HEALTH HOLDING

HAFER ALBATIN HEALTH CLUSTER
MATERNITY AND CHILDREN HOSPITAL

Department:	Emergency Room		
Document:	Multidisciplinary Policy and Procedure		
Title:	Assessment and Reassessment of Emergency Room Patients		
Applies To:	All Emergency Room Staff		
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1. PURPOSE:

1.1 Provide safe, timely and efficient management to the broad spectrum of patient's complaints presented to the emergency department.

1.2 Ensure reassessment of all patients at intervals appropriate to their condition and needs to determine response to treatment or need for hospital admission or discharge.

2. DEFINITIONS:

2.1 **Emergency Room (ER)** – is a medical treatment facility that provides acute care of patients who present without prior appointment by their own means or by an ambulance.
Due to the unplanned nature of patient attendance, the department must provide initial treatment for a broad spectrum of illnesses and injuries, some of which may be life threatening and require immediate attention.

2.2 **Triage** – is a system of prioritising patients so those in most need are seen first. It rapidly identifies patients that need immediate attention. It is not intended to make a diagnosis.

2.3 Patient assessment consists of three primary processes:

2.3.1 The initial assessment in emergency department is focused on the presenting problem; the present complaint with relevant past and family history, relevant physical examination, information on the patient's allergy, psychological, nutritional, rehabilitation, social and economic status and screening for pain and risk of fall. If further assessment is needed, the ER physician calls the concerned specialty specialist.

2.3.2 Analysing the data and information, including the results of laboratory and imaging diagnostic tests to identify the patient's health care needs.

2.4 **Reassessments in the Emergency Room** – are according to acuity of patient condition and his/her condition and needs.

3. POLICY:

3.1 All patients are triaged at their entry to Maternity and Children Hospital, Hafer Al Batin emergency department to prioritize them based on level of acuity or high risk presentation in order to 'stream" them to the ER area most appropriate for their needs and condition (refer to the policy on triage).

3.2 Initial assessment by ER physicians consists of pertinent history, relevant physical examination, needed laboratory or radiologic examinations, forming provisional diagnosis and developing a plan of care. It is documented on the emergency department assessment forms.

3.3 ER nurses will document the nursing assessment on the "Emergency Nursing Assessment Form".

3.4 Frequency of reassessment is determined by each patient's level of care and needs and both physician's order and the nurse's professional judgment.

3.5 If the patient needs further assessment, the ER physician will call the concerned specialty physician who will conduct a more detailed assessment and may decide the need for further consultations, referral or admission.

3.6 The physician who receives a patient in need for resuscitation will immediately initiate the resuscitation

process and order the charge/assigned nurse to announce Code blue.

3.7 Only qualified, Maternity and Children Hospital, Hafer Al Batin privileged healthcare workers permitted by licensure, applicable laws and regulations are allowed to perform the emergency department patient's assessment and reassessment

3.8 Healthcare workers working in the ER hold the Basic Life Support "BLS" certificate. Physicians hold the Neonatal Resuscitation Program "NRP", or Pediatric Advance Life Support "PALS", or Advanced Trauma Life Support (ATLS) or Advanced Life Support in Obstetrics (ALSO) according to physician specialty.

3.9 All admitted patients who stay in the ER until bed is available will have full initial assessment by the concerned department medical team within 6 hours (maximum of 24 hours) or earlier according to patient condition and needs. They receive same reassessments and level of care as provided to patients admitted to an inpatient unit

3.10 Assessments and reassessments in the ER are documented on designated forms and included in the patient's temporary medical record.

4. PROCEDURE:

4.1 This policy is used in accordance with the hospital policy "Multidisciplinary Assessment and Reassessment of Maternity and Children Hospital, Hafer Al Batin Patients".

4.2 For obstetrics and Gynecology department, this policy is also used in association with the Ministry of Health guidelines for obstetrics and gynaecology; 2013.

4.3 Patients suspected at triage to have infectious diseases are managed in the ER isolation rooms.

4.4 All Maternity and Children Hospital, Hafer Al Batin patients are triaged according to the Canadian Emergency Department Triage and Acuity Scale (CTAS) and Obstetrical Triage Acuity Scale (OTAS).

