Section:	Division of Nursing	**********	Index: 7010.086c
		* **GUIDELINE** *	Page: 1 of 8
Approval:	_____	**********	Issue Date: April 17, 2002
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_____

HACKETTSTOWN REGIONAL MEDICAL CENTER

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ED
(Scope)

TITLE: **EMERGENCY DEPARTMENT TRIAGE AND NURSES NOTES GUIDELINE (For Downtime Use Only)**

PURPOSE: To provide concise, pertinent and accurate information on patients seen in the Emergency Department (ED). This is only to be used in the event of an EMR downtime, otherwise Triage documentation will take place in Firstnet.

NATURE OF FORM: Permanent

RESPONSIBILITY:		
	Emergency Department Triage: (Page 1)	Registered Nurse
	Initial Observation: (Page 2 & 3)	Registered nurse
	Nursing Notes: (Page 3-4)	Registered Nurse or Licensed Practical Nurse

CONTENT: **PROCEDURE**:

Emergency Dept. Triage & Nurses Note Form

* Stamp date and time of patient's arrival

1. Check appropriate triage status according to 5-level triage as per the policy and assessment
2. Check mode of arrival, write in name of squad and name of ALS who accompanied patient if applicable.
3. Check with whom patient arrived and write in name.
4. Enter patient's first and last name
5. Check appropriate box for sex: male or female
6. Enter age
7. Write in date of last tetanus shot; if patient not sure write **unknown.**
8. Check appropriate boxes for treatment in progress on arrival, write in IV solution, size of catheter and location, O_2 and any other treatment given.
9. Check if patient is the informant/write in name if other than patient.
10. Document patient's chief complaint and any pertinent subjective information.
11. Document objective findings.
12. Document time of onset of symptoms.
13. Document mechanism of injury, if illness check NA
14. Weigh patient in kilograms and measure patient in centimeters and document
15. Ask patient for date of last menstrual period
16. Document if patient is pregnant or breastfeeding
17. If child $\leq$ 2 years is presenting with a head injury or history of hydrocephelas, enter head circumference, otherwise check N/A

18. Enter temperature and check appropriate box for means of obtaining
19. Enter B/P and check box for right or left extremity
20. Enter pulse
21. Enter respirations
22. Measure and document patients pulse ox
23. Write in room air (RA) or amount of O_2 used
24. Check interpretation needed: **yes or no**
25. Document, initial pain level, circle pain scale used, write in immediate intervention, check box when pain management reviewed with patient or significant other.
26. Document if vaccines are current for pediatric patients
27. Enter any allergies and type of reaction or check box **patient denies allergies.**
28. Check appropriate box for disposition of medication (if brought to HRMC)
29. If patient is taking medication at home, complete Med Reconciliation form as per policy.
30. Document past medical/surgical history or any hospitalizations or check **none/denies**
31. Document communication barriers/deficits. Barriers to learning by checking yes/no box. If patient denies barriers check yes in denies. No further documentation needed.
32. Document by checking yes/no box for alcohol use and write in amount per day.
33. Document by checking yes/no for illicit (street) drug use and write in explanation if yes.
34. Document by checking yes/no for caffeine intake and document amount daily.
35. Document by checking yes/no for tobacco use by patient or family member. Circle patient or family member. Check off type of tobacco and write in amount per day, length of time smoked and time of last smoke.
36. Document name of patient's primary physician. Check yes/no if patient contacted physician.
37. Document nursing action in appropriate space. If x-ray, write in specific area and laterality.
38. Signature of triage RN
39. Circle room number patient is brought to
40. Document time patient brought to room.
41. Signature of person bringing patient into room
42. Signature of nurse reviewing page 1 (Admission LPN/RN)
43. Document date and time of review
44. If patient is admitted or sent to OR, complete document is patient has had recent exposure to communicable disease. If **yes** explain.
45. Document if travel outside US within last 6 months. If yes, document country.
46. Check if history or MRSA/VRE. If **yes**, explain.
47. Document last flu vaccine
48. Document last pneumococal vaccine
49. Check **yes or no** for previous blood transfusion and explain
50. Check if reaction to anesthesia and explain
51. Check for family history of reaction to anesthesia and explain
52. Any use of cortisone, prednisone or other steroids used in last two years.
53. Signature of nurse completing admission section page 2

