Assessment & Reassessment Including Vital Signs

1. Nursing care provided will be documented in the patient's electronic medical record (EMR) and encompasses an ongoing assessment of the patient's clinical status and the nursing care delivered while a patient is in the Emergency Department.
2. Assessments and care are documented as soon as possible after they are performed. Including response to medications, adverse reactions, vital signs, intake and output, etc.
3. Vital Signs:
    a. Patients meeting ESI Level 1-3 acuity ratings will have their vital signs documented every two hours and PRN as necessitated by the patient's condition, and within 30 minutes of patient disposition. All abnormal vital signs are to be reassessed with subsequent physician notification
    b. Patients meeting ESI Level 4 or 5 acuity ratings will have their vital signs recorded every four hours and PRN as necessitated by the patients' condition
    c. All abnormal vital signs are to be reassessed with subsequent physician notification
    d. Developmentally appropriate, pain scale shall be documented along with ongoing vital signs and prn.
4. Weight in kilograms shall be documented on all patients
5. Peripheral IV site, central venous catheter (CVC), or intraosseous needle (IO) must be assessed for signs and symptoms of patency, infiltration and phlebitis at least every hour while infusing.
6. Assessments And Interventions:
    a. Initial primary nursing assessment shall include at a minimum: Respiratory assessment, Cardiovascular assessment, Neurological assessment, Extremity assessment as indicated by reason for visit, Focused assessment as indicated by reason for visit.
    b. Subsequent focused assessments shall be documented at transfer of care, change in patient condition, prior to disposition, and at a minimum every two hours for patients meeting Level 1-3 acuity rating.
    c. Interventions: Patient response to interventions shall be documented when applicable
7. Nursing Note Documentation
    a. Pertinent updates, changes and resolution of the problem are documented via modifying the initial ED Nursing Note.
    b. Physician notification of abnormal assessment findings, abnormal lab results, and changes in patient status should be included
    c. Prior to admission, transfer, or discharge documentation shall be updated to reflect the patient's clinical status at the time of disposition.
8. Medication
    a. Document medications after administration
    b. Record patients' response to medication(s) as indicated.

9. Depart Process
    a. A discharge summary shall be completed on all discharges/transfers and admits.
    b. RN reviews discharge instructions, completes discharge teaching, and answers questions of patient/parent/guardian
    c. RN documents disposition assessment and updates
    d. Transfer Out Patients: RN documents disposition assessment and updates in notes including the action of calling report to receiving facility RN and documents name of RN receiving
    e. Admission to Inpatient: RN documents disposition assessment and updates in notes including the action of calling report to inpatient RN and documents name of RN receiving