

Health C	Care Directive: ☐ Yes ☐ No		ACP status: ☐ R ☐ M ☐ C ☐ NA							
Schmid	It Falls Risk Screening Tool: Co	mnlete this	assessm	ent to ide	ntify the I	evel of Risk the nati	ent may Exr	nerience		
	Response:	inpicte tilis	Score			Response:				
Risk Factors	If more than one response applies, Sele response with the HIGHEST score	ect ONE	(circle)	Risk Factors	If more tha	nore than one response applies, Select ONE ponse with the HIGHEST score				
	Ambulates with no gait disturbance		0	4.		Yes- Before admission				
1.	 Ambulates or transfers with assistive assist 	device or	1	Prior		nome/previous in-patient care)				
Mobility	Ambulates with unsteady gait and no	assistance	1	Fall		uring stay in ED.		2		
	 Unable to ambulate or transfer 	400101011100	0	History	■ Unknown			0 1		
2.	 Alert, orientated x 3 		0	5.		Any Meds for: sleep, mood control,				
Cog-	Periodic confusion		1	Current		antiarrhythmics, anti-hypertensives,				
nition	Confusion at all times		1	Medi-		diuretics, diabetes, seizures, narcotics				
	Comatose 1 Unresponsive		0	cations	cations None of the above medications 0					
3.	 Independent in elimination 		0	Total Sc	oro:					
Elimi-	 Independent with frequency or di 	arrhea	1			reater, Implement Falls	Prevention a	and		
nation	 Needs assistance with toileting 		1		ment Proto					
- Tiddoii	Incontinence Province Management	_	1	a.iago.		onal Recommended				
	Required Measure	S		□ Inform				munitu		
	ersal Interventions for all patients					n to Consult Physiothera n to Consult Occupation				
	ly Rounding for all patients	-4				i to consuit occupation	iai Therapy iii	uic		
	bility risks present, Mobilize with assi- bility risks present, Ensure appropriat			community Educational materials provided						
	unition is compromised, use Distractio									
	s present related to elimination, Com		oiletina	Signature of Nurse Completing Falls Risk Assessment:						
☐ If hist	tory of prior falls, Lying/Standing B.P		o	, _						
	any medications listed above, Medica	tion review		Date:	Date:Time:					
If admit	ted, Receiving Unit aware of high	falls risk sco	re	Reasses	ssment: D	ate & time				
	☐ Yes ☐ No					on & Score:				
If disch	arged, Recommendations to mitig	gate fall risk p	provided							
	☐ Yes ☐ No ☐ NA			Signature	9:					
				•						
		<u>Guide</u>	to CTAS	Acuity Le	vels:					
	sk mechanism:	Descrivator		Hemodynamics Stability:						
	neral trauma: Y / N	Respirator	y distres	S :		☐ Severe end organ hypoperfusion (1)☐ Borderline perfusion (2)				
o Po.	ssible head trauma: Y / N	☐ Severe	(1)	☐ Mod	derate (2)					
o Po	ssible C-spine injury: Y / N		☐ Non		☐ VS upper & lowe	r limits norma	al (3)			
	Yes (2) □ No		aorato (0)	□ Normal Vital signs (4,5)						
			Pain Scale							
Level o	f Consciousness/Neuro:		ral Perip			heral				
☐ Unconscious GCS 3-9 (1) Acute				Chron	ic	Acute	Chronic	;		
☐ Altered LOC GCS 10-13 (2) ☐ Severe 8-				☐ Severe	8-10 (3)	☐ Severe 8-10 (3)	☐ Severe 8	-10 (4)		
	nal GCS (3, 4, 5)	(3)				☐ Mod. 4-7	(5)			
	1-/ / -/	☐ Mild 0-3	(4)	☐ Mild 0-	-3 (5)	☐ Mild (0-3) <i>(5)</i>	☐ Mild 0-3	(5)		
		SECOND ORI	DER MODI	FIERS TO	CONSIDER		1			
Known Bleeding Disorder, Blood Glucose Level, Hypertension, Dehydration, Mental Health, Pregnancy Related										
(over 20 wks.)										

