AH1010 - EMERGENCY DEPARTMENT DOCUMENTATION OF PATIENT ASSESSMENT AND REASSESSMENT

1.0 PURPOSE

To improve the quality and safety of patient care by adopting a standard of practice for documenting initial patient assessments, reassessment and treatment in Interior Health (IH) Emergency Departments (ED)

2.0 DEFINITIONS

TERM	DEFINITION
Nursing Assessment	The initial bedside nursing assessment in the ED.
Nursing Interventions	The function of performing an act in the care of the patient; performed specifically by a Nurse or delegate.
Nursing Reassessment	Subsequent bedside nursing assessments.
Physician Assessment	The initial physician assessment in the ED.
Physician Reassessment	Subsequent physician assessments.
Triage Assessment	The initial assessment of a patient upon presentation to the ED.
Triage Reassessment	Subsequent assessments of patients while they wait to be seen.
Physician Treatment	The function of Physician performing or ordering an intervention or act in the care of the patient.

3.0 POLICY

- EDs must use standardized IH documentation records and written processes for both nurses and physicians to document. Nurses must use #826066 for their system assessments, reassessments and nursing treatments. Physicians are to document their physician assessment, reassessment and treatment information on form #826041 or #826061.

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- The Canadian Triage Assessment Score (CTAS) dictates the requirements for reassessments and the frequency of reassessments including for unstable or potentially unstable conditions.

- Physicians are required to document the patient's condition at discharge, relative to their initial assessment and subsequent Physician Reassessments. Nurses are required to thoroughly document the patient's discharge experience in the provided discharge section on the Emergency Nursing Assessment Record (ENAR) #826066.

4.0 PROCEDURE

Emergency Department Administrators

- Ensure that the ED is utilizing regional standardized documentation records:
  - Emergency Nursing Assessment Record (ENAR) #826066
  - Emergency Outpatient Record #826041 or #826061
  - BC Perinatal Triage and assessment record http://www.perinatalservicesbc.ca/Documents/Form/Form1590_PerinatalTriageAssessment.pdf
  - BC Trauma record #826486
  - My Safety Plan #822917
  - Restraint documentation #826152 and #826153
  - MHSU referral form (electronic or #826481)
  - Graphic Clinical Record # 826067
  - Neurological Record #826914
  - Transfusion record #826421
  - Input / Output record #826439
  - Interdisciplinary notes
  - Procedural Sedation Adult #814196 or pediatric #814207
  - Notice of death #855067
  - ED discharge form #826238
  - Acute to Residential Transfer form #821257

- Site specific Resuscitation documentation

- Consider:
  - HEARTSMAP www.heartsmap.ca
  - PEWS ED TBA
  - Nurse Initiated protocols TBA

- Refer to the "Guide for Use" for the ENAR

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Physicians and Nurses

- Document assessment, reassessment, and treatment information as per the patient's clinical condition.

- Note: See AH1050 for information on providing information, notifications or instructions to patients at the time of discharge.

5.0 REFERENCES

- Provincial Cochrane Report Task Group. (2005) Selected Provincial Level Recommendations: Final Report Implementation Plan. Provincial Emergency Services Project.

- National Emergency Nursing Association (NENA): http://nena.ca/w/wp-content/uploads/2014/11/Role-of-the-Triage-Nurse-2.pdf

- Canadian Triage Assessment Scale Link (CTAS): http://caep.ca/resources/ctas

- Documentation: BCCNP's professional standards require nurses to document timely and appropriate reports of assessments, decisions about client status, plans, interventions and client outcomes: https://www.bccnp.ca/Standards/RN_NP/PracticeStandards/Pages/documentation.aspx