

Date/Time of Triage: October 30, 2024 1645hrs

<p>Gender Pronouns: <input type="checkbox"/> He/Him <input checked="" type="checkbox"/> She/Her <input type="checkbox"/> They/Them</p> <p>Accompanied by: <input checked="" type="checkbox"/> Self <input type="checkbox"/> Other _____</p> <p>Treatment prior to arrival: <input checked="" type="checkbox"/> None</p> <p><input type="checkbox"/> CPR initiated <input type="checkbox"/> Defibrillation <input type="checkbox"/> Cardiac Monitor</p> <p><input type="checkbox"/> Bag-valve Mask <input type="checkbox"/> C-collar <input type="checkbox"/> Backboard <input type="checkbox"/> Splint</p> <p><input type="checkbox"/> Oxygen (L/min): _____ <input type="checkbox"/> IV: _____</p> <p><input type="checkbox"/> Dressing <input type="checkbox"/> Meds given: _____</p>	<p>Travel History: Have you travelled outside Canada in the past month? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, where? _____</p> <p>Have you been in contact with anyone who has travelled outside of Canada in the past month? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Have you been told to self-monitor for any communicable disease? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Infection Control: Positive for current screening criteria (i.e. ILI, FRI, Ebola): <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Type: _____</p> <p>Isolation Precautions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, Type: _____</p>
<p>Reason for visit/Subjective</p> <p>Assessment: _____</p> <p><u>Patient was playing hockey this afternoon and was body checked on the ice.</u> <u>Patient states "two players fell on me in a pile up and I felt my left knee pop".</u> <u>She thinks it might be broken.</u></p> <p>_____</p> <p>_____</p> <p>Objective Assessment (and critical first look):</p> <p><u>Patient limps into the department leaning on someone for support. Patient cannot put weight on her left leg. Patient grimacing in pain, is distractible and able to focus when conversing. Patients left knee is swollen and deformed, colour is pink, cap refill 2 secs, has sensation and movement to toes and pedal pulses are present.</u> <u>Gave patient an ice pack and Tylenol for pain, instructed to keep it elevated as tolerated.</u></p>	<p>Vital Signs:</p> <p>Temperature: <u>36.9</u> Route: <u>oral</u></p> <p>Heart Rate: <u>87</u> <input type="checkbox"/> Irregular</p> <p>Respiratory Rate: <u>20</u></p> <p>SpO2: <u>100%</u> <input checked="" type="checkbox"/> on R/A <input type="checkbox"/> O2 @ _____ L/min</p> <p>BP L arm: <u>140</u> / <u>89</u></p> <p>BP R arm: _____ / _____</p> <p>Pain Scale (0-10): <u>7</u></p> <p>Weight (kg): <u>94</u></p> <p>Blood Glucose: _____</p>
<p>Airway: <input checked="" type="checkbox"/> Patent <input type="checkbox"/> Obstructed <input type="checkbox"/> ETT <input type="checkbox"/> Trach</p> <p><input type="checkbox"/> Other: _____</p> <p>Breathing: <input checked="" type="checkbox"/> Regular <input checked="" type="checkbox"/> Spontaneous <input checked="" type="checkbox"/> Symmetrical <input type="checkbox"/> Irregular</p> <p><input type="checkbox"/> Assisted <input type="checkbox"/> Laboured <input type="checkbox"/> Absent <input type="checkbox"/> Asymmetrical</p> <p><input type="checkbox"/> Other: _____</p>	<p>Circulation: <input checked="" type="checkbox"/> Pink <input checked="" type="checkbox"/> Warm <input checked="" type="checkbox"/> Dry <input type="checkbox"/> Dark pigment <input type="checkbox"/> Pale</p> <p><input type="checkbox"/> Hot</p> <p><input type="checkbox"/> Flushed <input type="checkbox"/> Diaphoretic <input type="checkbox"/> Cyanotic <input type="checkbox"/> Cool <input type="checkbox"/> Mottled</p> <p><input type="checkbox"/> Jaundiced</p> <p>Cap Refill: <input checked="" type="checkbox"/> 2 secs or less <input type="checkbox"/> more than 2 secs</p> <p><input type="checkbox"/> Other: _____</p>
<p>Medications: <input type="checkbox"/> None <input type="checkbox"/> E-chart <input type="checkbox"/> See BPMH Source: <input checked="" type="checkbox"/> Patient <input type="checkbox"/> Family <input type="checkbox"/> Other: <u>Vitamin B12, Vitamin D</u></p> <p>_____</p> <p>_____</p>	
<p>Immunizations up to date: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Date of last Tetanus/Diphtheria: _____</p>	
<p>Medical/Surgical History: <input type="checkbox"/> No med/surg history</p> <p>List: _____</p> <p>_____</p>	
<p>Allergies: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, list and describe: <u>Codeine - rash</u> Allergy Identifier applied: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p>	
<p>Fall in the last year: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, Apply identifier and Complete Schmid Falls Risk Screening Tool on secondary assessment (on page 2)</p>	
<p>Screen for Violence: <input checked="" type="checkbox"/> Completed <input type="checkbox"/> Unable to assess & rationale: _____</p>	
<p>Mental Health: Suicide Screening, Risk Assessment & Care Planning form CLI.4510.PL.010.FORM.01</p>	