PAGE 2

54. Review and document by checking boxes, patient teaching done: r/t call bell, unit/room environmental, siderail procedure.
55. Assess and document in check box general appearance
56. Assess and document in check box or fill in skin assessment
57. Assess and document in check box patient's speaks a foreign language, if document language.
58. Assess and document in check box patient's gait
59. Assess and document neuromuscular status including whether rings removed and dominant hand if applicable.
60. Assess and document in check box patient's pulses.
61. Assess and document capillary refill if indicated.
62. Assess and document cardiovascular status in check box.
63. If patient complains of chest pain, fill in type, location, intensity, radiation, duration and any other comments.
64. Assess and document mental status in check box.
65. Assess and document neurological status by circling findings and total score
66. Assess and document pupil size and reaction if applicable

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67. Assess and document respiratory status.
68. Document peak flow, O_2 in use or room air (FA), O_2 sat if applicable.
69. Assess and document abdominal status in check box or check not applicable NA
70. Assess and document GU/GYN status, document foley size of applicable or check NA
71. Assess and document visual acuity or in both eyes and circle yes or no with corrective lenses if applicable.
72. Assess and document pain assessment for chronic pain. Write in location of pain. Check type of pain and duration: check constant/intermittent. Intensity: circle appropriate level face as stated by patient. What relieves pain: check box(es) that apply or fill in patient's statement. *Document if patient/family verbalized understanding of pain scale.
73. Assess and document pain assessment (pain related to this admission). Write in location of pain. Check box for type of box and duration: check constant/intermittent. Intensity: circle appropriate level face as stated by patient. What relieves pain: check box(es) that apply or fill in patient's statement. *Document if patient/family verbalized understanding of pain scale.
74. Document nursing diagnosis specific to patient.
75. Document plan and implementation of interventions, noting time and initial as indicated.
76. Ask patient if s/he feels unsafe or abused in the home environment; check box **yes/no.** If yes, explain and follow Abuse Policy. (This question is asking if patient is being abused.)
77. RN to initial
78. RN's signature
79. Assess and document pain, write in time, location, pain level 0-10 scale, intervention, initials.
80. Reassess and document patient's response to pain intervention per Policy 8620.034a: write in time, pain level 0-10 scale, comments and initials.

81. Write in time, medication administered, dose, route and initial each entry. Write stop time for all medications including IV solution therapy.

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82. Write vital signs as per reassessment policy and as indicated.
83. Write in focus entry.
84. Document using D.A.R. format
85. Time and initial each entry
86. Document time PMD called and time responded
87. Document if patient is admitted: to floor, to room number and to whom report was given
88. Write in po and IV intake
89. Write in urine output, check if patient voiding, if Foley inserted write in initial output upon insertion then total urine output.
90. Document vital signs and pain level upon discharge or transfer
91. Document discharge time including mode and by whom patient is accompanied. If patient leaves against medical advice, check appropriate box.
92. Document if patient expires and notifications
93. Document if patient is transferred: to where, method of transport, completion of EMTALA form documented.
94. Document
95. Write in time private medical doctor called
96. Write in time private medical doctor responded
97. If patient elopes, write in time and document in nurses notes pertinent information.
98. If transferred or admitted document name of person receiving report.
99. Document name of person receiving patient.
100. Document discharge instructions given by circling written/verbal, write in name of relationship to patient receiving instruction and understanding of instructions.
101. Document name of nurse/physician giving discharge instructions.
102. Write in any additional comments/interventions of discharge instructions including Rx given, school/work notes given
103. Initials of RN
104. Signature of RN

ED ONLY / TRIAGE

TRIAGE STATUS: (1) 1 2 3 4 5

MODE OF ARRIVAL: ☐ Ambulatory ☐ Squad (2) ☐ ALS ☐ Carried ☐ Stretcher ☐ Wheelchair

