

Assessment and Reassessment of the Emergency Department Patient

	Initial Assessment	Ongoing reassessment minimum	Minimum stable reassessment minimum	Frequent reassessments (Every 1-30 min.)	Beginning of shift assessment	Discharge or transfer VS	Patient transport (Nurse escort)
Patient requiring Cardiac monitoring	<ul style="list-style-type: none"> • Primary and secondary assessment 	Every hour	Minimum of every 4 hours based on patient's condition and physician order	<ul style="list-style-type: none"> • When VS are not within expected limits of the patient's baseline • Following the administration of medication with the potential to alter VS such as narcotics or anti-arrhythmic • Following any intervention or procedure that has the potential to alter patient status such as IV bolus or invasive procedures • Any deteriorating change in patient status. 	<ul style="list-style-type: none"> • Head to toe • VS • Lines/tubes/infusions • Rhythm strip - analyzed • Plan 	VS within 1 hour Follow safe discharge policy	Minimum every 15 minutes, more frequent based on patient condition Focused Plus*
Non-Cardiac monitoring	<ul style="list-style-type: none"> • Primary and secondary assessment 	Every 2 hours			<ul style="list-style-type: none"> • Head to toe or Focused • Plus* • Lines/tubes/infusions • Plan 	VS within 1 hour Follow safe discharge policy	Hourly Focused
Meets Minor Treatment Criteria	<ul style="list-style-type: none"> • Focused • Plus * -Pain -Level of consciousness -skin -Vital Signs (VS) -Respiratory status/Airway 	Every 4 hours			<ul style="list-style-type: none"> • Focused • Plus* • Plan 	Patients treated for minor conditions and who have normal vital signs documented may not need Complete Vital Signs within one (1) hour of discharge (e.g. lacerations).	Not Applicable (N/A)
<p>Assess, identify problems, set problem specific goal/objective for patient, address interventions to alleviate problem, re-evaluate.</p> <p style="text-align: center;">Assessment Frameworks.</p> <p>Primary and secondary assessment - A-airway, B-breathing, C-circulation, D-disability, E-expose, F-focused/critical actions, G-give comfort measures, H-history and head to toe, I-inspect posterior</p> <p>Focused Assessment - A highly specific assessment, focusing on the system or systems involved in the patient's entrance complaint, history and level of distress.</p> <p>Plus* - Vital Signs (VS), Pain, Level of consciousness (LOC), Skin, Respiratory status/airway</p> <p>Ongoing Reassessment - An ongoing, focused, chronological assessment of patient status which includes vital signs, physical assessments, pain assessment and scale, treatments administered and responses to treatment(s) and ongoing plan of care.</p>							