Health Care for the Homeless
INFORMATION RESOURCE CENTER
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#8. CLINICAL GUIDELINES

Abrasion (*BAL 5a*)
Adult screening/counseling/immunization (*WES 7*)
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BAL 5a

ABRASIONS

Definition: A minor scraping away of the superficial layer of skin.

Biology: Result of injury or mechanical means.

Signs/symptoms: Slight bleeding, easily controlled. May have debris superficially embedded. May be associated with other injuries; lacerations, contusions, fractures.

Goal: Wound healing without infection.

NURSING PROCESS

Triage:

CATEGORY III	CATEGORY II
Fever, signs of infection, associated injury, no tetanus shot in ten years	No fever, associated injury, signs of infection, no need for tetanus shot.

Protocol:

S: Note tetanus status, cause of abrasion, time occurring, possible other injury (i.e.: head injury, loss of consciousness and refer according to triage guidelines).

O: Document size, appearance, location of wound.
If other injury noted, refer according to triage guidelines.
Take temperature. If >100', refer to medical clinic.
If purulence, tight, shiny skin, debris embedded in wound, edema, copious bleeding ———> refer to medical clinic.
If no tetanus shot in ==> ten years ———> refer to medical clinic.

If "no" to the above, continue with nursing protocol.

A: Abrasion

P: Cleanse wound gently with soap and water.
Apply antibiotic ointment and sterile dressing or bandaid if appropriate.

Approved by: _____ 10/23/95
Vel Natesan, MD *Date*

Barbara Clark CRNP 10/26/95
Barbara Clark, CRNP *Date*

Health Education: Keep area clean and dry. Look for signs of infection - - redness, pain, tenderness, draining and return to HCH if noted.

WES 7

***Selected MCHD Adult Screening, Counseling and Immunization Guidelines, 1997 (DRAFT)**

I. SCREENING:

A. VASCULAR DISEASES:

Cholesterol:
Screen all men 35-65y and women 45-65y for high blood cholesterol (fasting or non-fasting). May be recommended in young adults who have a FH of very high cholesterol,or premature CHD in a first-degree relative (<50 in men & <60 in women). Appropriate interval is not known. Insufficient evidence to recommend for or against routine screening in asymptomatic persons >65y. Insufficient evidence to recommend for or against routine measurement of HDL-C or triglycerides at initial screening.

B. CANCER SCREENING

Breast Cancer:
Women 40-49y: conflicting evidence of fair to good quality regarding clinical benefit from mammography with or without clinical breast exam (CBE) & insufficient evidence regarding benefit from CBE alone.

Women 50-69y: screen q1-2yrs with mammography alone or mammography and annual CBE. Insufficient evidence to recommend annual CBE alone.

Women 70-74y: limited and conflicting evidence regarding benefit for screening.

Women 75y+: no evidence regarding benefit for screening.
FP Grant requires: Initial exam: CBE on any woman on prescriptive methods (hormonal contraception IUD, or diaphragm) and instruct in breast self-exam. Annually: Hormonal contraceptive users must receive CBE.

Cervical Cancer:
PAP Smears: At least q 3y after onset of sex in women with a cervix. Interval to be determined based on risk factors. Insufficient evidence to recommend for or against an upper age limit.
S/P hysterectomy: d/c PAP unless hyst was for cervical CA or CIS/CIN.
FP Grant: qy if on hormonal contraception or IUD.

Colorectal Cancer:
Screen all 50+yrs. Effective methods include FOBT and sigmoidoscopy. insufficient evidence to determine which method is preferable. Good evidence to support FOBT annually, but insufficient evidence to recommend periodicity for sigmoidoscopy.

Prostate Cancer:
Routine screening with DRE , PSA or TRUS is not recommended.

Testicular Cancer:
Insufficient evidence to recommend for or against routine screening of asymptomatic men by clinical exam or pt self-exam. Pts with an increased risk of testicular cancer b/o h/o cryptorchidism, orchiopexy, or testicular atrophy should be informed of their increased risk and counseled about the options for screening.