ARRIVED WITH: ☐ Self ☐ Parent ☐ Spouse ☐ Friend ☐ Son ☐ Daughter ☐ Police ☐ Other (3)

NAME: (4)

AGE: (6)

☐ Male ☐ Female (5)

LAST TETANUS DATE: ☐ Within 5 Yrs ☐ More Than 5 Yrs ☐ N/A (7)

TREATMENT IN PROGRESS ON ARRIVAL: ☐ N/A ☐ CPR ☐ ET Tube ☐ S/P Collar ☐ IV ☐ CID ☐ Restraints ☐ Backboard ☐ NTG ☐ Monitor ☐ Splint ☐ Aspirin ☐ EKG ☐ Other ☐ FiO_2 (8)

INFORMANT: (9) ☐ Patient ☐ Other

CHIEF COMPLAINT / SUBJECTIVE: (10)

OBJECTIVE FINDINGS: (11)

(21)

ED / HOSPITAL ADMISSION DATA BASE

WEIGHT: (12) kg

HEIGHT: (12)

LMP: (13)

Pregnant- ☐ Y ☐ N ☐ ?

Breastfeeding- ☐ Y ☐ N (14)

VITAL SIGNS: TEMP: (15) ☐ Oral ☐ Rectal ☐ Axillary; BLOOD PRESSURE: (16); PULSE: (17); RESP: (18); PULSE OX: (19); O_2 AMT: (20)

PEDIATRIC PATIENTS ONLY:

Vaccines Current: ☐ Yes ☐ No, Explain: (24)

ALLERGY / *Reaction Information:* To ***Medication, Food, Herbs or Latex.***

List ***ALL with corresponding reaction.*** ☐ **Patient Denies Allergies** (25)

INTERPRETER NEEDED: ☐ Yes ☐ No ☐ Refused Interpreter

☐ Language (22) or ☐ American Sign Language

Provided by

INITIAL PAIN LEVEL: (23) Scale: N B NIPS FLACC Facial

Immediate Intervention:

Pain Management reviewed with patient or significant other: ☐ Yes ☐ No ☐ Unable

MEDICATIONS: See MRF- Include use of prescribed, birth control pills, respiratory treatments, over-the-counter, herbal remedies, teas, vitamin therapy, complementary therapies. (26) ☐ **Patient on No Medication**

MEDICAL/SURGICAL HISTORY INCLUDING HOSPITALIZATIONS *(Include Date & Location)* ☐ **None / Denies** (27)

History of Resistant Antibiotic Organism? ☐ No ☐ Yes, explain: (28)

Alcohol Use: ☐ No ☐ Yes, Amt. per day: (29)

Substance Use: ☐ No ☐ Yes, Amt. per day: (30)

If Yes, type:

Caffeine: ☐ No ☐ Yes, Amt. per day: (31)

Tobacco Use by patient or family member: ☐ No ☐ Cigarettes ☐ Cigar / Pipe ☐ Chewing Tobacco **How many years?** (32)

Amt. per day: How long ago did you stop?

Barriers to Communication and Learning ☐ Denies (33)

	Y	N		Y	N	Comments
Physical limitation			Cultural/Religious beliefs			
Emotional			Non English speaking			
Developmental			Able to read in native language			
Cognitive limitation (read/write)						

Learning Needs- Learning Style: ☐ Reading ☐ Visual ☐ Hearing ☐ Written ☐ Doing

	Y	N	Comments
Able to read and comprehend English			
Desire and motivation to learn			

PMD: (34) Patient notified PMD- ☐ Yes ☐ No

NURSING ACTION: ☐ N/A ☐ Aseptic Dressing ☐ Wound Cleansed ☐ Elevation ☐ Other (35) ☐ Dry Sterile Dressing ☐ Ice ☐ Splint ☐ Urine Container Given ☐ Xray ☐ Left ☐ Right

NURSE'S SIGNATURE (Completing): (36) DATE: TIME:

ADMIT To: (37)

ROOM: 1 2 3 4 5 6 7 8 9 10 11 12D 12W Time in ED: (38) By: (39)