Triage Treatment: None C-collar Elevate Ice Sling Splint Wound Care EKG Lab Other: _____
 Nurse Initiated Protocol: ED adult clinical decision tool Nurse Initiated Medication(s): Acetaminophen 1000mg PO
If applicable, proceed to standardized care map or clinical protocol (describe): _____

Presenting Complaint (CEDIS): Lower Extremity Injury

CTAS Acuity Score: <input type="checkbox"/> Level 1 Resuscitation <input type="checkbox"/> Level 2 Emergent <input checked="" type="checkbox"/> Level 3 Urgent <input type="checkbox"/> Level 4 Less Urgent <input type="checkbox"/> Level 5 Non Urgent	<input type="checkbox"/> Scheduled Visit <i>(all scheduled visits require a CTAS score)</i>	Disposition post triage: <input checked="" type="checkbox"/> ED waiting room <input type="checkbox"/> Trauma Room <input type="checkbox"/> Treatment Area <input type="checkbox"/> Walk-in/ Doctor's office <input type="checkbox"/> Other: _____	Instruct patient to let the nurse know if they: <input type="checkbox"/> Start to feel worse OR <input type="checkbox"/> Notice any changes to your symptoms OR <input type="checkbox"/> Have any new health concerns OR <input type="checkbox"/> They plan to leave before being seen by a doctor/health professional
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Triage Nurse Signature and Designation: _____

