Emergency Department Assessment and Documentation Guidelines with CST-Cerner

Site Applicability

Acute Care areas of St. Paul's Hospital (SPH) and Mount Saint Joseph (MSJ) Emergency Departments (ED)

Practice Level

Basic – within scope of all Nurses in the Emergency Department

Requirements

Staff who will be completing emergency department documentation require access to Cerner FirstNet. This guideline is not for use during episodes of Cerner downtime.

Quick Links - Contents

a. Appendix A: Canadian Triage Acuity Scale (CTAS)
b. Appendix B: Documented items at triage
c. Appendix C: Documented items for physical assessment
d. Appendix D: Reviewing completed emergency nursing charting

Need to Know

Emergency Department (ED) nurses are responsible for performing initial and ongoing assessments to prioritize patient care. These assessments are important to establish a baseline of hemodynamic and physiological stability and to changes in the patient's condition. Any abnormal finding requires further focused assessments and prompt attention of the most responsible provider (MRP).

The Emergency Department prioritizes different care spaces for patients depending on their presentation and acuity. Patients requiring resuscitative or emergent care require the highest level of monitoring; for example, in St. Paul's Hospital ED Trauma Room or Acute Care stretchers. Patients who have less-urgent or non-urgent presentations may have the lowest level of monitoring.

Guideline

Assessment Frequency

The following table will be used to guide how often these assessments should be done based on patient acuity and/or current presentation. Frequency of vital signs, head-to-toe, and focused assessments may increase or decrease based on clinical judgement, changes to patient acuity and/or provider orders.

Vital Sign Frequency		
For patients not in Fast Track/Treatment area.		
Non-admitted patients in the emergency department		
	Initially/Until Seen by Provider	**Once Seen by Provider**
CTAS 1 / Resuscitation	Continuous	Every 15 t 60 minutes
CTAS 2 / Emergent	Every 15 minutes	Every hour
CTAS 3 / Urgent	Every 30 minutes	Every 2 hours
CTAS 4 / Less Urgent	Every 60 minutes	Every 2 hours
CTAS 5 / Non-Urgent	Every 2 hours and as clinically indicated	
Admitted patients in the emergency department		
Patients not admitted under the mental health (MH) program	Every 4 hours or per provider orders, whichever is more frequent	

Patients admitted under the MH program	Once per shift or per provider orders, whichever is more frequent
For patients in Fast Track/Treatment area of St. Paul's Hospital.	
All patients	Every 4 hours or as clinically indicated

Assessment Principles

The following table indicates the guiding principles around the frequency and scope of assessment. Assessment frequencies are irrelevant of patient's admission status.

Best practice is for documentation to be completed as close to the time of assessment and intervention as possible. Details about each assessment is found under "Specific Assessment and Documentation by Area."

Area of the Department	Head-to-Toe Assessment	Focused and Ongoing Assessments
Acute care stretchers MSJ ED stretchers ABSU DTU/HUB Trauma room	Initially on admission to the area and at the start of a nurse's shift	Initially on admission, every 1 to 2 hours, and as clinically indicated
Fast Track	Not required unless clinically indicated	Initially, every 4 hours, and as clinically indicated

Specific Assessment and Documentation by Area

Triage

All patients require a completed triage note (either the **ED Triage – Adult** or **ED Triage - Pediatrics**), regardless of length of stay or reason for visit.

- Triage nurses who record (or confirm) an allergy must put a red allergy band on the patient.
- A Canadian Triage Acuity Scale (CTAS) score is to be recorded on all patients. See Appendix A: Canadian Triage Acuity Scale (CTAS) for more information.
- See Appendix B: Documented Items at Triage for more information on specific items that are expected to be documented at triage.

Acute Care

(Acute Stretchers, MSJ ED Stretchers, Acute Behavioural Stabilization Unit [ABSU], Diagnostic Treatment Unit [DTU], HUB, Trauma)

Initial Assessment

The initial assessment in acute care consists of the chief complaint and history, head-to-toe assessment, and ED screening.

