Document Owner:	Reviewed By:	Approved By:
Manager ECC	ECC Manager, ECC Asst Manager, Senior Educator/Nurse Clinician, Emergency Management	Dir, Acute Care

	Triage Nurse	Primary Nurse	Required for all Patients	Continuous	Every 5 minutes	Every 15 minutes	Every 1 hour	Every 2 hours	Every 4 hours	NOTES:
Triage Navigator										
Arrival Info	x	x	x							
Communication/Language Assessment	x	x	x							
Visit Info (Reason for Visit)	x	x	x							
Travel Screening	x	x	x							
ILI Symptoms	x	x	x							
Tetanus Status	x	x	x							
Allergies	x	x	x							• Red bracelet applied with listed allergies

	Triage Nurse	Primary Nurse	Required for all Patients	Continuous	Every 5 minutes	Every 15 minutes	Every 1 hour	Every 2 hours	Every 4 hours	NOTES:
Initial Vital Signs	x	x	x							
Temperature (rectal under 1 year of age)	x	x	x							
Heart Rate	x	x	x							
Respiratory Rate	x	x	x							
Blood Pressure (3 years old and above)	x	x	x							
SPO2	x	x	x							• Remember to document if patient is on 02
Pain Level and location	x	x	x							
Weight	x	x	x							
Height	x	x	x							
Hendrich II Falls Assessment-Triage Falls Risk	x	x	x							
ED Triage note	x	x	x							
Patient Type/Acuity/Status	x	x	x							

	Triage Nurse	Primary Nurse	Required for all Patients	Continuous	Every 5 minutes	Every 15 minutes	Every 1 hour	Every 2 hours	Every 4 hours	NOTES:
Screening Navigator										
Home Medications		x	x							
History		x	x							
Implants		x								**Required if the patient has any sort of implant**
Abuse/Maltreatment		x	x							
Suicide Risk Assessment		x	x							
Violence Assessment		x	x							
Hendrich II Falls Assessment		x	x							
Risk for Injury		x	x							
Infection/Exposure		x	x							
HCD Questionnaire		X	x							

	Triage Nurse	Primary Nurse	Required for all Patients	Continuous	Every 5 minutes	Every 15 minutes	Every 1 hour	Every 2 hours	Every 4 hours	NOTES:
General Assessments/Charting (Found in General Narrator Tab)										
Head to Toe Assessment for ESI #1, #2 & #3		x	x							• Full head to toe assessment required on all patients including a GCS • If patient is in ECC longer than 8 hours, a repeat head to toe assessment is needed
Focused Assessment for ESI #4 & #5		x	x							• If a patient's ESI score changes to a 1, 2, or 3 from a 4 or 5, a complete head to toe assessment must be completed
Pain Reassessment		x								• Reassess within 2 hours of each intervention
Critical Lab Call		x								• Immediately enter and notify MD
Swallow Screen		x								• Required on any patient with neuro issues (Must be documented prior to PO meds)
Nursing Procedures		x								• Blood draw, to imaging, ear irrigation, ekg, enema, equipment teaching, eye irrigation, orthostatic vital signs, pelvic/vag bleed exam, point of care tests, quick cath, splinting, visual acuity, warming devices, wound prep/dressing applied
Patient Handoff		x	x							• Utilize anytime patient care is transferred to new RN
Behavioral Patients										
Behavioral Assessment		x								
Behavioral Reassessment		x						x		
Behavioral Observation Check		x		x		x				

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Patient Vital Sign Monitoring During ECC Stay										
ESI #1		x			x					• And as condition warrants
ESI #2		X				x				• And as condition warrants • ESI #2 Behavioral without med administration: Every 4 hours and as needed • ESI #2 Behavior with mediation administration: Every 1 hour
ESI #3		x					x			• And as condition warrants
ESI #4 and #5		X						x		• And as condition warrants
Sp02 after narcotics or sedatives		x		x						• And as condition warrants
BP after narcotics or sedatives		x				x				• And as condition warrants
BP after Nitro		x			x					• And as condition warrants
LDA's										
IV, Ports, Central Lines		X						x		• Reassess site every 2 hours
Catheters		X								• Make sure to accurately document output and reason for catheter

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Disposition Navigator (Discharge)										
Diagnosis		x	x							• To be entered by provider. RN to ensure complete
Discharge Instructions		x	x							
D/C Vital Signs		x	x							
D/C Outcome Assessment		x	x							
Cognitive/Functional Status		x	x							
Current Infusion		x								• Stop any actively running medications on the MAR
LDA Removal		x								• Discontinue any LDA's as appropriate
Comm Management		X								• Work/School Note appropriate
Police Department Notification		x								• As appropriate
Disposition and Follow-up		X	X							• To be entered by provider. RN to ensure complete
My Chart Signup		X	X							
ED Notes		x	x							• Discharge note on each patient
D/C RX		x								• To be ordered by provider. RN to ensure patient receives all prescriptions at time of d/c
Print AVS		X	X							•

Table of Revisions

Date	Description of Change(s)
7/2018	Updated to align with LEAN documentation changes
5/2019	Updated to align with Re-Fuel Project