- 4.4.1 Resuscitation; Blue code; Patients who need resuscitation, threats to life or limb, or imminent risk of deterioration, are assessed by physician immediately.
- 4.4.2 Emergent: Red code: Patients with potential threat to life, limb or function, will be assessed within a maximum of 15 minutes.
- 4.4.3 Urgent: Yellow code: Conditions that could potentially progress to a serious problem requiring emergency intervention; time to physician < 30 min.
- 4.4.4 Less urgent/ semi-urgent: Green code: conditions related to patient age, distress, or potential for deterioration or complications would benefit from intervention or reassurance within 1-2 hours; time to physician < 1 hours.
- 4.4.5 None urgent: Conditions that may be acute but non-urgent as well as conditions that may be part of a chronic problem with or without evidence of deterioration. The investigation or interventions for some of these illnesses or injuries could be delayed, or even referred to other areas of the hospital or health care system. Time to physician < 2 hours.

4.5 Emergency Department (ER) physician will:

- 4.5.1 Take history of present illness, relevant medical, surgical, and family history, allergies, current medications, psychosocial, menstrual and obstetric (when applicable).
- 4.5.2 Pertinent physical examination.
- 4.5.3 Order laboratory or radiologic investigations as needed.
- 4.5.4 Form provisional diagnosis and associated conditions.
- 4.5.5 Order needed medications.
- 4.5.6 If the patient needs further assessment or admission, call the concerned specialty required,
- 4.5.7 Document the assessment on the:
  - 4.5.7.1 Emergency Physician Assessment Form.
  - 4.5.7.2 Obstetrician Emergency Assessment Form.

4.6 Concerned specialty physician will:

- 4.6.1 Conduct patient assessment and decide if the patient needs another service consultation, fulfils criteria of admission or discharge or needs referral.
- 4.6.2 Assess the need of none eligible patients for admission according to the following criteria of lifesaving. Lifesaving patients will be managed regardless of their nationality:
  - 4.6.2.1 Need for resuscitation,
  - 4.6.2.2 There are threats to life or limb,

4.6.2.3 There is imminent risk of deterioration and patient's medical/surgical condition need to be stabilized, and when refusal to admit may result in serious or permanent harm or aggravation of an injury or disease.

4.6.3 Initiate the full initial assessment for patients who will be admitted.

4.7 The assigned nurse will:

4.7.1 Assist in resuscitation as orders and in required procedures,

4.7.2 Ask about reason for visit,

4.7.3 Check vital signs; heart rate, respiratory rate, blood pressure, temperature, SpO_2

4.7.4 Check weight and height,

4.7.5 Screens for pain. If present, assess it, provide none-pharmacologic management and inform physician for pharmacologic management:

4.7.5.1 Use the visual Analogue Scale (VAS) and Numeric Rating Scale (NRS) for adults

4.7.5.2 For younger children 7 years and above, use pain scales with happy and unhappy faces; Wong-Baker FACES Pain Rating Scale.

4.7.5.3 For children 1 months to 7 years; use the FLACC (Face, legs, Activity, Cry, Consolability) score.

4.7.5.4 For newborn and up to 21months of age, use the Neonatal Pain Scale (CRIES)

4.7.5.5 Document on the pain assessment and reassessment form.

4.7.6 Screen for fall. If at risk for fall perform fall risk assessment.

4.7.7 Document immunization and head circumference for children.

4.7.8 Document patient education, psychosocial and nutritional status and functional assessment.

4.7.9 If pregnant; gestational age, presence of bleeding or contractions,

4.7.10 Document all medications administered,

4.7.11 All events on the progress notes,

4.7.12 Document on the "Emergency Nursing Assessment Form".

4.8 For critical patients:

4.8.1 Ensure that potentially life-threating conditions are identified and addressed. Assessment includes, but not limited to, "ABCDE": Airway, Breathing, Circulation, Disability (e.g. resulting from spinal injury and level of consciousness) and Exposure:

4.8.1.1 Is the airway obstructed e.g. is the patient vocalizing sounds appropriate for age, check for visible material in oropharynx as loose teeth, foreign object, bleeding, vomitus, or other secretions, look for swelling or edema to lips, mouth, tongue, or neck. Is the patient drooling, have stridor or wheezing.

