Standard Operating Procedure (SOP): Triage and Initial Patient Assessment Protocols

Purpose: To establish a systematic approach for prioritizing patient care based on severity, ensuring rapid assessment, accurate categorization, proper documentation, and effective communication for optimal resource utilization and patient outcomes in emergency and clinical settings.

1. Scope

This SOP applies to all clinical and emergency department staff responsible for the initial assessment and triage of patients upon arrival to the healthcare facility.

2. Definitions

- **Triage:** The process of rapidly assessing and prioritizing patients according to the urgency of their condition.
- **Initial Patient Assessment:** A quick evaluation of a patient's presenting complaints, vital signs, and risk factors upon arrival.

3. Responsibilities

- Triage nurse or appointed clinical staff: Conducts initial assessment and categorizes patients.
- All staff: Ensure timely and accurate communication and documentation during the triage process.

4. Procedure

1. **Patient Arrival and Registration**
    - Patients are to be greeted promptly upon entry.
    - Collect basic information: Name, age, presenting complaint, and time of arrival.
    - Assign a triage number or identifier.
2. **Rapid Primary Assessment**
    - Assess Airway, Breathing, Circulation, Disability (neurological status), and Exposure (ABCDE approach).
    - Obtain vital signs: temperature, pulse, blood pressure, respiratory rate, oxygen saturation.
    - Identify immediate life-threatening conditions and initiate interventions if necessary.
3. **Triage Categorization**

Category	Criteria	Target Response Time
Red (Immediate)	Life-threatening conditions; requires immediate intervention	0-1 min
Yellow (Urgent)	Serious, but not immediately life-threatening; needs prompt care	10 mins
Green (Standard)	Minor injuries or stable condition; non-urgent	30 mins
Black (Deceased/Expectant)	No signs of life or injuries incompatible with survival	As appropriate

4. **Documentation**
    - Record all assessment findings, vital signs, triage category, and time of triage in the patient's medical record or electronic health system.
    - Include details of any immediate interventions.
5. **Communication**
    - Notify appropriate clinical teams of incoming high-priority cases (e.g., Red/Immediate category).
    - Update waiting area staff and continue to reassess patients if delays occur.
    - Handover care using structured checklists to ensure critical information is communicated during transitions.
6. **Reassessment**
    - Periodically reassess waiting patients if their condition changes or delays are encountered.

5. Quality Assurance and Review

- Monitor triage accuracy and response times through regular audits.
- Review incidents and update protocols as needed for continuous improvement.

6. References

- National guidelines on emergency triage systems.
- Facility-specific emergency department protocols.

7. Document Control

- **Effective Date:** [Insert Date]
- **Review Date:** [Insert Date]
- **Approved by:** [Insert Approver]