



TITLE

**ASSESSMENT AND REASSESSMENT OF PATIENTS**

SCOPE

Provincial: Emergency Department and Urgent Care Centres

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**NOTE:** The first appearance of terms in bold in the body of this document (except titles) are defined terms – please refer to the Definitions section.

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## OBJECTIVES

- 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

Compliance with this document is required by all Alberta Health Services employees, members of the medical and midwifery staffs, students, volunteers, and other persons acting on behalf of Alberta Health Services (including contracted service providers as necessary).

## ELEMENTS

**Note:** All assessments and reassessments shall be documented on the patient's **health record**.

### 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 Assessments

- 2.1 Triage Assessment:
  - a) 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.

- b) 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.
- c) Complete vital signs measures shall include:
  - (i) temperature;
  - (ii) heart rate (HR)/pulse;
  - (iii) blood pressure (BP);
  - (iv) respiratory rate (RR);
  - (v) oxygen saturation (O2 sat); and
  - (vi) pain scale score or the absence of pain as applicable.
- d) 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.
  - (i) 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.
  - (ii) 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).
- e) Neurological vital signs measures, including Glasgow Coma Scale (GCS), pupil size and reaction, motor power and sensation assessment to all four (4) 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).

## 2.2 Triage Reassessments:

- a) Alberta Health Services 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 (see Appendix A - *CTAS Guideline – Reassessment In Waiting*)

Areas). Alberta Health Services 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.

- b) Recommended triage reassessments and vital signs measures frequency to be completed on all patients awaiting initial Physician assessment or Physician/Nurse Practitioner directed care are based on the following guidelines, Table 1:

**Table 1: Frequency of Post-Triage Reassessments and/or Vital Signs**

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

\*CTAS guideline

- c) If there is a marked change in the patient's condition, a complete set of vital signs measures shall be repeated.
- (i) Priority for care may be adjusted with acuity change, however the initial CTAS score does not change.

- (ii) 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.
- d) The triage health care professional shall:
  - (i) inform all patients to return immediately to the triage desk if they feel their condition is worsening; and
  - (ii) inform all patients to tell the health care professional if leaving the Emergency Department prior to formal discharge.

### 3. Ongoing Assessment and Reassessment

#### 3.1 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 measurement 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 clinician 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.

- 3.2 Frequency of reassessment and/or vital signs measures to be completed on all patients after receiving initial Physician/Nurse Practitioner assessment, unless otherwise ordered, as follows:
- a) a minimum of every four (4) hours for all patients; and/or
  - b) a minimum of every one (1) hour for patients who require continuous cardiac monitoring.
- 3.3 More frequent reassessment in the following circumstances:
- a) clinical judgment;
  - 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.
- Note: For Calgary Zone see additional Appendix B *Calgary Zone Specific Details Regarding More Frequent Assessment and Reassessment* for additional information.
- 3.4 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).
- 3.5 Documentation should include:
- a) ongoing reassessments, 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.

- 3.6 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.

#### 4. Beginning of Shift or Transfer of Care

- 4.1 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 (e.g., endotracheal tubes, oro/nasogastric tube, and foley catheter) according to Alberta Health Services *Invasive Line and Tubing Verification Policy*;
  - 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).
- 4.2 At beginning of shift or transfer of care, the receiving health care professional is expected to review patient orders.

#### 5. Admitted Patients in the Emergency Department

- 5.1 Assessments and reassessments shall follow the inpatient admission orders.

#### 6. 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/Nurse Practitioner. 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/Nurse Practitioner:

- 6.1 A complete set of vital signs measures is required for all patients within one (1) hour before the time of discharge or transfer from the Emergency Department or Urgent Care Centre.

- 6.2 Document any discharge instructions given to the patient or family/care providers.
- 6.3 All follow up instructions, appointments and prescriptions given are to be recorded in the health record prior to patient discharge.