Chief complaint and **History**	Completed on every patient in the acute care area, regardless of length of stay or reason for visit.
	• It is written as a *flagged annotation* in a time column closest to when a patient was admitted into an area in Interactive View (IView) and must describe the patient's presenting concern via an acceptable emergency nursing framework standard, including:
	  • LOTARP (Location, Onset, Type and Timing, Associated and Aggravating factors, Radiation, Precipitating and Palliating factors),
	  • PQRST (Precipitating and Palliating factors, Quality, Radiation and Region, Severity, Time), or
	  • SAMPLE (Signs and Symptoms, Allergies, Medications, Pertinent history, Last oral intake, Events leading to injury or illness).
	• Simple chief complaints may be charted in the clinical comment, provided it follows the emergency nursing framework as described above.
	• Additional medical history may be recorded as part of the chief complaint and communicated to the MRP.
	• Allergies are verified as part of the history (even if it was checked at triage).

Head-to-toe / physical assessment	Documented in either the **ED Initial Assessment – Adult** or **ED Initial Assessment – Pediatrics** PowerForm. The minimum requirements for this head-to-toe assessment are described in Appendix C: Documented Items for Physical Assessment. • The nurse uses their clinical judgment based on the patient's presentation to determine if additional items need to be assessed and charted.
ED screening	Documented in either the **ED Screening – Adult** or **ED Screening – Pediatrics** PowerForm. The minimum ED screening in acute areas is: • Falls risk screen • Violence risk screen

	• Suicide risk screen, for mental health patients and patients whose current presentation warrants a suicide risk screen • Domestic violence, for patients who present with risk factors for domestic violence) as per the Screening Patient and Residents for Abuse policy

Ongoing Assessment

Ongoing documentation includes at least one of the following:

- Clinical comments
- Flagged annotations
- Any applicable sections of iView other than vital signs
- Freetext notes (see "Resuscitations and Trauma")

Clinical comment	The *Clinical Comment* field can be used for a variety of purposes: • A subjective report on the patient's status at regular intervals during the patient's stay. It's intended to highlight the patient's condition clearly or summarize a focused assessment for other staff members. • When patients are transported to another area of the ED, or when transfer of accountability (TOA) occurs. **Clinical Comments should not be used when another field in iView is readily available in the emergency nurse's default iView bands**.
Flagged annotations	In addition to the chief complaint, the flagged annotation can be used to document a significant point-in-time event, such as a Code White or an adverse event.
iView documentation	Whenever possible, nursing staff should chart directly into applicable iView sections to track patient changes more clearly in the Cerner system. This includes: • Re-assessments • Line-related interventions (e.g. IV, NG, chest tube, urinary catheters, central lines, etc.) • Point-of-care results • Intake and Output

Interventions

All interventions (such as peripheral IV insertions, chest tube care, and procedural sedation) are documented as per College requirements and SHOP Decision Support Tools (DSTs). Elsevier Clinical Skills can also be used to help guide assessments and interventions.

Fast Track/Treatment

While a complete initial assessment is not required on all Fast Track patients, nurses are expected to read the triage note to ensure the chief complaint is sufficient for the patient's presenting concern. Otherwise, a more thorough chief complaint should be documented.

A further focused examination should be completed on arrival relevant to their presenting condition. Documentation should otherwise be completed when any additional assessment is performed or when any intervention is done.

Patients who are admitted to the hospital should have an initial assessment completed as per the Acute Care areas.

Specific Assessments and Documentation by Presentation

Mental Health Patients

A patient certified under the Mental Health Act (MHA) requires a completed Form 4 (and 6), available electronically in Cerner. For provision of care, all certified patients require a completed Form 5, 13, 15, and 16. These documents are available in Cerner's FormFast.

The initial assessment is completed as per the Acute Care guidelines. In addition, a mental status examination (MSE) is assessed and documented under the **ED Mental Health** iView band and encompasses the following:

- Affect (e.g. patient's appearance and eye contact)
- Behaviour (e.g. observable actions and speech)
- Cognition (e.g. thoughts, feelings, and insight)

The MSE is also completed by a nurse every shift with any significant changes to the patient's presentation.

