SOP: Initial Patient Health Assessment and Triage Guidelines

This SOP defines the procedures for **initial patient health assessment and triage guidelines**, focusing on rapid and accurate evaluation of patient conditions, prioritization of care based on severity, systematic collection of vital signs and medical history, identification of life-threatening symptoms, communication protocols for healthcare teams, and documentation standards. Its objective is to ensure timely and effective patient management, optimize resource allocation, and enhance overall clinical outcomes in emergency and clinical settings.

1. Purpose

To establish standard procedures for assessing, triaging, and prioritizing patients upon presentation to emergency or clinical settings to improve outcomes and resource allocation.

2. Scope

This SOP applies to all healthcare personnel responsible for patient assessment and triage in emergency departments, urgent care, outpatient clinics, and other relevant clinical environments.

3. Responsibilities

- **Triage Nurse:** Perform initial patient assessment and assign triage category.
- **Healthcare Providers:** Support in-depth evaluation and manage care as indicated by triage.
- **Administrative Staff:** Document and communicate assessment results as needed.

4. Procedure

1. **Patient Arrival & Registration**
    - Greet the patient, verify identity, and record basic details (name, date of birth, arrival time).
2. **Initial Assessment**
    - Rapid evaluation of airway, breathing, and circulation (ABCs).
    - Check responsiveness, level of consciousness, and obvious distress.
3. **Vital Signs Collection**
    - Record temperature, heart rate, blood pressure, respiratory rate, oxygen saturation, and pain score.
4. **Medical History & Presenting Complaint**
    - Briefly obtain chief complaint, relevant history, allergies, medications, and comorbid conditions.
5. **Identification of Life-Threatening Symptoms**
    - Assess for signs of respiratory distress, shock, chest pain, severe trauma, altered mental status, uncontrolled bleeding, or other critical symptoms.
6. **Triage Classification**
    - Assign the appropriate triage category based on assessment:

Triage Category	Description	Priority
Immediate (Red)	Life-threatening conditions requiring immediate intervention	Highest
Urgent (Yellow)	Serious but not immediately life-threatening	High
Delayed (Green)	Minor injuries/illnesses, can safely wait	Moderate
Expectant (Black)	Unsurvivable injuries, palliative support as able	Lowest

7. **Communication Protocols**
    - Report critical findings immediately to the designated healthcare provider/team.
    - Use clear and concise handoff communication (e.g., SBAR: Situation, Background, Assessment, Recommendation).
8. **Documentation Standards**
    - Record all assessment findings, triage decision, communications, and interventions in the medical record promptly.
    - Update records as patient condition evolves or reassessment is performed.
9. **Ongoing Monitoring**
    - Reassess patient condition at regular intervals or as indicated by clinical status.
    - Update triage category and notify healthcare team if patient condition deteriorates.

5. References

- Hospital policy and triage protocols
- Emergency Nurses Association (ENA) Triage Guidelines
- World Health Organization (WHO) Emergency Triage Assessment and Treatment (ETAT)

6. Review

This SOP will be reviewed annually and updated as required based on clinical best practices and organizational standards.