From the Office of Health Informatics

Quick Reference Guide (QRG)
Triage a Patient

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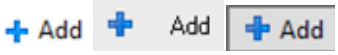
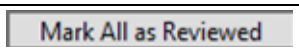
This Quick Reference Guide (QRG) demonstrates the workflow to triage a patient in Oracle Health (Cerner) Millennium – FirstNet.

Common Buttons & Icons

	**Document All** checkbox
	**Go Back** icon
	**Add** button(s)
	**Mark All as Reviewed** button
	**Binoculars** icon
	**Sign** icon
	**Document Medication by History** button
	**Document History** button

Document the Patient Triage Form

➢ **From ED LaunchPoint:**

STEP 1: Click the **Activities** cell for the appropriate patient. The Activities screen displays.

STEP 2: Select the **Document All** checkbox.

STEP 3: Click **Document**. The Triage Form opens in a new window.

NOTE: **Required fields are marked by yellow highlight. It is best practice to document all fields as appropriate for the patient.**

STEP 4: Document the **Chief Complaint** and **Mode of Arrival**.

STEP 5: Complete the remaining documentation.

Complete Stroke Documentation

➢ **From the ED Triage Form:**

STEP 1: Select the **Stroke** checkbox. The Stroke Symptom Details window displays.

STEP 2: Complete documentation as required and appropriate for the patient.

STEP 3: Click the **Go Back** icon to return to documentation.

Complete Infectious Disease Screening

- **From the ED Triage Form**

STEP 1: Click **Document Infectious Disease Screening**. The ID Risk Screen window displays.

STEP 2: Complete documentation as required and appropriate for the patient.

NOTE: **If the patient responds Yes to any risk factor for COVID-19, the precaution window displays. Review the information; then, use the Go Back icon to return.**

- **Use the table headers to quickly populate all cells of the table. Then, adjust as needed.**

STEP 3: Click the **Go Back** icon to return to documentation.

Document Prearrival Interventions

- **From the ED Triage Form:**

STEP 1: Click **Document pre-arrival interventions**. The Pre-Arrival Interventions window displays.

STEP 2: Complete the documentation as appropriate for the patient.

STEP 3: Click the **Go Back** icon to return to documentation.

Complete Triage Interventions

- **From the ED Triage Form:**

STEP 1: Click **Document Triage Interventions**. The Triage Interventions window displays.

STEP 2: Complete the documentation as appropriate for the patient.

STEP 3: Click the **Go Back** icon to return to documentation.

Complete Triage Assessments

- **From the ED Triage Form:**

STEP 1: Click **Document Triage Assessment**. The Triage Assessment window displays.

STEP 2: Complete the documentation as appropriate for the patient.

STEP 3: Click the **Go Back** icon to return to documentation.

Document a Behavioral Health Complaint

- **From the ED Triage Form:**

STEP 1: Click **Yes** if the patient has a behavioral health complaint. The CSSRS Screen window displays.

NOTE: **If the response is No, there is no further required documentation.**

STEP 2: Complete the documentation as appropriate.

NOTE: **Use the examples and blue reference text as needed.**

STEP 3: Click the **Go Back** icon to return to documentation.

Add an Allergy

➢ **From the ED Triage Form:**

STEP 1: Click **Document** in the Allergies field. The ED Triage Allergies window displays.

STEP 2: Click **Add**. The Add Allergy/Adverse Effect window displays.

STEP 3: Click the **Substance** field.

NOTE: **Enter the allergy and use the binoculars icon to search or use the Common folders in the bottom pane to locate the allergen.**

STEP 4: Document the details of the allergy as required and appropriate for the patient.

STEP 5: Click **OK**.

Cancel an Allergy

➢ **From the ED Triage Allergies window:**

STEP 1: Right-click the allergy row. A dropdown menu displays.

STEP 2: Click **Cancel**. The Cancel Allergy window displays.

STEP 3: Confirm the Canceled status; then, click **OK**.

NOTE: **The allergy now displays in a Canceled Status with a red strikethrough.**

Review Allergies

➢ **From the ED Triage Allergies window:**

STEP 1: Click **Mark All as Reviewed** once all allergies have been added, modified, and reviewed with the patient.

STEP 2: Click the **Go Back** icon to return to documentation.

Complete Fall Risk Documentation

➢ **From the ED Triage Form:**

STEP 1: Click **Document Kinder Fall Risk**. The Fall Risk Assessment window displays.

STEP 2: Complete the documentation as appropriate for the patient.

NOTE: **If the patient is a High fall risk, document the Fall Interventions Initiated in the bottom section.**

STEP 3: Click the **Go Back** icon to return to documentation.

Complete the Triage Form

➢ **From the ED Triage Form:**

NOTE: **It is important to document the patient's vital signs and measurements so the provider can enter orders that require weight information.**

STEP 1: Scroll down to the **Vital Signs** section.

STEP 2: Use the fields to document the appropriate information for the patient.