4.8.1.2 Is the patient spontaneously breathing, equal rise and fall of the chest, respiratory rate and pattern, cyanosis, use of accessory muscles (nasal flaring, retractions), integrity of chest wall, position of trachea, assess lung sounds.

4.8.1.3 Circulation: quality and rate of pulse (connect to cardiac monitor), skin temperature, moisture, pale or cyanosed, capillary refill time in seconds (on forehead or chest), bleeding.

4.8.1.4 Disability; assess level of consciousness. Check pupil's equality and reactivity to light.

4.8.1.5 Exposure: Remove the patients clothing to thoroughly examine and identify any underlying cause of illness or injury. Cover the patient to maintain privacy and prevent heat loss.

4.8.2 Follow resuscitation steps as needed. The charge nurse will announce "code blue" with mentioning location.

4.8.3 Obtain full set of vital signs; temperature, heart rate, respiratory rate, blood pressure and Hemoglobin, saturation (SpO2).

4.8.4 Get vascular access and assess need for urinary catheter.

4.8.5 Order needed investigations as required e.g. blood gases, radiology, septic work up etc.

4.8.6 Conduct head to toe physical examination.

4.8.7 Facilitate family presence, assess their needs and get any needed further history.

4.8.9 Develop action plan and document it on the physician emergency assessment form.

4.9 For comatose patients:

4.9.1 Focused history,

4.9.2 Head to toe with full neurologic examination
4.9.3 Investigate for cause. May use the mnemonic "AEIOUTIPPS" to remember checking for causes of coma: A; alcohol, E; Epilepsy/ Electrolyes (metabolic) /Eclampsia, /Endocrine, I: Insulin (hypo/hyperglycemia), O: Opiates, U: Uremia (other organs failure), T; Trauma, I: Infection, P: Poison/Psychosis, S: Stroke/Syncope/Space occupying lesion.
4.9.4 If stroke is suspected, urgently consult neurologist to determine the need for fibrinolytic therapy.

5. MATERIAL AND EQUIPMENT:

5.1 Forms:
- 5.1.1 Pediatric Emergency room assessment form.
- 5.1.2 Obstetrician Emergency Assessment Form;
- 5.1.3 Pain assessment, reassessment form

5.2 Equipment:
- 5.2.1 Vital signs monitor.
- 5.2.2 Stethoscopes
- 5.2.3 Weighing scales.
- 5.2.4 Measuring length and height equipment.

6. RESPONSIBILITIES:

6.1 Assigned Emergency Room Physicians
6.2 Assigned Concerned Specialties Consultants, Specialists and Residents
6.3 Emergency Department Nursing Staff
6.4 Assigned Social Workers

7. APPENDICES:

7.1 Emergency Nursing Assessment Form

8. REFERENCES:

8.1 Maternity and Children Hospital, Directorate of Health Affairs Holy Capital, Kingdom of Saudi Arabia.
8.2 Central Board for Accreditation of Healthcare Institutions (CBAHI). Saudi National hospital standards. Third edition, 2015.

9. APPROVALS:

	Name	Title	Signature	Date
Prepared by:	Ms. Alreem Mofareh Al Rashidi	Head Nurse of PER		January 05, 2025
Prepared by:	Ms. Reem Kammadh Al Dhafeeri	Head Nurse of OBSER		January 05, 2025
Reviewed by:	Mr. Sabah Turayhib Al Harbi	Director of Nursing		January 06, 2025
Reviewed by:	Dr. Amal Abdullah Al Harbi	Pediatric Emergency Room Consultant		January 07, 2025
Reviewed by:	Dr. Mohannad Yaghmour	OBS-ER Head of the Department		January 08, 2025
Reviewed by:	Mr. Abdulelah Ayed Al Mutairi	QM&PS Director		January 09, 202
Reviewed by:	Dr. Tamer Mohamed Naguib	Medical Director		January 12, 2025
Approved by:	Mr. Fahad Hezam Al Shammari	Hospital Director		January 19, 2025

