment regarding the patient's presenting complaint; and

iii. as appropriate for the patient's condition, a comprehensive multisystem assessment.

NOTES:

- **Manual vital sign measurement** during initial assessment can provide important clinical information such as pulse quality, rate, rhythm, and skin temperature. A manual blood pressure measure is recommended for patients with an irregular heart rhythm.

- **For pediatric patients, rectal temperatures** are the most reliable source of temperature for patients less than two years of age. Sites may choose to routinely measure rectal temperatures at a lower age range, or choose to measure rectal temperatures in patients based on clinical assessment.

b) Neurological vital signs shall be assessed based on patient presentation.

c) The receiving health care professional shall identify any changes or indications that a higher level of care or observation may be appropriate and shall make recommendations and/or arrangements to provide that level of care.

4.2 Frequency of reassessment and/or vital signs measures to be completed on all patients after receiving initial physician/NP assessment, unless otherwise ordered, as follows:
4.3 More frequent reassessment in the following circumstances:

a) clinical judgement;

b) vital signs are not within expected limits for the patient;

c) after the administration of medication with the potential to alter vital signs or patient condition such as narcotics, anti-arrhythmics, or bronchodilators;

d) after any intervention or procedure that has the potential to alter vital signs or patient condition such as intravenous (IV) fluid bolus or invasive procedures; and/or

e) any change in patient condition.

4.4 Frequency of vital sign monitoring may be determined as per established protocols/guidelines.

a) diagnosis/symptom based (e.g., stroke, ST segment elevation myocardial infarction [STEMI] protocols); and/or

b) medication (as per pharmacy monographs).

4.5 Documentation should include:

a) ongoing reassessment, including effects of medication, complete vital signs measures and observations appropriate to the patient’s condition;

b) all treatment/procedures and interventions, and the patient’s response;

c) known consults (with time called/paged and response); and

d) patient location changes with complete vital signs measures as appropriate.

4.6 Blood pressure, pulse and respiratory rate measures shall be documented in a trended format and monitored for evidence of change in the patient’s physiological status and hemodynamic stability.
5. **Beginning of Shift or Transfer of Care**

5.1 At the beginning of the health care professional's shift or upon transfer of assignment of a patient, the following is expected to be assessed and documented as per site specific documentation:

   a) comprehensive or focused assessment depending on patient presentation;

   b) complete vital signs measures, to ensure correlation with monitors within first hour of shift;

   c) neurological vital signs measures as required;

   d) verify placement of invasive lines or tubes (eg. endotracheal tubes, oro/nasogastric tube, and foley catheter) according to Covenant Health policy #VII-A-75, *Infusion Line and Tubing Verification*;

   e) assess IV site patency and document same;

   f) confirm IV solution, rates and pump settings;

   g) ensure intake and output record is updated; and

   h) cardiac rhythm strip if patient cardiac monitored – attach to the patient chart (and document interpretation).

5.2 At beginning of shift or transfer of care, the receiving health care professional is expected to review patient orders.

6. **Admitted Patients in the Emergency Department**

6.1 Assessments and reassessment shall follow the inpatient admission orders.

7. **Discharge from the Facility**

   **NOTE:** The following discharge planning activities may not occur with the involvement of other health care professionals if the patient was discharged out of the Emergency Department or Urgent Care Centre by the physician/NP. When other health care professionals are involved then the following discharge planning activities can occur; the following may vary under the direction of the discharging physician/NP.

7.1 A complete set of vital signs measures is required for all patients within one hour before the time of discharge or transfer from the Emergency Department or Urgent Care Centre.
7.2 Document any discharge instructions given to the patient or family/care providers.

7.3 All follow-up instructions, appointments and prescriptions given are to be recorded in the health record prior to patient discharge.

8. **Documentation**

8.1 All assessment, reassessment, interventions, and patient response to interventions shall be documented in the patient's health record per Covenant Health policy #III-120, *Clinical Documentation*.

**Definitions**

**Health care professional** means an individual who is a member of a regulated health discipline, as defined by the *Health Disciplines Act* (Alberta) or the *Health Professions Act* (Alberta), and who practices within scope and role.

**Health record** means Covenant Health's legal record of the patient’s diagnostic, treatment and care information.

**Manual vital sign measurement** means the blood pressure and heart rate or pulse must be assessed via auscultation, palpation or via vascular Doppler.

**Previous Version Date(s)**

N/A