C. METABOLIC DISORDERS:

Diabetes Mellitus:
Insufficient evidence to recommend for or against routine screening in nonpregnant adults. May decide to screen persons at high risk of NIDDM (obese persons over 40; pts with strong FH of NIDDM, and members of Native American, Hispanic and African American ethnic groups) on other grounds.

Obesity:
Periodic HT & WT measurements are recommended for all pts.

D. INFECTIOUS DISEASES:

Sexually Transmitted Diseases: (if pregnant , screen for all) Take a complete sexual and drug use history on all pts.

Chlamydia:
In high risk only: h/o prior STD, new or multiple sex partners, age <25, inconsistent use of barrier contraceptives, cervical ectopy and unmarried. ***Region X:*** *2 or more of the following: age <24 if sexually active; new partner within 60 days; 2 or more partners in 6 months; sex with multiple partners; use of nonbarrier or no birth control.*

Gonorhea:
In high risk women only: sex workers, h/o repeated episodes of GC, women under age 25 with 2+ partners in the last year. In communities with high prevalence broader screening may be warranted.

Syphilis:
In high risk only: sex contacts with active syphillis, sex workers; persons who exchange sex for money or drugs; persons with other STDs, persons who engage in sex with multiple partners in areas in which syphillis is prevalent.

Hep B:
Insufficient evidence to recommend for or against routine screening of asymptomatic high-risk individuals before vaccination but recommendations may be made based on cost-effectiveness analyses. Screening is usually cost-effective in high risk: sex contact of HBV+ person; h/o illicit injection drug use (IIDU); men who have sex with men; recipients of certain blood products; health care workers with exposure to blood or blood products, refugees, persons with multiple sex partners or hx of recent STD.

HIV:
Offer counseling and testing to all at high risk of infection: those seeking tx for STD; men who have had sex with men after 1975; past or present IIDUs; persons who exchange sex for money or drugs, and their sex partners; women and men whose past or present sex partners were HIV-infected, bisexual or IIDU; and persons with h/o transfusion between 1978-85.

Turberculosis:
Tuberculin skin testing should be performed on those at high risk of acquiring TB:
- Medically underserved low income populations (this includes all MCHD pts); IIDUs, alcoholics; contacts of TB cases; chronic medical condition (includes DM, ESRD, etc); persons from endemic areas. Frequency is a matter of clinical discretion.
- Once a year: HIV infection, homeless.

E. VISUAL IMPAIRMENT:
Insufficient evidence to recommend for or against routine screening in nonelderly adults. Routine vision screening with Snellen acuity testing is recommended 65y+.

F. GLAUCOMA:
Insufficient evidence to recommend for or against routine screening by primary care providers. Best performed by eye specialists. High-risk pts may be referred on other grounds: ie, populations in whom the prevalence is >1%: includes Af-Ams >40y and whites >65y; pts with FH; pts with glaucoma or severe myopia

G. SUBSTANCE ABUSE:

Tobacco Use:
Screen all pts at least once a year.

Problem Drinking:
Screen all. Should involve a careful hx of alcohol use and/or the use of other potentially dangerous activities after drinking.

Drug Abuse:
Insufficient evidence to recommend for or against routine screening for drug abuse with standardized questionnaires or biologic assays. Including questions about drug use when taking a hx may be recommended on other grounds, including the prevalence of community drug use and the serious consequences of drug abuse and dependence.

II. COUNSELING:

Tobacco cessation:
Offer on a regular basis to all pts who use tobacco products. Nicotine replacement products are recommended as an adjunct for selected pts.

Drugs/Alcohol:
All persons who use alcohol should be informed of the health and injury risks associated with use and encouraged to limit to moderate levels (<2 drinks/day). Counsel re: danger of operating motor vehicles and engaging in other potentially dangerous activities when using.

HIV/STDs:
Advise all about risk factors for STDs and counsel appropriately about effective measures to reduce risk of infection.

