COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
ED Assessment Reassessment Policy		**EMD-005**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Emergency Department		
DEPARTMENT	REFERENCE	
Emergency Department		

I. SCOPE

This policy applies to Mangum Regional Medical Center Emergency Department's (ED) nursing and medical staff and any other individuals acting on behalf of Mangum Regional Medical Center.

II. PURPOSE

To provide the ED nursing and medical staff with direction and expectations for the initial assessment, ongoing reassessment, transition of care and discharge assessments of patients in the ED to ensure safe and quality patient care.

III. DEFINITIONS

A. **Assessment:** means the collection of data regarding the patient's physiological, psychological, sociological and spiritual condition by a registered nurse (RN).

B. **Medical Screening Examination (MSE):** means an examination performed by a licensed physician or Qualified Medical Person (QMP) including any ancillary services to determine with reasonable clinical confidence whether an EMC does or does not exist.

B. **Triage:** entails the clinical assessment of the individual's presenting signs and symptoms at the time of arrival at the hospital, in order to prioritize when the individual will be seen by a physician or other QMP.

IV. POLICY

Triage is a process that will be initiated upon patient arrival to rapidly assess the severity of the patient's injury or illness and assign priorities of care to be provided. This process ensures patients are placed in the right location at the right time to receive the appropriate level of care and facilitates the allocation of the appropriate resources to meet the patient's medical needs. Goals of triage include:

- Rapid identification of life-threatening illnesses or injuries

- Prioritizing care for patients with emergent needs
- Facilitate the flow of patients through the ED
- Refer patients to the appropriate level of care in the ED

The ED triage assessment of the patient will include the rapid systematic collection of subjective and objective data that is relevant to each patient. A primary nursing assessment will be obtained for all patients presenting to the ED, regardless of initial complaint, to ensure that potentially life-threatening conditions are identified and immediately addressed. Nursing staff will perform a secondary nursing assessment (brief focused assessment) after the primary assessment and any resuscitation efforts. The purpose of the secondary assessment is to identify any other abnormalities or injuries the patient may have that are not life-threatening.

All patients who present to the ED will receive an appropriate medical screening examination (MSE), including any labs and/or diagnostic testing if indicated by a physician or mid-level provider.

The assessment of patients is an interdisciplinary process. Data received from the patient and/or family will be included in the assessment. Assessment data is documented in the patient's medical record and will be shared among disciplines to enhance the continuity of care.

V. PROCEDURE

A. Triage Assessment

1. All patients who present to the ED will be assessed using the Emergency Severity Index (ESI) triage tool to assign an acuity score based on the patient's presenting chief complaint, signs/symptoms, triage assessment, and vital signs.
2. Vital signs may be deferred in triage if the patient is being transferred on arrival to an ED room for emergent/urgent assessment. The triage assessment and primary nursing assessment may be completed concurrently if the patient is being transferred immediately to an ED room on arrival.
3. Complete set of vital signs will be obtained on all patients and include the following:
    a. Blood Pressure (BP);
    b. Heart Rate (HR)/pulse;
    c. Respiratory Rate (RR);
    d. Temperature (T);
    e. Oxygen Saturation (O2 sat); and
    f. Pain Score or the absence of pain as applicable: using a validated pain rating scale (i.e. Numeric Pain Scale, Wong-Baker Faces Scale, etc.)
4. All pediatric patients' HR/pulse, RR, O2 sat, temperature and pain score (if applicable) will be obtained as part of the triage assessment. Blood pressures will be obtained on pediatric patients aged five (5) years and older.
    a. When there is difficulty obtaining a blood pressure on a pediatric patient, it is acceptable to defer BP measurement until the patient is taken into the ED room.

b. A weight will be obtained on all pediatric patients. It is acceptable to defer obtaining the weight until the patient is roomed in the ED area. All weights will be obtained in kilograms (kg). A length-based resuscitation tape (i.e. Broselow Pediatric Emergency Tape) may be used for higher acuity presentations.

5. Neurological vital signs will be assessed based on patient presentation (i.e. altered level of consciousness, suspected stroke, suspected head injury, seizures, etc.) and include but not limited to the following:
   a. Glasgow Coma Scale (GCS);
   b. Pupil size and reaction
   c. Motor assessment
   d. Sensation assessment

B. Triage Reassessment

1. Triage nurse will perform accurate and timely reassessment of the patient's condition and vital signs for those waiting examination by the physician/mid-level provider per the following timeframes:

ESI	I	II	III	IV-V
	Immediate; life-threatening	Stable; as soon as possible	Stable; no distress	Stable; no distress
Reassessment	Continuous	Every 15 minutes	Every 60 minutes & PRN	Every 2-4 hours & PRN
Examples	Cardiac arrest; major trauma; respiratory distress	Stroke; severe pain; open fracture	Closed fracture; acute abdomen	Rash; constipation;

2. [insert Hospital's name] recognizes that there may be times when acuity is high or ED volume is at maximum and it may prohibit meeting the identified reassessment guidelines, and therefore the RN may have to modify the minimal reassessment timeframes to meet the needs of all patients.