CTAS Modifiers Resource: *Use CTAS Interactive Quick Look booklet*

Complaint Specific Modifiers: N/A Assigned: Obvious Deformity - CTAS 3

Respiratory Distress: <input type="checkbox"/> Severe (1) <input type="checkbox"/> Mild (3) <input type="checkbox"/> Moderate (2) <input checked="" type="checkbox"/> None Hemodynamic Stability: <input type="checkbox"/> Shock/Severe End Organ hypoperfusion (1) <input type="checkbox"/> Hemodynamic compromise/Borderline Perfusion (2) <input type="checkbox"/> VS upper or lower ends of normal (3) <input checked="" type="checkbox"/> Normal Vital signs (4, 5)	Temperature Adults: <input type="checkbox"/> Greater than 38° <input type="checkbox"/> Less than 36° <input checked="" type="checkbox"/> Normal <i>If temp greater than 38° or less than 36° and:</i> <input type="checkbox"/> Immunocompromised (2) <input type="checkbox"/> Looks Septic (2) <input type="checkbox"/> Looks unwell (3) <input type="checkbox"/> Looks well (4)	High Risk Mechanism of Injury: <input type="checkbox"/> General Trauma (2) <input type="checkbox"/> Head trauma (2) <input type="checkbox"/> Neck trauma (2)	Bleeding Disorder: <input type="checkbox"/> Life or limb threatening (2) <input type="checkbox"/> Moderate/Minor (3)																																																	
	Temperature Pediatrics: <input type="checkbox"/> Temp greater than 38.5° or less than 36° and is 0 to 3 months old (2) <input type="checkbox"/> Immunocompromised and all ages (2) ➤ <i>If age greater than 3 months to 18 months and:</i> <input type="checkbox"/> looks unwell (2) <input type="checkbox"/> looks well (3) ➤ <i>If age greater than 18 months and:</i> <input type="checkbox"/> looks unwell (3) <input type="checkbox"/> looks well (4)	Hypertension: SBP greater than 220mmHg or DBP greater than 130mmHg: <input type="checkbox"/> with symptoms (2) <input type="checkbox"/> no symptoms (3) SBP 200-220mmHg or DBP 110-130: <input type="checkbox"/> with symptoms (3) <input type="checkbox"/> no symptoms (4)	Blood Glucose: Hyperglycemia (greater than 18mmol/L): <input type="checkbox"/> with symptoms (2) <input type="checkbox"/> no symptoms (3) Hypoglycemia (less than 4mmol/L): <input type="checkbox"/> with symptoms (2) <input type="checkbox"/> no symptoms (3)																																																	
Level of Consciousness: <input type="checkbox"/> Unconscious: GCS-3-9 (1) <input type="checkbox"/> Altered: GCS 10-13 (2) <input checked="" type="checkbox"/> Normal: GCS 14-15 (3, 4, 5)	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th colspan="2">Pain:</th> <th colspan="2">Adult Central</th> <th colspan="2">Adult Peripheral</th> </tr> <tr> <td></td> <td></td> <td>Chronic</td> <td></td> <td>Chronic</td> <td></td> </tr> <tr> <td>Acute</td> <td></td> <td></td> <td>Acute</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Severe 8-10</td> <td>2</td> <td>3</td> <td><input type="checkbox"/> Severe 8-10</td> <td>3</td> <td>4</td> </tr> <tr> <td><input type="checkbox"/></td> <td>3</td> <td>4</td> <td><input checked="" type="checkbox"/> Moderate 5-7</td> <td>4</td> <td>5</td> </tr> <tr> <td><input type="checkbox"/></td> <td>4</td> <td>5</td> <td><input type="checkbox"/> Mild 0-3</td> <td></td> <td></td> </tr> <tr> <td>Moderate 5-7</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Mild 0-3</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>		Pain:		Adult Central		Adult Peripheral				Chronic		Chronic		Acute			Acute			<input type="checkbox"/> Severe 8-10	2	3	<input type="checkbox"/> Severe 8-10	3	4	<input type="checkbox"/>	3	4	<input checked="" type="checkbox"/> Moderate 5-7	4	5	<input type="checkbox"/>	4	5	<input type="checkbox"/> Mild 0-3			Moderate 5-7						<input type="checkbox"/> Mild 0-3						Dehydration: <input type="checkbox"/> Severe dehydration (1) <input type="checkbox"/> Moderate dehydration (2) <input type="checkbox"/> Mild dehydration (3) <input type="checkbox"/> Potential dehydration	Others, If applicable: <input type="checkbox"/> Frailty Modifier (3) <input type="checkbox"/> Mental Health modifiers <input type="checkbox"/> Pregnancy Modifiers
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Schmid Falls Risk Screening Tool: Complete this assessment to identify the level of risk the patient may experience

Risk Factors	Response	Score (circle)	Risk Factors	Response	Score (circle)
	If more than one response applies, Select ONE response with the HIGHEST score			If more than one response applies, Select ONE response with the HIGHEST score	
1. Mobility	▪ Ambulates with no gait disturbance	0 1	4. Prior	▪ Yes- Before admission (home/previous in-patient care)	1 2

Triage and Emergency Department Record

	<ul style="list-style-type: none"> ▪ Ambulates or transfers with assistive device or assist ▪ Ambulates with unsteady gait and no assistance ▪ Unable to ambulate or transfer 	1 0	Fall History	<ul style="list-style-type: none"> ▪ Yes - During stay in ED. ▪ No ▪ Unknown 	0 1
2. Cognition	<ul style="list-style-type: none"> ▪ Alert, orientated x 3 ▪ Periodic confusion ▪ Confusion at all times ▪ Comatose/Unresponsive 	0 1 1 0	5. Current Medications	<ul style="list-style-type: none"> ▪ Any meds for sleep, mood control, antiarrhythmics, anti-hypertensives, diuretics, diabetes, seizures, narcotics ▪ None of the above medications 	1 0
3. Elimination	<ul style="list-style-type: none"> ▪ Independent in elimination ▪ Independent with frequency or diarrhea ▪ Needs Assistance with toileting ▪ Incontinence 	0 1 1 0	Total Score: _____ For Score of 3 or greater, implement Falls Prevention and Management Protocol. Implemented <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		