Healthy Diet:
Counsel to limit diet intake of fat (total fat to <30% cals, sat fat <10% and chol<300mg/day), maintain caloric balance, and emphasize fruits vegetables(at least 5 svgs/day) and grain productes containing fiber (at least six servings of breads, cereals or legumes/day).

Regular Physical Activity:
Counseling to promote regular physical activity is recommended for all.

Unintended pregnancy:
Periodically counsel all men and women at risk for unintended pregnancy.

Aspirin Prophylaxis:
Insufficient evidence to recommend for or against routine ASA prophylaxis for the primary prevention of MI in asymptomatic persons. In men with other risk factors for CHD who lack contraindiations (CI) to ASA use the benefit may outweigh harms. In asymptomatic men w/o risk factors for CHD or with relative CI to ASA use, the harms may outweigh the benefits. If ASA tx is considered pts should understand the potential benefits and risks for beginning tx. Data are insufficient to support or refute use of ASA prophy in women.

Folic Acid:
Folic acid supplementation at 4mg/day , 1-3mos prior to conception and through the first trimester is tecommended for women who have previously had a pregnancy affected by a neural tube defect . Also, women planning pregnancy should take a daily multivit supplement with 0.4 -0.8mg of folic acid beginning at least 1 mo prior to conception and through the first trimester. A daily multi vit with 0.4 mg of folic acid is also recommended for all women capable of becoming pregnant, to reduce the risk of neural tube defects in unplanned pregnancies.

Osteoporosis:
All postmenopausal women should be counseled about hormone prophylaxis and be advised of the importance of smoking cessation, regular exercise & adequate calcium intake.

Calcium:
Women should be encouraged to consume recommended quantities of calcium (<25yo 1200-1500mg/day; 25- 50yo 1000/day; postmenopausal 1000-1500/day, pregnant & nursing 1200-1500/day)

Estrogen:
Counsel all women around the time of menopause about the possible benefits and risks of postmenopausal hormone therapy and the available treatment options.

Dental Health:
Counsel pts to visit a dental care provider on a regular basis based on evidence for risk reduction from such visits when combined with regular personal oral hygiene.

Household/Recreational Injury Prevention:

All who use ETOH or other drugs:
Counsel to avoid potentially dangerous activities while intoxicated (e.g. swimming, boating, handlingof firearms, smoking in bed, hunting, bicyling).

Homeowners:
Install & regularly test smoke detectors, set hot water heaters at 120F, and keep firearms unloaded in locked compartment.

Bicyclists:
Counsel about the importance of wearing safety helmets and avoiding riding in motor vehicle traffic.

Elderly:
Counsel re: measures to reduce risk of falling e.g. exercise/balance training, safety skills, environmental hazard reduction, medication adjustments.

Motor Vehicle Injuries:
Counsel all pts to use occupant restraints, to wear helmets when riding motorcycles, and to refrain from driving while under the influence of alcohol or other drugs.

III. IMMUNIZATIONS

Influenza:
Administer qy to all 65+yrs; residents of chronic care facilities; those suffering from chronic cardiopulmonary disorders, metabolic disease, hemoglobinopathies, immunosuppression or renal dysfunction; health care providers for high risk pts.

Pneumovax:
All immunocompetent persons 65+yrs at increased risk for pneumococcal disease: institutionalized persons 50+yrs, persons with chronic cardiac or pulmonary disease, DM & anatomic asplenia; those who live in special enrironments or social setting with increase risk (eg. certain Native American and Alaska Native populations). Insufficient evidence to recommend for or against pneumococcal vaccine for immunocompromised individuals, but may vaccinate based on other grounds.

Td:
Optimal interval for booster not established. Std is at least once every 10 yrs. In US q15-30yrs may be adequate in those who recd a five-dose series in childhood. If unsure if ever had full series: do series of 3 (baseline, 2 mos, 8-14 mos); if had partial, complete for total of 3.