Hackettstown Regional Medical Center

H0007082

Form 7092 (10/02/08)

EMERGENCY DEPARTMENT NURSES NOTES - Page 1

The following items were reviewed with the patient and/or Significant Other: ☐ Call Bell ☐ Unit/Room Environment ☐ Side Rails (40)

INITIAL ASSESSMENT

GENERAL APPEARANCE: (41)
☐ Facial features symmetrical, Conjunctivae moist and pink, No observable masses or abnormalities.
☐ Frail ☐ Obese ☐ Emaciated ☐ Other _____

SKIN ASSESSMENT: (42)
☐ Skin warm, dry and intact. Mucous membranes pink and moist. No cyanosis or jaundice noted. No rashes, blisters, lesions, ecchymosis noted.
☐ Pale ☐ Jaundiced ☐ Cool
☐ Flushed ☐ Mottled ☐ Hot ☐ Other _____ ☐ Transdermal Patch _____
☐ Cyanotic ☐ Rash ☐ Diaphoretic ☐ Body Piercings _____

SPEECH: ☐ Clear and understandable. (43)
☐ Loud ☐ Talkative
☐ Slurred ☐ Mumbling ☐ Foreign Language _____

GAIT: ☐ Steady ☐ Unsteady (44)
☐ Other _____

NEUROMUSCULAR: ☐ **N/A** (45)
☐ Absence of joint swelling/tenderness. No muscle weakness/contractions/atrophy. ROM of major joints. No paralysis, weakness, numbness or tingling noted.
Location: _____ ☐ Swelling ☐ Discoloration ☐ Deformity
☐ Pain with: ☐ *Movement* ☐ *Weight Bearing* ☐ *Palpation*
☐ History of Previous Injury ☐ Abnormal Sensation or ROM: _____
☐ Broken Skin ☐ Rings Removed Dominant Hand: ☐ Left ☐ Right

CARDIOVASCULAR: ☐ **N/A** ☐ Regular apical pulse. No edema, S1 S2 clear. (46)
☐ Heart Rate Irregular ☐ JVD
☐ Implantable Device _____ Insertion Date _____ ☐ Other _____
Chest Pain: Type (47) _____ Location _____ Intensity _____ (0-10
Radiating _____ Duration _____ Comments: _____

Edema: Location/Assessment- ☐ None ☐ Non-pitting Pitting: ☐ 1+ ☐ 2+ ☐ 3+ ☐ Anasarca **Capillary Refill:** ☐ Normal ☐ Sluggish
Pulses: (0 = absent; D = doppler; 1+ = weak/thready; 2+ = normal; 3+ = bounding)
Radial- R _____ L _____ Post Tibial- R _____ L _____ D. Pedal- R _____ L _____

RESPIRATORY: ☐ **N/A** (48)
☐ Respirations 12-20/minute for adult, even and easy at rest. Breath sounds bilaterally clear and equal. Denies shortness of breath. No cough noted.

Respirations:
☐ Assisted ☐ Labored ☐ Retractions
☐ Shallow ☐ Nasal Flaring ☐ Orthopnea
☐ Deep ☐ Stridor
☐ Other _____

Cough:
☐ Nonproductive
☐ Productive, Sputum Color _____
Sputum Consistency _____

Breath Sounds:
Wheezes ☐ R ☐ L Peak Flow: _____
Decreased ☐ R ☐ L
Rales ☐ R ☐ L O_2: _____
Rhonchi ☐ R ☐ L
Absent ☐ R ☐ L O_2 Sat: _____

MENTAL STATUS ASSESSMENT: ☐ Awake, alert and oriented to person, place and time. Behavior appropriate to situation.
Affect: ☐ Aggressive ☐ Defensive ☐ Unable to assess ☐ Flat ☐ Hostile ☐ Crying ☐ Unresponsive
Thoughts: ☐ Disorganized ☐ Hallucinating ☐ Slow to respond
Memory: ☐ Impaired ☐ Confused (49)

