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

This SOP details the **initial patient assessment and triage guidelines**, focusing on systematic evaluation of patients upon arrival, prioritization based on severity of condition, utilization of standardized triage scales, documentation of vital signs and medical history, identification of life-threatening conditions, and efficient communication with healthcare teams to ensure timely and appropriate care delivery.

1. Purpose

To ensure rapid, accurate, and systematic assessment and triage of patients upon presentation, facilitating timely care based on clinical urgency.

2. Scope

This guideline applies to all healthcare personnel involved in the initial assessment and triage of patients within emergency departments, urgent care centers, and acute care settings.

3. Responsibilities

- **Triage Nurse/Designated Clinician:** Carry out initial assessments, triage patients, document findings, and escalate care when required.
- **Healthcare Team:** Respond promptly to urgent cases and provide necessary interventions as communicated by triage staff.

4. Procedure

1. **Patient Arrival:** Immediately greet and identify the patient. Ensure the patient is comfortable and in a secure environment.
2. **Primary Assessment (ABCDE):**
    - **A**irway: Assess patency, clear obstructions if necessary.
    - **B**reathing: Evaluate respiratory effort and rate, apply oxygen if indicated.
    - **C**irculation: Assess pulse, blood pressure, perfusion status.
    - **D**isability: Assess mental status (AVPU or GCS scale).
    - **E**xposure: Look for injuries/conditions requiring immediate response.
3. **Obtain Vital Signs:**
    - Temperature
    - Pulse
    - Respiratory Rate
    - Blood Pressure
    - Oxygen Saturation
4. **Medical History & Presenting Complaint:** Document relevant medical history, current medications, allergies, and reason for visit.
5. **Triage Scale Application:** Utilize a standardized triage tool (e.g., ESI, CTAS, MTS) to assign acuity level based on findings.
6. **Identification of Life-Threatening Conditions:** Prioritize and immediately escalate cases with airway compromise, respiratory distress, circulatory compromise, severe trauma, or altered mental status.
7. **Documentation:** Record all assessment findings and triage decisions in the patient's medical record in real time.
8. **Communication:** Notify the healthcare team of critical findings; ensure concise and clear handover using standardized tools (e.g., SBAR).
9. **Reassessment:** Regularly review waiting patients, update triage category if condition changes.

5. Standardized Triage Scales

Scale	Levels	Description

Emergency Severity Index (ESI)	1 (Most urgent) â€“ 5 (Least urgent)	Assigns priority based on severity of presenting problem and anticipated resource needs.
Canadian Triage & Acuity Scale (CTAS)	1 (Resuscitation) â€“ 5 (Non-urgent)	Applicable for all patient ages and medical/surgical complaints.
Manchester Triage System (MTS)	Red (Immediate) â€“ Blue (Non-urgent)	Category-based assessment using presenting complaint flow-charts.

6. Documentation

Accurate documentation is required for all assessment findings, triage decisions, and communication with the broader care team. Use electronic or standardized paper records as per institutional protocol.

7. References

- Institutional Triage Policy
- Emergency Nurses Association (ENA) â€“ Triage Guidelines
- World Health Organization (WHO) â€“ Emergency Triage Assessment and Treatment (ETAT)

8. Review and Updates

This SOP should be reviewed annually and updated as necessary to reflect current best practices and institutional requirements.