Close Observation

Patients under close observation (which includes all certified MHA patients and all patients in ABSU) should have q15min checks recorded under the **ED Mental Health** iView band in the **Behaviour Log** section. The q15min checks include the following:

- Patient location
- Patient activity

Every 1 to 2 hours, the full Behaviour Log section must be completed (including the items on Affect, Motor Activity, and Behaviours). The **Observation Comment** in the Behaviour Log can be used similarly to the Clinical Comment.

Pediatric Patients

The pediatric early warning system (PEWS) score must be completed at triage, and whenever vital signs are assessed. The PEWS score is completed in either the **ED Triage – Pediatrics** PowerForm or the **ED Pediatric Systems Assessment** iView band. The nurse is responsible for alerting the provider as per the Pediatric Early Warning System (PEWS) EHR protocol.

In addition, all pediatric patients should have a thorough history and assessment done. An acceptable Emergency Nursing Framework Standard for pediatric patients includes CIAMPEDS:

- **C**: chief complaint
- **I**: immunizations
- **A**: allergies
- **M:** medications
- **P**: past medical history
- **E**: events surrounding illness or injury
- **D**: diet and diapers
- **S**: symptoms associated with illness or injury

Resuscitations and Traumas

During the initial resuscitation, documentation is completed in real-time. There are several places where this documentation can be completed. Whenever paper documents are used for nursing documentation, most charting does not need to be duplicated in Cerner. When the patient stabilizes, indicate on Cerner under a Flagged Annotation that nursing documentation was completed on paper.

Cardio-pulmonary Resuscitation Record on paper	For all cardiac and respiratory arrests.
Trauma Nursing Assessment Record on paper	For all CTAS 1 and 2 trauma patients.
Nurses notes, on paper, *or* **Freetext note**, in Cerner	For all other resuscitations. The first line of this document should be a one-sentence summary of the patient's complaint. Afterward, nurses should use a <time> - <description> format to chart narratively. Medications and blood products should be charted in all-caps. For example: 0824 – O_2 78% on room air. KETAMINE 50MG IV given by KT.

Transitioning from Paper and Freetext Documentation

Following a resuscitation and once the patient has been stabilized, the nurse will return to chart in Cerner. The following will need to be transcribed into iView:

- The latest set of vital signs
- The latest set of pertinent assessment findings
- All lines inserted (e.g. IV, CVC, Foley, NG, chest tubes, etc.)
- Total intake and output volumes.

One-time critical care medications (such as intubation medications or Advanced Cardiac Life Support (ACLS) medications), shock joules, and physician interventions documented on the Cardio-pulmonary Resuscitation Record, the Trauma Nursing Assessment Record, or in Nurses notes/Freetext note do not need to be re-recorded.

All other medications should be ordered by the physician and charted against in the medication administration record (MAR), such as a vasopressor infusions, seizure medications, analgesics, and antibiotics.

Miscellaneous Cerner Charting

Communication and Results

There are a variety of ways for staff to communicate to each other in Cerner FirstNet.

LaunchPoint Nursing Comments and **Staff Comments**	The “Nursing Comment” field in Launchpoint is used for any important comments that are relevant to nursing only and may assist in patient flow and organization. Use “Staff Comment” for comments relevant to all staff members (such as consults, reminders, timing of diagnostic tests, non-urgent requests, etc.). Both the “Nurse Comment” and “Staff Comment” section are not areas for legal documentation.
Situational Awareness and Team Communication	Situational Awareness and Team Communication are not used regularly by ED staff. Consulting services, however may enter information in this section when a patient is admitted so it should be reviewed regularly. It is not an area for patient care documentation however, information entered here is discoverable on chart review.

Discharge and Admission

Prior to any discharge or admission transfer, nurses are expected to review any outstanding tasks or medications that need to be completed and ensure that relevant individuals (e.g. Clinical Support Clerks, receiving nurse) are aware of the task.

For patients being discharged, charting is completed in the **Disposition Documentation**. After completing the **Disposition Documentation**, the nurse can also discharge the patient from the Cerner system.