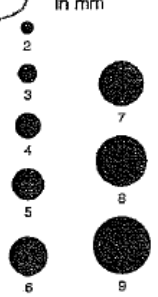
PSYCHOSOCIAL ASSESSMENT: (50)
Has anyone ever physically or emotionally abused you? . . . ☐ Yes ☐ No If Yes, explain: _____
Has anyone taken your money or withheld/prevented you from obtaining food/shelter/medical care, etc.? . . . ☐ Yes ☐ No
Do you have concerns about your safety in returning home? . . . ☐ Yes ☐ No

NEUROLOGICAL ASSESSMENT: ☐ Absence of dizziness, headache or seizures. Pupils equal, round and reactive to light. (51)
Complete neurological assessment below if above neurological assessment and mental status abnormal.

			R	L
Eyes Open: **Closed by** Swelling = C	Spontaneously	4		
	To Speech	3		
	To Pain	2		
	None	1		
Verbal Response: ET tube or Trach = T	Oriented	5		
	Confused	4		
	Inappropriate Words	3		
	Incomprehensible Sounds	2		
	None	1		
Motor Response: Usually record best arm response	Obeys Commands	6		
	Localizes Pain	5		
	Flexion-Withdraws	4		
	Flexion-Abnormal	3		
	Extension	2		
	None	1		
	TOTAL SCORE:			
Arms: Record Left and Right Sides	Normal Strength	5		
	Good Strength	4		
	Fair Strength	3		
	Weak Movement	2		
	Trace	1		
	No Muscle Movement Pronator Drift +/–	0		
Legs: Record Left and Right Sides	Normal Strength	5		
	Good Strength	4		
	Fair Strength	3		
	Weak Movement	2		
	Trace	1		
	No Muscle Movement	0		
Plantar Flex and Dorsiflex:	Normal Strength	5		
	Good Strength	4		
	Fair Strength	3		
	Weak Movement	2		
	Trace	1		
	No Muscle Movement	0		

EYES: Size R _____ L _____ Reaction R _____ L _____ (52)

PUPILS SIZE In mm



PUPIL REACTION:
S = Sluggish
F = Fixed B = Brisk
C = Swollen Closed
X = Not Bound

Form 7082 (10/02/0

INITIAL ASSESSMENT - *Continued*

ABDOMEN: ☐ N/A (53)
☐ Soft, bowel sounds present in all quadrants. No pain, masses, distention or rigidity on palpation. No nausea/vomiting noted. Denies blood in stool, diarrhea or constipation.
☐ Rigid ☐ Absent BS ☐ Nausea ☐ Diarrhea ☐ Tender _____
☐ Distended ☐ Vomiting ☐ Constipation Comments: _____

GU / GYN: ☐ N/A (54)
☐ Denies pain or burning. Denies incontinence, frequency, hematuria, nocturia and retention. No urinary diversion/ostomy noted. No vaginal bleeding. No penal discharge.
☐ Urgency ☐ Burning ☐ Dysuria ☐ Discolored _____ ☐ Vaginal Bleeding _____ ☐ Discharge _____
☐ Frequency ☐ Anuria ☐ Incontinence
☐ Foley in Place:

VISUAL ACUITY: ☐ N/A ☐ WNL (55)
With Corrective Lens- ☐ Yes ☐ No ☐ Both _____ L _____ R _____

PAIN ASSESSMENT: *Not Related To This Admission* (CHRONIC) (56)
Pain/Discomfort: ☐ No ☐ Yes - Where? _____
Type: ☐ Burning ☐ Dull ☐ Pressure ☐ Heavy ☐ Sharp ☐ Cramping ☐ Other _____
Duration: ☐ Constant ☐ Intermittent
Intensity: _____ (0-10) / N / B / BIPS / FLACC / Facial
What Relieves the Pain? _____
☐ Resting ☐ Heat ☐ Cold ☐ Medication

PAIN ASSESSMENT: *Related To This Admission* (ACUTE) (57)
Pain/Discomfort: ☐ No ☐ Yes - Where? _____
Type: ☐ Burning ☐ Dull ☐ Pressure ☐ Heavy ☐ Sharp ☐ Cramping ☐ Other _____
Duration: ☐ Constant ☐ Intermittent
Intensity: _____ (0-10) / N / B / BIPS / FLACC / Facial
What Relieves the Pain?
☐ Resting ☐ Heat ☐ Cold ☐ Medication