## 7. Documentation

- 7.1 All assessments, reassessments, interventions and patient response to interventions shall be documented on the patient's health record.

## 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 practises within scope and role.

**Health record** means the Alberta Health Services 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.

## REFERENCES

- Appendix A *CTAS Guideline – Reassessment In Waiting Areas*
- Appendix B *Calgary Zone Specific Details Regarding More Frequent Assessment and Reassessment*
- Alberta Health Services Governance Documents:
  - *Alberta Health Services Invasive Line and Tubing Verification Policy (#PS-15)*
- Non-Alberta Health Services Documents:
  - Canadian Association of Emergency Physicians – *Canadian Triage Acuity Scale 2011*
  - Canadian Association of Emergency Physicians - *The Canadian Triage and Acuity Scale – Combined Adult/pediatric Educational Program Participant's Manual*
  - Temperature measurement in paediatrics: Position Statement. D Leduc, S Woods; Canadian Paediatric Society (CPS), Community Paediatrics Committee. Updated: October 15, 2015.

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## APPENDIX A

**CTAS Guideline – Reassessment In Waiting Areas**

*“All patients waiting for an initial assessment by a definitive care provider should be reassessed within the following time frames:*

*Level 1 – Continuous*

*Level 2 – Every 15 minutes*

*Level 3 – Every 30 minutes*

*Level 4 – Every 60 minutes*

*Level 5 – Every 120 minutes*

*The extent of reassessment depends on the presenting complaint, the initial triage level and any changes identified by the patient. Document your reassessment findings and any changes to their acuity score (which may require you to increase the priority to be seen), but never change the initial triage score.”*

CAEP (2013). *The Canadian Triage and Acuity Scale – Combined Adult/pediatric Educational Program Participant’s Manual*

## APPENDIX B

**Calgary Urban ED Zone Specific Details Regarding More Frequent Assessment and Reassessment: Based on Safety Recommendations**

Refer to Section 3.3.f:

1. Vital signs shall be assessed as frequently as every five (5) minutes to every thirty (30) minutes in the following circumstances:
  - a. During the treatment of hyperkalemia
  - b. During treatment of an asthmatic patient who is hypoxic (oxygen saturations less than 88% on room air) or who has a pediatric respiratory assessment measure (PRAM score) greater than or equal to 9.
2. Patients receiving opioids for relief of acute pain shall receive continuous cardiac and oxygen saturation monitoring (with alarms activated) as follows:

**Note:** the monitor may be portable.

  - a. the opioid order has a maximum amount of opioid indicated (morphine 20 mg or fentanyl 200 mcg) where:
    - i. a patient has received 20 mg of morphine or 200 mcg of fentanyl, while in ED, within the shortest time period allowed (20 mg morphine within 30 minutes or 200 mcg fentanyl within 15 minutes); and
    - ii. the physician orders additional analgesia; **OR**
  - b. the opioid order does not have a maximum amount of opioid indicated:
    - i. a patient has received 20 mg of morphine, or 200 mcg fentanyl, or three (3) mg hydromorphone in the shortest time period allowed (20 mg morphine within 30 minutes or 200 mcg fentanyl within 15 minutes or three (3) mg hydromorphone within 20 minutes); and
    - ii. the patient requires more analgesia to control acute pain.
3. Ongoing Reassessment:
  - a. The standard of practice for documentation of patient status for ED and Admitted patients is every four (4) hours.
4. Emergency Inpatients (admitted patients awaiting transfer to inpatient unit) Who Deteriorate
  - a. When an Emergency Inpatient develops an altered level of consciousness or an airway, breathing, or circulation problem, the following will occur:
    - i. Bedside nurse will contact the Admitting Service/Most Responsible Physician **and** the Nurse Clinician/Charge Nurse
    - ii. If the Admitting Service does not respond, or there is a delay in reassessment of the patient, then the Nurse Clinician/Charge Nurse will have an Emergency Department physician assess the patient.