KINGDOM OF SAUDI ARABIA

وزارة الصحة
Ministry of Health

Hospital: _____ مستشفى:

Region: _____ المنطقة/المحافظة:

Dept./Unit: _____ القسم/الوحدة:

MRN: | | | | | | | | | | رقم الملف الطبي:

Name: _____ الاسم:

Nationality: _____ الجنسية:

Age: _____ ☐ سنة Years ☐ شهر Months ☐ يوم Days العمر:

Date of Birth: ____/____/14____ H ____/____/20____ تاريخ الميلاد:

Gender: ☐ Male ☐ Female الجنس:

EMERGENCY NURSING ASSESSMENT FORM

☐ FAST TRACK ☐ OBSERVATION AREA ☐ RESUSCITATION AREA ☐ MINOR O.R. ☐ CLINICS

DATE: / / TIME: Reason for Visit:

ID BAND APPLIED: Yes By:

SOURCE OF INFORMATION: ☐ Patient ☐ Family ☐ Medical Record ☐ Other:

VALUABLES: ☐ None ☐ Given to family ☐ Given to security ☐ Other:

VITAL SIGNS RECORD:

Date	Time	Temp. °C	Pulse Rate /min	Respiratory Rate /min	BP /mm Hg	Pain Reassessment Score	Pain Tool	O_2 Saturation	RN Initial /Job number

IF IN PAIN, INTERVENTION PROVIDED :

A.) PHARMACOLOGICAL: ☐ YES ☐ NO

B.) NON-PHARMACOLOGICAL: ☐ YES ☐ NO

☐ Repositioning /turning or ambulating as needed. ☐ Heat and cold packs as prescribed

☐ Micro massage , immobilization, TENS ☐ Relaxation exercises , deep breathing, rhythmic breathing

If at risk for FALLS: Perform assessment ☐ Yes ☐ No

Morse Fall Risk Score:
Low risk: (0-25)
Medium risk : (30-55)
High risk: (55 above)

Humpty Dumpty Fall Risk Score:
Low risk: (7-12)
High risk : (12-23)

Height: cm. Weight: kg.

PEDIATRIC: ☐ Yes ☐ No : If yes : Current immunizations:

Head circumference: cm.

OB-GYNE: ☐ Yes ☐ No If yes: Vaginal bleeding: ☐ Yes ☐ No Mild Moderate Severe

Pregnant: ☐ Yes ☐ No Age Of Gestation: weeks Show Contractions

Patient education: Readiness to learn: ☐ Yes ☐ No

Topics for teaching:

Psychological status: ☐ Relaxed ☐ Anxious ☐ Distressed Other:

Communication barrier: ☐ No ☐ Yes Specify

NUTRITIONAL STATUS:

☐ Malabsorption ☐ Renal disease ☐ Unable to take oral feeding ☐ Diabetes

BMI less than 19 or greater than 40 Liver Disease Other:

Physician informed: ☐ Yes ☐ No

FUNCTIONAL ASSESSMENT:

Needs assistance /dependent in performing activities of daily living: (ADL) (ie. feeding , toileting, bathing, grooming, walking, others) ☐ Yes ☐ No

Name: الاسم:	MRN: رقم الملف الطبي:

MEDICATION ADMINISTRATION RECORD (MAR) No medications ordered

Date and Time	Medication	Dose	Route	RN Initial and Job number		Date Time	IV Fluid	RN Initial and Job Number	
				RN	RN			RN	RN

NURSES PROGRESS NOTES

Date and Time	Nurse Notes (D-data A-action R-response)	RN Initial / Job Number

DISPOSITION: Date:

Home at: Clinic at: AMA at: LWBS at:
LBCT at: DOA at: Admitted to: Time:

DISCHARGE PLAN (Patient discharged from ED with the following):

IV CANNULA REMOVED: ❑No ❑ Yes ❑ O_2 therapy ❑Patient valuables given ❑ Patient/Family

NURES NAME: **Signature:** **Job #** **Date: / / Time:**

Note: Write the time in each entry & affix your initial at the end of each paragraph. Draw a line across empty spaces.