Required Measures: <input checked="" type="checkbox"/> Universal Interventions for all patients <input type="checkbox"/> Hourly Rounding for all patients <input type="checkbox"/> If mobility risks present, mobilize with assist <input type="checkbox"/> If mobility risks present, ensure appropriate gait aid <input type="checkbox"/> If cognition is compromised, use distraction and insight <input type="checkbox"/> If risks present related to elimination, commode/urinal/toileting <input type="checkbox"/> If history of prior falls, lying/standing blood pressure <input type="checkbox"/> If on any medications (listed above), medication review	If admitted: Receiving unit aware of high falls risk score <input type="checkbox"/> Yes <input type="checkbox"/> No If discharged: Recommendations to mitigate fall risk provided <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Signature of Nurse: _____ Date/time: _____
Additional Recommended Measures: <input type="checkbox"/> Information given to consult Physiotherapy in the community <input type="checkbox"/> Information given to consult Occupational therapy in the community <input type="checkbox"/> Educational materials provided	Reassessment: Date/Time: _____ Reassessment reason & Score: _____ Signature: _____

Triage Reassessment for patients in ED waiting area:
Reassessment Level Guidelines: Level 1: continuous; Level 2: q15min; Level 3: q30min; Level 4: q60min; Level 5: q120min
Note: Never change the initial CTAS score. You can change the reassessment level after the first reassessment, if your reassessment determines the patient is more acute or less acute, document below.

Time	T °C	HR /min	BP mm/Hg	R min	SpO2 %	Observations/Interventions/Outcomes	R/A Level	Initials
1725	36.7	77	132 / 77	14	99% RA	Patient has left leg elevated on a chair, ice packs on and off. Pain improved to 5/10. In no distress talking with her friend.	4	AB
1755	0	80	130 / 75	16	99% RA	Patient has left leg elevated on chair, ice packs on and off. Pain 6/10. Watching her cell phone, appears comfortable.	4	AB

Date & Time to treatment/trauma area: October 30, 2024 1810 <input type="checkbox"/> N/A If patient is triaged in treatment room/trauma room by the same nurse.	FOCUSED SECONDARY ASSESSMENT Systems identified below that are shaded are assessed for every patient. If documentation areas provided are insufficient for the narrative, document on vital signs sheet or IPN. For non-regional centres only: See Nursing Admission History <input type="checkbox"/> Yes <input type="checkbox"/> No
Vital Signs: Temp/route: 36.7 Heart Rate: 76 Resp: 14 SpO ₂ : 99% on RA BP: L 135/83 / _____ R _____	

Neurological (e.g.): Alert/orientation; Behaviour; Motor & sensory; Pain; Speech	Patient is alert and oriented to person, place and time, rates pain to left leg 7/10. Tylenol and ice helped to alleviate pain "a bit" Breathing easy, no distress, no dyspnea. Chest is clear bilaterally with good air entry.
Respiratory (e.g.): Resp. rate & quality; Air entry; Chest sounds; Work of breathing	Skin is pink, warm and dry, pedal pulses present bilaterally 2+. Cap refill 2 seconds to peripheries bilaterally.
Cardiovascular (e.g.): Skin; Pulses; BP; Edema; Pain; Cap refill; Cardiac rhythm	Patient is calm and cooperative. ACP-R See Advanced Care Planning goals of care form.
Psychosocial (e.g.): Behaviour; Mental health status; Substance misuse; Community services (e.g., Home Care), ACP status	
Gastrointestinal (e.g.): Nausea/vomiting/emetesis; Pain; BMs; Inspect/auscultate/palpate	
Genitourinary (e.g.): Bladder; Urine; Pain; Perineum	
Reproductive (e.g.): Menses; Pregnancy; Male/Female organs	Left knee is swollen with red/purple bruising, knee cap is deformed medially. Patient has difficulty bending/straightening left leg. Distal to injury, posterior tibial and dorsalis pedis pulses are 2+, no pitting edema, cap refill is 2 secs, sensation is normal, with normal movement to toes. Grimaces with movement to left leg and cannot weight bear.
Eyes/Ears/Nose/Throat (ENT): Pain; Visual acuity; Discharge; Trauma; Aids	
Musculoskeletal (e.g.): Mobility; Aids; Pain; ROM	
Integumentary (e.g.): Skin integrity/conditions;	
Nurse Signature & Designation: cara Lott, RN Date/Time: October 30, 2024 1840	

Vital Signs Sheet

Time	BP	T	ST Segment / Rhythm	P Radial/Screen	RR	SpO ₂	Pain (0-10)	Observations/Interventions/Outcomes NB: All medications administered to be recorded on the Medication Administration Record (MAR)	NURSE Initials
1930	138/78	36.8		80 screen	16	99% RA	8	Patient returned from X-Ray dept in wheelchair. Left leg is "throbbing in pain". Will request analgesia	CL