For admitted patients, admission documentation includes:

- **Perioperative Pre-Procedure Checklist** (for all patients going to the operating room or for endoscopy)
- **COVID-19 Screening Form** (for all patients going to the operating room or for endoscopy)
- **Valuables/Belongings**
- **Transport Ticket** (if the nurse is not accompanying the patient)
- **Disposition Documentation**

For admitted patients, only the clinical support clerk or clinical nursing leader (CNL) can admit the patient in the Cerner system.

Tasking

It is the responsibility of the nurse who reviews a task to ensure that it is documented against or moved from the task list. If any tasks are no longer required, they should be removed prior to shift change. Any tasks that are/were accidentally removed should be re-added.

The Emergency department does not recommend saving tasks to be completed later. If a task cannot be completed at the present time, cancel the documentation and complete it at a later time.

If in a team assignment, tasks requiring action should have a Nurse Review completed only if the user reviewing the tasks will perform the task in a timely manner. If a nurse has reviewed the task and is unable to complete it, they must verbally handover the task to another nurse.

On handover, patient orders are to be reviewed with oncoming staff, including:

- Any outstanding nursing tasks
- Any medications that are pending
- Any communication orders

Related Documents

1. BCD-11-11-4000: Allergy Documentation Policy
2. B-00-07-10008: Documentation
3. BCD-11-11-41002: Documentation Policy
4. B-00-16-10036: Downtime and Recovery – Cerner
5. BCD-11-11-41006: Medication Administration Policy
6. D-00-07-30091: Emergency Department Assessment and Documentation Guidelines with CST Cerner (Vancouver Coastal Health)
7. B-00-13-10109: Intravenous Medication Administration in Critical Care Areas
8. BCD-11-13-41001: National Early Warning Score (NEWS 2) for Clinical Deterioration in Adults
9. B-00-11-10106: Screening Patients and Residents for Abuse

References

1. Accreditation Canada. (2018). Standards Emergency Department. Version 14. Accreditation Canada.
2. Bullard, M.J., Musgrave, E., Warren, D., et. Al. (2016). Revisions to the Canadian Emergency Department Triage and Acuity Scale (CTAS) Guidelines 2016. Retrieved on January 26, 2021 from: http://ctas-phctas.ca/wp-content/uploads/2018/05/ctas_guidelines_-_2014.pdf
3. Canadian Association of Emergency Physicians. (2013). The Canadian Triage and Acuity Scale combined adult/paediatric education program: Participant's manual. Version 2.5b.
4. Fraser Health Authority. (2017). Reassessments and Vital Signs Guideline Principles for Emergency Patients.
5. Fraser Health Authority. (2019) Reassessment and Vital Signs Algorithm for Emergency Patients
6. Fraser Health Authority. (2022). Nursing – Emergency Department – Care Standard

Appendices

- Appendix A: Canadian Triage Acuity Scale (CTAS)
- Appendix B: Documented Items at Triage
- Appendix C: Documented Items for Physical Assessment
- Appendix D: Reviewing Completed Emergency Nursing Charting

Appendix A: Canadian Triage Acuity Scale (CTAS)

CTAS is a nationally recognized assessment standard to prioritize patients based on objective findings and clinical judgment at the time of presentation. Factors such as vital signs, pain, and mechanism of injury can help delineate triage scores. Patients who score a CTAS of 1 require immediate attention from ED providers. Patients who score a CTAS of 5 are considered stable but may still require a careful workup.

