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Origination	June 13th, 2023	Owner	Ben Rider
Last Approved	June 13th, 2023	Department	Emergency Department
Last Revised	June 13th, 2023	Applicability	Presbyterian/St. Luke's Medical Center
Next Review	June 12th, 2025		

Emergency Department Assessment-Reassessment

SCOPE:

This policy applies to Emergency Department patient assessment and reassessment

PURPOSE:

I. To establish guidelines for assessment of the patient's status to determine the need for care or treatment.

II. To facilitate data collection and analysis related to all aspects of the patient in order to determine the patient's specific needs and to plan a coordinated course of treatment.

III. To determine the need for further assessment.

POLICY:

I. The assessment will begin during the admission process and continue through discharge. Reassessments will be completed as patient condition warrants. Admission/shift assessment will begin upon arrival to the emergency department.

II. The data collected during each assessment and the concurrent reassessments will identify actual and potential patient needs. Reassessment may be conducted by any licensed members of the care team, as appropriate, to determine the patient's response to treatment and/or the potential for further assessment and treatment needs.

III. All assessments are documented in the patient's medical record.

PROCEDURE:

I. Definitions

A. **Screening** – Data gathered to determine need for additional or more in-depth assessment to be performed by a licensed member of our care team.

B. **Assessment** – The systematic collection and analysis of patient specific data necessary to determine patient care and treatment. This is performed by a licensed member of the care team including RN or Provider.

C. **Reassessment** – Further data collection and analysis, the scope of which is determined by the patient's diagnosis, the treatment setting, the patient's desire for treatment and the patient's response to treatment. Performed by a licensed member of the care team including RN or Provider.

II. Scope of Assessment/Data Collection by Clinician Type

1. Nursing Assessments

A. Analysis of the data collected and the nursing physical assessment is the responsibility of the registered nurse. Some portions of the data collection may be delegated to other licensed staff members as listed:

i. Registered Nurse

a. Collect information and physical assessment through Rapid initial assessment.

b. Complete a focused assessment as patient condition warrants.

c. Collect information to identify patient problems or needs and will initiate an individualized plan of care.

ii. EMT or Paramedic

a. Complete patient identification, using two identifiers.

b. Obtain intake data to include Chief complaint, full set of vital signs, height, and weight.

c. Initiate plan of care based on written orders within scope of practice.

d. Report any changes in condition or vital signs to a licensed RN or provider.

2. Patients in the waiting room will receive:

A. Rapid Initial Assessment (Rapid Triage) with assigned acuity performed by a qualified RN or a Medical Screening exam performed by a licensed provider as quickly as possible following arrival to the Emergency Department.

B. Reassessments are completed by a licensed RN or provider and may include, change in status, symptoms, response to treatment, or vital signs. Frequency of

reassessment may be determined by the patient's chief complaint, acuity, condition, symptoms, treatments and orders.

3. Patients (ESI 1-3) presenting to the Emergency Department will receive:

A. Rapid Initial Assessment (Rapid Triage) with assigned acuity performed by a qualified RN or a Medical Screening exam performed by a licensed provider as quickly as possible following arrival to the Emergency Department.

B. Chief Complaint or focused Assessment

C. Detailed Assessment

D. Suicide Risk Screening (on all patients >12 years old presenting with primary chief complaint related to behavioral health)

E. Discharge Assessment (all vital signs will be assessed prior to discharge/disposition, with any abnormal vital signs reported to physician/provider prior to departure)

4. Patients (ESI 4-5) presenting to the Emergency Department will receive:

A. Rapid Initial Assessment (Rapid Triage) with assigned acuity performed by a qualified RN or a Medical Screening exam performed by a licensed provider as quickly as possible following arrival to the Emergency Department.

B. Non-Urgent Patient Assessment

C. Suicide Risk Screening (on all patients >12 years old presenting with primary chief complaint related to behavioral health)

D. Discharge Assessment (all vital signs will be assessed prior to discharge/disposition, with any abnormal vital signs reported to physician/provider prior to departure)

III. The components of the Emergency Department Assessment and Reassessment standards are described below:

1. Screening Process:

A. Paramedics can utilize the paramedic intake process that includes collection of data such as Vital signs, height, weight and stated reason for visit.

B. EMTs will complete data collection such as vital signs, height, weight, and will complete written note with stated reason for visit.

2. Rapid Initial Assessment: The Rapid Initial Assessment is the information-collecting and decision making process to sort ill patients into categories of acuity based on the urgency of medical and psychological needs.

A. Triage Acuity Levels

i. Level 1 Resuscitation

ii. Level 2 Emergent

iii. Level 3 Urgent

iv. Level 4 Semi-Urgent

v. Level 5 Non-Urgent

3. Detailed Nursing Assessment

A. The Detailed Nursing Assessment uses data collected during the initial and/or focused assessment to determine holistic health care needs. The Detailed Assessment may include some or all aspects of the Focused Assessment, with the addition of the following:

i. Documentation of other signs, symptoms or complaints that have not been addressed elsewhere.

4. Reassessment

- All patients waiting for a Medical Screening Exam (MSE)– regardless of location - should be reassessed at least hourly from the time of arrival and more frequently based upon the clinical condition of the patient
- Prior to the MSE, the depth of the reassessment is based on acuity and chief complaint
- Once the MSE has begun – Frequency of reassessment may be determined by the patient's chief complaint, acuity, condition, symptoms, treatments and orders.

A. **Recommended Time frames for Reassessment of patients who have not received a Medical Screening Exam and may be sooner if clinically indicated:**

i. Triage Level 1 Immediate evaluation by physician

ii. Triage Level 2 Every 30 minutes

iii. Triage Level 3 Every 60 minutes

iv. Triage Level 4 Every 60 minutes

v. Triage Level 5 Every 60 minutes

B. **Recommended time frames once the Medical Screening Exam has occurred and may be sooner if clinically indicated:**

i. Triage Level 1 Vital signs and reassessments every 1 hour or sooner if clinically indicated.

ii. Triage Level 2 Vital signs and reassessments every 2 hours or sooner if clinically indicated. For Behavioral Health patients, may consider every 3 hours once medically cleared.

iii. Triage Level 3 Vital signs and reassessments every 3 hours or sooner if clinically indicated.

iv. Triage Level 4-5 Vital signs and reassessments every 4 hours or sooner if clinically indicated.

C. **The documented reassessment may involve some or all of the following:**

i. Vital sign

ii. Chief Complaint or focused Assessment

iii. Triage reassessment
iv. Pain assessment
v. General Appearance
vi. Provider documented updates to the patient regarding care plan
vii. Response to interventions or treatments

Approval Signatures

Step Description	Approver	Date
Regulatory/Quality	Sarah Bertsch: Director of Quality	June 13th, 2023
CNO Approval	John Goerke: CNO	June 13th, 2023
Quality and Risk	Michelle Grimpo: VP of Quality	June 6th, 2023
ED Medical Directors	Krista Culp: Physician/Med Staff	June 6th, 2023
ED Medical Directors	Ben Rider	May 9th, 2023
Policy Owner/ED Manager	Ben Rider	May 8th, 2023

Applicability

Presbyterian/St. Luke's Medical Center