C. Nursing Assessment and Reassessment

1. The initial primary patient assessment should be completed on all patients within 5 minutes after admission to the ED and should include but not be limited to the following:
   - Chief complaint including precipitating event/onset of symptoms, mechanism of injury
   - Progression of condition: from symptom onset or injury to initiation of care including history of present illness/injury, location of problem, duration of symptoms, characteristics, aggravating/relieving factors, treatment prior to arrival
   - Objective data collection (**ABCDE**):
     - **A**irway patency with cervical spine protection for all suspected trauma patients: assessment of airway
     - **B**reathing effectiveness: assessment of breathing
     - **C**irculation effectiveness: assessment of circulation, perfusion and signs of bleeding

- **D**isability (brief neurologic examination)
- **E**xposure/environmental controls: assessment of environmental, infectious exposure, environmental trauma, substances/alcohol

2. The goal of resuscitation is to correct a life-threatening condition and should follow the same **ABCDE** mnemonic to ensure interventions occur simultaneously during the primary assessment. These include but should not be limited to the following:
    - **A**irway/Cervical Spine protection: basic airway management, immobilization/stabilization of the cervical spine
    - **B**reathing: non-invasive ventilation, CPAP, Bipap, advanced airway management including rapid sequence induction protocols
    - **C**irculation/Bleeding: chest compressions, control significant bleeding, splint fractures, control of epistaxis, administer fluids and/or blood
    - **D**isability (Neurologic status): identify possible etiologies of decreased level of consciousness or altered mental status, perform neurological assessments including Glasgow Coma Scale and National Institutes of Health Stroke Scale, administer pharmacological therapy as indicated.
    - **E**xposure/Environmental Controls: remove clothing, caution for sharp objects, weapons. Prevent heat loss and increase in coagulopathies.
3. The secondary patient assessment is a brief/focused assessment that should occur after the initial primary assessment and any resuscitation efforts. The purpose of the secondary patient assessment is to identify any other abnormalities or injuries that are not life threatening. This assessment should include but not be limited to:
    - A full set of vital signs, including assessment of pain
    - Head to Toe assessment: a complete/comprehensive head-to-toe assessment should be completed for all critically ill or injured patients. A more focused head-to-toe assessment may be completed for patients who present to the ED with a specific minor injury or complaints that are limited to one body system.
4. The frequency of reassessment and/or vital signs to be completed on all patients, unless otherwise ordered should be as follows:
    a. A minimum of every four (4) hours for all patients; and/or
    b. A minimum of every hour for all patients who require continuous cardiac monitoring.
    c. More frequent reassessments may be considered in the following situations:
        i. clinical judgment;
        ii. vital signs or patient assessment not within expected limits for the patient;

iii. after administration of medication with the potential to alter vital signs or patient condition (i.e. narcotics, anti-arrhythmics, blood pressure medications)
iv. any change in patient's medical condition.

d. Vital sign frequency may be determined based on established protocols/guidelines, including but not limited to:
i. Diagnosis based (i.e. stroke, STEMI, Chest pain, Sepsis)
ii. Medication (Heparin, Cardene, Alteplase)

e. Documentation in the patient's medical record should include assessment of:
i. Effects of medication
ii. Complete set of vital signs
iii. Observations of the patient's medical condition
iv. All treatments/procedures/interventions, and the patient's response

D. Physician/Mid-Level Provider Assessment

1. An appropriate MSE will be performed on each patient who presents to the ED and be tailored to each patient's presenting symptoms and complaints. Depending on the patient's presenting symptoms and complaints, the MSE may be as simple as a brief history and physical exam or a more complex process that involves ancillary studies, lab test, x-rays, and/or other diagnostic studies.
2. If the patient experiences a change in condition while in the ED the physician/mid-level provider will perform a reassessment that may include additional ancillary studies depending on the patient's condition.
3. The physician/mid-level provider must document the MSE and any treatment in the patient's medical record.

E. Shift Change or Transition of Care Assessments

1. At the beginning of each shift or transfer of care, the RN should assess and document in the patient's medical record the following information:
a. a comprehensive or focused patient assessment depending on patient presentation;
b. a complete set of vital signs, including assessment of pain;
c. verify placement of invasive lines and/or tubes (i.e. foley, nasogastric tubes, etc.)
d. assessment of IV site patency;
e. review of the IV solution, rates and pump settings;
f. update intake and output (I&O); and
g. obtain cardiac rhythm strip if patient is being monitored and attach to patient's chart.
2. At the beginning of shift or transfer of care the RN should review the orders in the patient's medical record.

F. Discharge Assessment

1. Prior to discharge the RN should perform a focused reassessment to determine the patient's clinical condition and readiness for discharge.

2. Any changes in the patient's clinical condition should be immediately reported to the physician/mid-level provider.

VI. DOCUMENTATION

All assessment, reassessment, interventions, and patient responses should be documented in the patient's medical record.

VII. RESPONSIBLE PARTIES/QUALITY ASSURANCE

Hospital leadership including but not limited to, the Nursing Department Director are responsible for ensuring that all individuals adhere to the requirements of this policy, procedures are implemented and followed at the Hospital and instances of non-compliance with the policy are reported to the Chief Nursing Officer and an incident report completed.

All incident reports will be forwarded to the Quality Risk Manager and reported to the QAPI, MEC, and Governing Board.

ATTACHMENTS

NA

REFERENCES

Emergency Nurses Association (2018). *Emergency Nursing: Core Curriculum. 7th Edition.*

Emergency Nurses Association (2019). *Position Statement: Safe Discharge from the Emergency Department.*

Munroe, Belinda RN, MNurs (AdvPrac), PhD Candidate; Curtis, Kate RN, PhD; et al. (2015) HIRAID: An evidence-informed emergency nursing assessment framework. *Australasian Emergency Nursing Journal 18, 83-97*. [Electronic Version]. Retrieved on 11/15/19 from https://www.ausemergcare.com/article/S1574-6267(15)00026-9/pdf

Han, C., Barnard, A. & Chapman, H. (2009). Discharge planning in the emergency department: A comprehensive approach. Journal of Emergency Nursing, 35(6), 525–527. https://doi.org/10.1016/j.jen.2009.01.015

REVISIONS/UPDATES

Date	Brief Description of Revision/Change