SOP Template: Patient Triage and Initial Assessment Protocols

This SOP defines the **patient triage and initial assessment protocols** to ensure timely and accurate prioritization of patients based on the severity of their condition. It includes guidelines for initial patient evaluation, vital signs measurement, symptom documentation, and risk assessment to facilitate effective resource allocation and prompt medical intervention. The goal is to enhance patient outcomes by streamlining the triage process and ensuring consistent clinical decision-making in emergency and clinical care settings.

1. Purpose

To outline the process for triaging and initially assessing patients to prioritize care, optimize resource use, and improve clinical outcomes in emergency or clinical care environments.

2. Scope

This protocol applies to all healthcare staff involved in the triage and initial assessment of patients presenting to the facility.

3. Responsibilities

- **Triage Nurse/Clinician:** Conducts the initial assessment and assigns triage category.
- **Clinical Team:** Reviews triage assessments and provides appropriate care.
- **Supervisors/Managers:** Ensure adherence to this protocol.

4. Triage Process

1. **Patient Registration:** Collect basic demographic information upon arrival.
2. **Immediate Identification of Critical Cases:** Rapidly identify and prioritize visibly critical patients (e.g., unresponsive, severe bleeding).
3. **Initial Assessment:**
    - Obtain chief complaint and history of present illness.
    - Record allergies, medications, and relevant past medical history.
    - Document onset and duration of symptoms.
4. **Vital Signs Measurement:**
    - Temperature
    - Pulse rate
    - Blood pressure
    - Respiratory rate
    - Oxygen saturation
    - Pain score (if applicable)
5. **Symptom Documentation:** Accurately document presenting complaints and observable signs.
6. **Risk Assessment:**
    - Utilize standardized triage scales (e.g., ESI, CTAS, MTS) to assign priority level.
    - Identify risk factors for deterioration (e.g., age, comorbidities, abnormal VS).
7. **Triage Category Assignment:** Assign a triage category according to assessment findings (see triage category table).
8. **Clinical Handover:** Communicate findings promptly to the treating clinical team.
9. **Documentation:** Enter all findings and actions in the patient's medical record.

5. Triage Category Table

Category	Criteria	Response Time
Immediate (Red)	Life-threatening conditions, unstable vital signs, critical symptoms	Immediate intervention
Urgent (Orange)	Potentially serious, pain or abnormal vital signs, requires prompt assessment	Within 15 minutes
Semi-Urgent (Yellow)	Stable but requires medical attention; no immediate danger	Within 60 minutes

Non-Urgent (Green)	Minor ailments, stable condition	Within 120 minutes

6. References

- Emergency Severity Index (ESI) Implementation Handbook
- Canadian Triage and Acuity Scale (CTAS) Guidelines
- Manchester Triage System (MTS) Manual
- Local institutional policies and protocols

7. Revision History

Date	Version	Change Description	Author
2024-06-20	1.0	Initial SOP Template Creation	Clinical Governance Team