NURSING DIAGNOSIS: (58)
☐ Knowledge Deficit
☐ Mobility Impaired
☐ Alteration in Comfort
☐ Sensory/perception Altered
☐ Impaired Skin Integrity
☐ Potential for injury
☐ Fluid Volume Deficit
☐ Fluid Volume Excess
☐ Altered Tissue Perfusion
☐ Altered Thought Process
☐ Potential for Violence
☐ Compliance with Previous Plans for Sober Life
☐ Impaired Gas Exchange
☐ Ineffective Breathing Pattern
☐ Urinary Elimination/Alteration
☐ Bowel Elimination/Alteration
☐ Other _____

PLANS AND IMPLEMENTATION: (59)

Action	*Time*	*Initials*	*Action*	*Time*	*Initials*
☐ Prepared for Exam			☐ Restraints		
☐ Explain Procedure			☐ Emotional Support		
☐ Brakes On			☐ Staff/Family Comm		
☐ Side Rails Up			☐ Explain Wait Time		
☐ Bed/Litter in Low Position			☐ Soak:		

PAIN

TIME	LOCATION	LEVEL	INTERVENTION	INIT
	(60)			

PAIN REASSESSMENT

TIME	LEVEL	COMMENTS	INIT
		(62)	

Intensity (Level) 0-10: (0 = no pain – 10 = worst pain imaginable) A = asleep Reassessment with intensity scale

MEDICATIONS

TIME	MEDICATION	DOSE	ROUTE	Stop Time	INIT	TIME	MEDICATION	DOSE	ROUTE	Stop Time	INIT
	(63)										

CRITICAL TEST RESULTS

TIME	TEST	RESULT	READ BACK TO	MD NOTIFIED	TIME	INITIALS
	(64)					

NURSES NOTES

TIME	BP	PULSE RHYTHM	RESP O_2SAT	T	NURSES NOTES	INITIALS
	(65)				(66)	(67)

TIME	INTAKE	TIME	OUTPUT
	(68)		Foley:
			Initial Foley Output: (69)
TOTAL			TOTAL

PMD CALLED AT: (70) | RESPONDED AT:

VITAL SIGNS AND PAIN LEVEL AT DISCHARGE OR TRANSFER

TEMP	HR (71)	RESP	BP	O_2 SAT	PAIN LEVEL

DISCHARGE: Time: (72)
Mode: ☐ Ambulatory ☐ Stretcher ☐ W/C ☐ Ambulance ☐ Carried
☐ AMA, form signed
☐ Eloped
Accompanied by: _____

TRANSFERRED: To: (75)
Via:
Squad: _____
☐ EMTALA completed
☐ ACLS ☐ BLS
☐ Helicopter

EXPIRED: (76)
☐ ME called
☐ Family notified
☐ Sharing Network notified

☐ Discharge Instructions Given: ☐ Written ☐ Verbal - Given to: (73) Given by: (74)
☐ Patient/Family verbalizes understanding of teaching instructions.

ADMITTED TO: (77)

Recent exposure to communicable disease within the past month? ☐ Yes ☐ No - If Yes, explain: (78)

Any travel outside the U.S. within the last 6 months? ☐ Yes ☐ No - If Yes, explain: (79)

Blood Transfusion reaction? (80) ☐ Yes ☐ No Cortisone, Prednisone or other steroids use in last 2 years? (83) ☐ Yes ☐ No Last Flu vaccine? (84) _____

Reaction to Anesthesia? (81) ☐ Yes ☐ No Family history of reaction to anesthesia? (82) ☐ Yes ☐ No Last Pneumococcal? (85) _____

If Yes to answer, explain: (86)

INITIALS	SIGNATURE	INITIALS	SIGNATURE
(87)	(88)		
INITIALS	SIGNATURE	INITIALS	SIGNATURE

Form 7082 (10/02/08)