CTAS	Description	Examples
1	Resuscitation – "conditions that are threats to life or limb (or immediate risk of deterioration) requiring immediate aggressive interventions."	• Cardiac arrest • Respiratory arrest • Major trauma in shock • Shortness of breath (severe respiratory distress) • Altered level of consciousness (unconscious, GCS 3 to 9)
2	Emergent – "conditions that are a potential threat to life, limb or function, requiring rapid intervention."	• Shortness of breath (moderate respiratory distress) • Vomiting blood (dizzy on sitting up) • Hypertension (SBP greater than 220 or DBP greater than130 with symptoms) • Altered level of consciousness (GCS 10 to 13) • Fever (greater than38^{C}), looks septic (3 SIRS criteria) • Chest pain, cardiac features or significant chest pain ripping or tearing • Abdominal pain (severe acute pain) • Headache (sudden, severe, worst ever) • Major trauma – blunt, no obvious injury
3	Urgent – "conditions that could potentially progress to a serious problem requiring emergency intervention. May be associated with significant discomfort or affecting ability to function at work or activities of daily living."	• Shortness of breath (mild respiratory distress) • Hypertension (SBP greater than 220 or DBP greater than 130 with no symptoms) • Vomiting and/or nausea (mild dehydration) • Abdominal pain (moderate acute pain) • Headache (moderate acute pain) • Diarrhea (uncontrolled bloody diarrhea)
4	Less Urgent – "conditions that relate to patient age, distress, or potential for deterioration or complications, which would benefit from intervention or reassurance within 1 to 2 hours."	• Confusion (chronic, no change from usual) • UTI complaints/symptoms (with mild dysuria) • Constipation (with mild pain)
5	Non-Urgent – "conditions that may be acute but non-urgent, as well as conditions which may be part of a chronic problem, with or without evidence of deterioration."	• Diarrhea (mild, no dehydration) • Minor bites (+/- mild acute peripheral pain) • Dressing changes (uncomplicated) • Medication request

Appendix B: Documented Items at Triage

For most patients, the following items in the triage note must be completed:

- Chief complaint
- Adverse drug event (ADE) risk screen
- Infectious disease risk screen
- Vital signs: blood pressure (BP), heart rate (HR), oxygen saturation (SpO_2), respiratory rate (RR), temperature (T), Glasgow Coma scale (GCS), AVCPU.
    - Entering the above vital signs will automatically calculate a National Early Warning Score (NEWS 2).
    - *For pediatric patients*: pediatric early warning score (PEWS)
- Capillary blood glucose (CBG), if diabetic and/or clinically relevant
- Allergies
- Complaint-orientated triage (COT) descriptor
- CTAS score

Certain situations such as ongoing cardiac arrest or isolation for highly-infectious diseases require the patient to be placed directly in a care space. For patients who are being triaged directly to a care space, the following items must be completed:

- Chief complaint
- ADE risk screen – select “unable to obtain”
- Infectious disease risk screen – if known, fill in all relevant details; otherwise select “unable to obtain”
- COT descriptor
- CTAS score

Appendix C: Documented Items for Physical Assessment

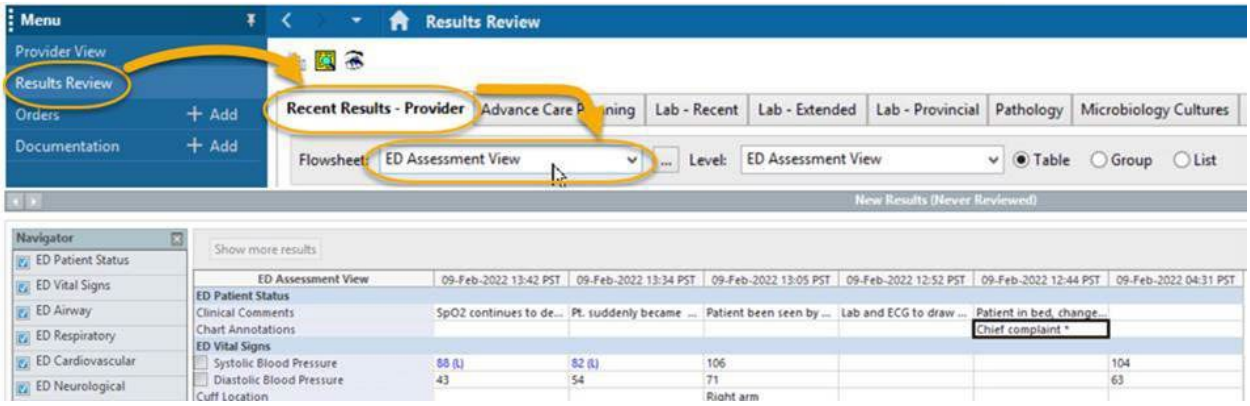
The minimum requirement for the head-to-toe or physical assessment, with relevant iView sections in brackets, is as follows:

- Airway (Primary Airway Assessment)
  - Airway patency
- Breathing (Respiratory)
  - Respiratory assessment
  - Respiratory sounds
- Cardiovascular (Cardiovascular)
  - Cardiac assessment
  - Heart sounds
  - Edema
- Neurological (Neurological)
  - GCS +/- level of consciousness
  - Pupils
  - Hand grips
  - Leg strength
- Gastrointestinal (Gastrointestinal)
  - Abdominal sounds
  - Abdominal assessment
  - Last bowel movement
- Genitourinary (Genitourinary)
  - Urinary assessment
  - Last urinary assessment
  - Last menstrual period (for females of child-bearing age)
- Psychosocial (Psychosocial)
  - Affect
  - Behaviour
  - Cognitive concerns (e.g. hallucinations, delusions)

Nurses are expected to use their clinical judgment based on a preliminary primary assessment (e.g. airway, breathing, circulation) to determine if additional secondary assessments are required.

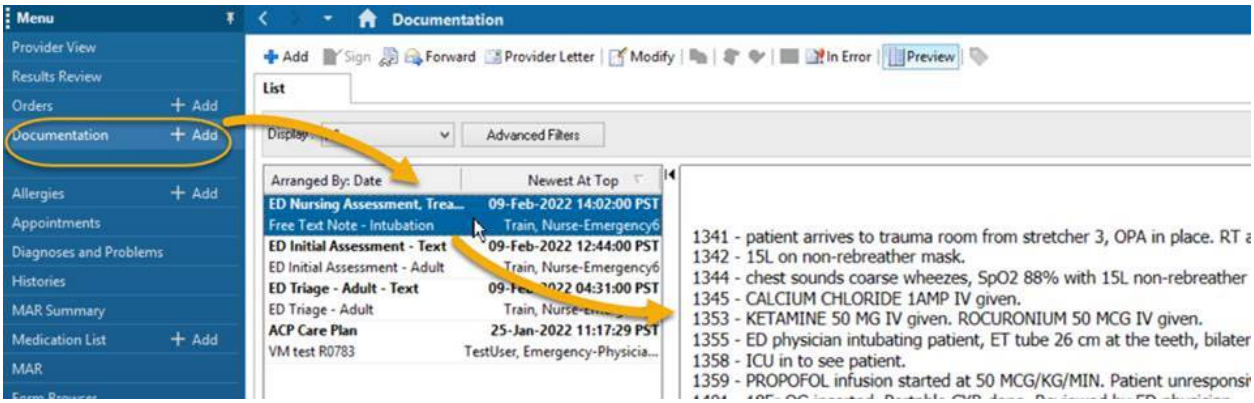
Appendix D: Reviewing Completed Emergency Nursing Documentation

Most nursing documentation in IView in the emergency department can be found under **Results Review**. In the tab "Recent Results" (or "Recent Results – Provider"), change the flowsheet to "ED Assessment View".



All items that were charted in ED Adult Systems Assessment (or ED Pediatric Systems Assessment) will show here, including clinical comments and flagged annotations at the top of the view.

If a clinically significant event occurred and documentation was done using a free text note, that documentation will show in the **Documentation** section of the chart.



Persons/Groups Consulted:

Nurse Educator, Emergency Department SPH

Nurse Educator, Emergency Department MSJ

Nurse Educator, Emergency Department LGH

CNLs, Emergency Department SPH

PCM, Emergency Department MSJ

Authors:

Nurse Educator, Emergency Department SPH

CNLs, Emergency Department SPH

First Released Date:	25-APR-2023
Posted Date:	25-APR-2023
Last Revised:	25-APR-2023
Last Reviewed:	25-APR-2023
Approved By:	PHC
	Professional Practice Standards Committee
Owners:	PHC
	Emergency Department