Triage Guidelines

DEVELOPED BY THE HEALTH CARE FOR THE HOMELESS CLINICIANS' NETWORK

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Goal of the Triage Process

- These triage guidelines are designed to assist in determining the acuity of a client's needs and the proper action to take. The goal of the triage process is to ensure that a reasonable and responsible level of care regarding the client's presenting problem is accessible to all clients. The guidelines are designed to evaluate clients who call or walk in for care or are encountered through outreach.

General Policies

- **Adapt to your model of care.** Projects can adapt these general guidelines to fit various practice settings and models of care.
- **Triage process implementation.** It is recommended that designated triage personnel with appropriate clinical training implement the triage process. It is not recommended that non-medical personnel evaluate a patient complaint or offer medical advice although they may schedule an appointment or refer the patient to other sources of medical care according to the project's backup/coverage schedule.
- **Registration of emergency clients.** Immediately assess clients with emergency needs rather than seeing them in order of registration. In a clinic setting, the triage staff person will review clients registered for any acute or urgent entries as recorded by the receptionist.
- **Documentation.** Document all encounters with clients in the chart.
- **Emergency referrals.** All staff must be aware of policies and procedures governing emergencies including triage guidelines. Clear interagency agreements to facilitate emergency referrals are essential.

Triage Levels

- **Use of guidelines.** An assessment of acuity using these triage guidelines determines the priority level. The volume of clients in the clinic or waiting room, the time of day, or the day's staffing pattern does not determine priority level. These factors may affect subsequent actions, but it is essential that all clients be given proper attention and either care or referral that is appropriate for the assessed acuity level.
- **Assignment of priority level.** A client may present with symptoms spanning more than one priority level. In these cases, the triage staff person will use his or her best clinical judgment in determining the level of acuity. When in doubt as to the level of acuity, assign the client to the more acute priority level. In cases for which assessment is ambiguous or questionable, the triage staff person should consult with a medical provider.
- **Change of priority level.** Client reassessment is necessary to change the triage level; and only the designated triage staff person—in consultation with a medical provider, if necessary—may change the triage level.

	PRIORITY LEVEL I	PRIORITY LEVEL II	PRIORITY LEVEL III	PRIORITY LEVEL IV
MEDICAL NEEDS	Acute urgent symptoms such as acute chest pain, profuse bleeding, unconsciousness, etc. Best managed by prompt attention of an emergency department.	Symptomatic with non-emergent needs such as cough, abscess, has run out of seizure meds, 2nd or 3rd trimester of pregnancy with no prior prenatal care, etc.	Asymptomatic or mildly symptomatic with routine needs such as running low on meds, needs TB test, needs exam for completion of papers, etc.	Asymptomatic and non-urgent such as wants HIV test, wants eye exam, has only one more refill on meds for chronic condition, etc.
SOCIAL SERVICE NEEDS	First time homeless; recent eviction or dangerous living environment; no support system; no financial resources; unable to care for self; has young dependents.	Vulnerable client experiencing crisis with housing or shelter arrangement. Needs specific support to get through night such as blanket, food, referral, etc.	Known to agency. Requests assistance in filling out papers or obtaining identification or transportation to other agency in order to obtain services such as public aid, medical appointment, etc.	New client requesting shelter but has bed for night or next few days. Requests information about other agencies.
MENTAL HEALTH NEEDS	Suicidal or homicidal ideation with plan. Unable to control self; real or potential harm to self or others. Severe psychotic symptoms such as hallucinations, delusions, severely impaired reality testing, etc.	Suicidal or homicidal ideation without a plan. Mild psychotic symptoms; can safely wait for mental assessment today.	Has significant mood change such as depression, anxiety, hypomania, etc. Change in activities of daily living, eating, sleeping patterns. No suicidal or homicidal ideation. Out of psychotropic medication.	Has ongoing psychological or mental health needs with no current stressor or change in activities of daily living. Missed last appointment but has enough meds to last until appointment can be rescheduled.
SUBSTANCE ABUSE NEEDS	Evidence of toxicity due to substance abuse such as slurred speech, labored breathing, pupils non-responsive, unconscious or stuporous, etc. Alcohol withdrawal; history of seizures or DTs; most recent drink less than 12 hours. Fluctuating vital signs; hallucinations.	Requesting substance abuse services. Reports regular use of substances and has used within past 24 hours. Unsteady gait; impaired judgment; appears unable to follow through with recommendations on own.	History of substance abuse within past 30 days and concerned about relapse.	History of substance abuse. Denies use within past 30 days and does not exhibit signs of impairment such as slurred speech or unsteady gait.
ACTION RESPONSE	Send to emergency department or other appropriate emergency facility or agency. Triage staff may ask for a clinic provider to assist with needed care until paramedics or transportation arrives. Call to notify referral facility of impending arrival. Follow indicated emergency procedures.	Make arrangements for client to see appropriate provider today or refer to another appropriate facility that can provide service today.	Make arrangements for client to see appropriate provider as soon as possible or return the next day for reassessment, if appropriate. May need referral for meds.	Give next available routine appointment with appropriate provider.