NOTE: **It is best practice to be as thorough as possible.**

STEP 3: Scroll down to the **Pain Assessment Adult** section.

STEP 4: Complete documentation as appropriate.

STEP 5: Scroll down to the **Patient Acuity** section.

NOTE: **Use the Emergency Service Index to determine the patient's acuity if needed.**

STEP 6: Click the **Tracking Acuity** dropdown arrow and make the appropriate selection.

STEP 7: Scroll down to the **Problems** section.

STEP 8: Click **Add**. The Add Problem section displays.

STEP 9: Enter the Problem in the field; then, click the **binoculars** icon. The Problem Search window displays.

STEP 10: Double-click the problem from the search results.

STEP 11: Complete the remaining documentation on the problem. Then, click **OK.**

STEP 12: Click the **Sign** icon.

NOTE: **Because Document All was selected from the Activities screen, the ED Intake Form automatically displays.**

Document the ED Intake Form

➢ **From the ED Intake Form:**

NOTE: **Required fields are marked by yellow highlight. It is best practice to document all fields as appropriate for the patient.**

STEP 1: Complete the **General Information** fields as necessary for the patient.

Document the Patient's Communication Needs

➢ **From the ED Intake Form:**

STEP 1: Click **Document Communication Needs/Preferences**. The Communication Needs and Preferences window displays.

STEP 2: Complete all fields as appropriate for the patient.

STEP 3: Click the **Go Back** icon to return to documentation.

Complete the Glasgow Coma Assessment

➢ **From the ED Intake Form:**

STEP 1: Click **Open Glasgow Coma Assessment**. The Glasgow Coma Scale window opens.

STEP 2: Document all fields for the patient.

STEP 3: Click the **Go Back** icon to return to documentation.

Add Home Medications

➢ **From the ED Intake Form:**

STEP 1: Click **Document** in the Home Medications section. The ED Triage Medications window displays.

STEP 2: Click **Document Medication by Hx**. The Document Medication by Hx window displays.

STEP 3: Click **Add**. The Add Order window displays.

NOTE: **Use the Search field to enter the medication or use the common home medication folders by starting letter.**

STEP 4: Select the appropriate medication from the results. The Order Sentences window displays.

STEP 5: Make the appropriate selection; then, click **OK**.

STEP 6: Click **Done** when all medications are entered. The Details pane for the medication displays.

STEP 7: Document the details of the medication.

NOTE: **Confirm the details of the order. Navigate to the Compliance tab to document the current status and last dose date/time.**

STEP 8: Click **Document History**.

Remove a Home Medication

- **From the ED Triage Medications window:**

STEP 1: Click the medication from the list. The Details pane for the medication displays.

STEP 2: Click the **Status** dropdown arrow.

STEP 3: Click **Not taking**.

STEP 4: Click **Sign**.

STEP 5: Click the **Go Back** icon once all home medications are accurate.

Add a Procedure

- **From the ED Intake Form:**

STEP 1: Click **Open Procedure History Documentation**. The Procedure History window displays.

STEP 2: Click **Add**.

STEP 3: Enter the Procedure in the field; then, click the **binoculars** icon.

STEP 4: Click the appropriate procedure from the search results; then, click **OK**.

STEP 5: Enter the details of the procedure.

NOTE: **Change the Date format using the blue link.**

STEP 6: Click **OK**.

STEP 7: Click **Mark all as Reviewed** once all procedure history is entered and reviewed with the patient.

STEP 8: Click the **Go Back** icon to return to documentation.

Complete Social History Documentation

- **From the ED Intake Form:**

STEP 1: Click **Open Social History Documentation**. The Social History window displays.

NOTE: **All prior encounter documentation for this section will pull forward. Tobacco history, Alcohol, Substance Use History, Abuse/Neglect, and Spiritual/Cultural must be documented for each visit.**

STEP 2: Click **Add**. The Tobacco section expands.

NOTE: **Required fields are marked by an asterisk and bold text.**

STEP 3: Complete the required and appropriate fields for the patient. Then, scroll down.

STEP 4: Complete the **Electronic Cigarette/Vaping** documentation as appropriate for the patient.

STEP 5: Scroll down to complete the **Alcohol** documentation as appropriate for the patient.

STEP 6: Scroll down to complete the **Substance Use History** documentation for the patient.

NOTE: **Continue documentation as needed for the patient.**

STEP 7: Click **OK** once all documentation is complete.

STEP 8: Click the **Go Back** icon to return to documentation.

Finalize ED Intake Form

- **From the ED Intake Form:**

STEP 1: Confirm all documentation is complete.

STEP 2: Click the **Sign** icon.

NOTE: **The Activities screen populates. Information documented in the form can be viewed in the patient summary.**

Modify Completed Forms

- **From the charting window of the Clinical Entry Workspace:**

STEP 1: Click **Modify** for the appropriate form. The form displays.

STEP 2: Make the appropriate modifications; then click the **Sign** icon.