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	icy Department Necord						
Date:	Critical First Look Scan (ho						
Language(s):		Allergies None	or 🗌 Yes (I	list and describe reaction)			
Subjective:							
·		Allegen Alegatica	nameliad 🖂 :	W No N/A			
		Allergy Alert identifie					
		Immunizations: U		☐ Yes ☐ No ☐ Unknown			
		Last Tetanus/Diphthe		Times taken			
		Medications	Dosage	Times taken Last dose			
Objective:							
-							
Medical/Surgical History:	. □ Healthy						
		Information Source:	☐ Patient □	 ☐ Family ☐ DPIN ☐ ERIK			
		□ eChart □ Other					
				ital Signs Shoot □ RDMU			
Fall in the leaf war V	na 🗖 Na	Medication list continued on: Vital Signs Sheet BPMH NB: Complete Medication Reconciliation forms for ALL patient's being Admitted					
Fall in the last year Ye		112. Complete Medical		in terms for 7122 patients being 71411111104			
Mechanism of Injury/E		Canina iniumu V / N I	ممر باماد باماد	ahaniam D Vas. D Na			
	Possible head trauma: Y / N; Possible	C-spine injury: Y / IN I	High risk me	ecnanism Yes No			
EMS Treatment Prior to	o Arrival:						
A*	11	1		VPC-1-2			
Airway:	Hemodynamic Stability:	Level of Consciou		Vital signs:			
	☐ Capillary Refill:sec.	☐ Alert	Speech:				
☐ Patent	Skin Colour Skin Moisture	☐ Verbal	Cohere	nt Route			
☐ Obstructed	☐ Normal ☐ Normal	☐ Drowsy	Incoher	ent I			
☐ Stridor	☐ Pale ☐ Dry	Responds	☐ Silent	Pulse			
☐ Normal	☐ Cyanotic ☐ Moist	to Pain	Slurred	☐ reg ☐ irreg			
□ Deep	☐ Flushed ☐ Diaphoretic	Lethargic		BP L arm			
☐ Shallow	☐ Jaundiced	☐ Unconscious	Gait:	BP R arm			
□ Rapid	Bleeding Skin Temp	Seizure	☐ Normal				
□ Slow	☐ None ☐ Normal	Activity	☐ Ataxic	Resp. R. <u>:</u>			
☐ Breathing with ease	☐ Present ☐ Hot	☐ Confused	☐ Unable	SpO ₂ :			
☐ Labored	Est. Blood Cool	☐ Combative		□ R/A □ O _{2 @}			
☐ Accessory Muscle	Loss:mls Cold	☐ Flat Affect	□ See				
☐ Audible wheeze	NB: If applicable, proceed to	Anxious	neurologic	al Weight:kg			
☐ Tracheal tug	standardized care map	Oriented	record	Height:			
	☐ Yes ☐ No Name:	_ X		Blood Glucose:			
				Presenting Complaint			
	atient rates as (circle one):	CTAS Acuity Leve	els/	(CEDIS):			
0 1 2 3	4 5 6 7 8 9 10	Priority		(02510).			
		☐ Level 1 Resusc	itation	Triage Treatment:			
Infection Control: Posit	tive for current screening criteria	☐ Level 2 Emergent ☐ None ☐ Wound Can					
(e.g., febrile respiratory illn	esses, Ebola): ☐ Yes ☐ No	☐ Level 3 Urgent					
Type:		Splint □ Sling □ Ice □ Level 4 Less Urgent □ Other (specify):					
Isolation Precautions:] Yes 🔲 No Type:	Level 5 Non Urg		☐ Other (Specify)			
		`	•	dook DDN			
	Directed to ED Waiting Area	☐ Instructed to return to Triage desk PRN☐ Patient has met criteria for Nurse Managed Care					
triage: Nurse Signature & Des	Directed to Treatment Area	☐ Patient has met	criteria for N	vurse ivianaged Care			
	IGDSTIAN:						

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CTAS Gui	deline	for Tri	age R				ent for patients in I tinuous; Level 2 q15 i			g60min; Level 5a	120 min		
Time	T	P	R	BP	SpO ₂	RBS	Observations/I			√ No change	Initials		
					1								
			l										
Date & Ti	me to	treati	ment	area:		FOCUSED SECONDARY ASSESSMENT Systems identified below that are shaded are assessed for every patient. If documentation areas provided are insufficient for the narrative, use vital signs and							
□ N/A If treatmen						progres	s notes section. n-regional centres onl						
Vital Sigr	ns: Te	mp/ro	ute: _		Ρι	ılse:	Resp:	_ SpO ₂ :	BP: L	R			
Neurolog	ical (e	.g.):		_									
Alertness													
Motor & s			ı; Spe	ech _									
Respirato				_									
Resp. rate													
Chest sou				ıtnıng _									
Cardiova Skin; Puls				ain:									
Cap refill;				uii, _									
Psychos			******										
Behaviou			alth sta	atus;									
Substance				nity _									
services (_									
Gastroin				_ -									
Nausea/vomiting/emesis; Pain; BMs; Inspect/auscultate/palpate													
BIVIS; Insp	ect/au	sculta	ite/pal	pate _									
Genitour				-									
Bladder; l	Jrine; F	Pain; I	Perine	eum -									
Reprodu	ctive (e.g.):											
Menses; I													
Female/N	lale org	gans											
Eyes/Ear													
Pain; Visual acuity; Discharge;													
Trauma; A	Aids												
Musculos Mobility; A		•		-									
Integume	entary	(e.g.)	:										
Skin integ		ndition	ns:										



Vital Signs and Progress Notes

Time	BP	T	ST Seg- ment / 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

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