MMR:
Immunize those born after 1956 w/o evidence of immunity to measles. 2nd vaccine for young adults in setting where such individuals congregate if not previous recd a 2nd dose. Screen by hx or serology all women of childbearing age at 1st encounter. Do not administer during pregnancy.

Hep B:
All young adults not previously immunized. Also, susceptible adults in hi-risk groups: men who have sex with men, IIDU and their sex partners, persons with hx of sex with multiple partners in previous 6mos or who have recent STD, internatl travelers to countries of high or intermediate endemicity, and persons in h ealth-related jobs with frequent exposure to blood or blood products.

Hepatitis A:
Recommended for all at high risk for hepatitis A virus: persons living in , traveling to, or working in areas where hep A is endemic and periodic outbreaks occur; men who have sex with men; users of illicit injection and street drugs; military personnel and certain hospital and lab workers. May be considered in institutionalized persons and workers in these institutions and day care centers.

*Based on Report of U.S. Preventive Services Task Force, 1996. See report for full recommendations and clinical interventions.

BAL 5b

ATHLETE'S FOOT

Definition: A skin infection (fungal) of the foot

.iology: Fungal. Thrives in warm, moist areas.

Signs/Symptoms: Small fluid filled blisters on plantar surface of foot and between toes and/or coarse and scaling skin, itching, foul odor.

Goal: Foot free of infection

NURSING PROCESS

Triage:

CATEGORY III	CATEGORY II
Purulent drainage, raw or bleeding areas, difficulty ambulating. History of circulatory problems; PVD, diabetes. Refer to HCH provider.	None of the above.

Protocols:

S: Note history of previous fungal infections, any complicating factors (lack of socks, poorly fitting shoes, etc.) length of time problem has existed.

O: Describe appearance of feet. If feet have purulence, raw or bleeding areas or blisters ——> refer to medical clinic. If history of PVD, diabetes ——> refer to medical clinic.

If "no" to the above, continue with nursing protocol.

A: Tinea pedis

P: Plan: discuss foot hygiene. Give clean white socks to client. Use antifungal powder after washing feet and drying them carefully. Change socks every day. Provide tolfonate powder.

Approved by: Natesan
Vel Natesan, MD — 10/23/95 *Date*

Barbara Clark CRNP
Barbara Clark, CRNP — 10/26/95 *Date*

Health Education: Keeping feet clean and dry will help eliminate reoccurrence. Come to HCH if the fungal infection does not improve within a week. Chronic skin infections may indicate an immune system problem.

BAL 5c

BLISTERS

Definition: A collection of fluid below or within the top layer of skin.

Etiology: Friction against the skin, as in shoes rubbing. Burns, including sunburn (see "burns, minor")

Signs/Symptoms: A clear fluid-filled sac on the surface of the skin. If large, or if the blister has broken may be very painful.

Goal: Wound healing without infection, prevention of further trauma.

NURSING PROCESS

Triage:

CATEGORY III	CATEGORY II
Signs of infection or bleeding, history of PVD or diabetes. Blisters related to burns. Refer to medical provider.	Blisters related to ill-fitting shoes.

Protocols:

S: Obtain history of cause, length of time a problem.

O: Document size, appearance, location of blister. If the result of burn (including sunburn) ——> refer to medical clinic. If history of PVD, diabetes ——> refer to medical clinic. If signs of infection or bleeding ——> refer to medical clinic.

If "no" to the above, continue with nursing protocol.

A: blister

P: Plan: cleanse with mild soap and water and apply non-adhering dressing. DO NOT puncture the blister. Provide clean socks. Refer to social services for shoes if appropriate.

Approved by: Vel Natesan, MD — 10/23/95 Date

Barbara Clark CRNP
Barbara Clark, CRNP — 10/26/95 Date

Health Education: Keep area clean and dry. Return to HCH if area becomes infected or painful.

BAL 5d

COLD SYMPTOMS

Definition: A collection of viral upper respiratory reactions; clear nasal drainage, mild cough, slight fever, headache, sore throat, general aches, loss of energy

Etiology: Usually a viral illness spread through airbourne droplets or hand to mouth.

Signs/Symptoms: See definition.

Goal: Relief of symptoms and prevention and/or early identification or bacterial infection.

NURSING PROCESS

Triage:

CATEGORY III	CATEGORY II
Fever over 100, purulent nasal drainage, productive purulent cough, swollen glands, white patches in throat. Refer to medical clinic.	None of the above. Symptoms as noted in the definition.

Protocols:

S: Record history and symptoms.

O: Assess and describe respirations.
If any adventitious sounds or diminished ——> refer to medical clinic.
Take vital signs. If temp >100' ——> refer to medical clinic.
If purulent nasal drainage or productive cough with purulence ——> refer to medical clinic
Palpate sinuses. If painful with elevated temp ——> refer to medical clinic.

If "no" to all of the above, continue with nursing protocol.

A: Viral upper respiratory infection

P: May give tylenol 325 mg. ii q 4 hrs. #12 for pain relief. If no history of asthma or high blood pressure, (>= 140/90) may give actifed i q 6 hrs. #12 for allergy symptom (runny nose, sneezing).

Approved by: Vel Natesan, MD — 10/23/95 (Date)

Barbara Clark, CRNP — 10/26/95 (Date)

Health Education: Wash hands every time you sneeze or cough if possible. Drink two quarts of water or juices a day. Cut back or stop smoking. Rest as much as possible. Come to the clinic if symptoms become worse.

BAL 5F

SCABIES

Definition: A skin infestation by the mite scarcoptes scabiei, usually spread by skin to skin contact causing generalized pruritis, frequently with secondary bacterial infections.

Etiology: Acquired by sleeping with or in the bedding of an infested person or from skin to skin contact with an infested person.

Signs/symptoms: Insidious onset of intense itching, especially at night. Lesions manifest themselves as papules and "runs and burrows." Lesions are most commonly found on the sides of the fingers, heels of the palm, wrists, elbows, axilla, buttocks, and feet. May be seen in females on the nipples, and in males on the scrotum.

Goals: Eradicate scabies mites and heal secondary dermatitis.

NURSING PROCESS

Triage:	Category II	Category III
	See symptoms described above.	Lesions are open, infected, purulent, erythema, and painful. Temp. >98.6.

Protocol:

S: Insidious onset of intense itching, especially at night. Areas of itching not on the face. Client sleeping at a homeless shelter.

O: Lesions appear as papules, "runs and burrows" on the sides of fingers heels of palm, wrist , elbow, axilla, buttocks, and feet (face spared).

A: Scabies

P: Instruct client to bathe thoroughly with soap and water then apply Lindane lotion from the neck down and leave on 8 - 12 hours. After 8 - 12 hours wash again thoroughly with soap and water. Wash clothes and bedding before treatment with lotion. Advise client to return to clinic if symptoms persist. Give verbal and printed instructions

Refer to medical clinic if temp > 100 and if client is pregnant.

Client Education: Lindane is nephrotoxic, advise client not to give to children and do not use more than recommended.

Approved by: Vel Natesan, MD Date 10/17/96

Barbara Clark, CRNP Date 10/17/

Education about risk factors, early detection, and treatment of tuberculosis is provided to each homeless client. Risk factors include HIV infection, diabetes mellitus, prolonged shelter residence.

Outcome(s): A plan for case management of clients with a positive PPD is in place.

A plan for assessing the result of the PPD is in place.

BAL 5e

TOOTHACHE

Definition: Aching or throbbing in gum and jaw related to dental caries, broken tooth.

Etiology: Poor dental hygiene, poor diet, lack of access to dental care, injury to face/ mouth may cause injury to or exposure of nerve in tooth.

Signs/Symptoms: Tooth/teeth has/have obvious areas of decay, tooth is broken, jaw may be swollen, breath is foul, filling is lost from tooth.

Goal: Assessment of dental problem, relief of pain, referral to dentist.

NURSING PROCESS

Triage:

	CATEGORY IV	CATEGORY III	CATEGORY II
Ask how long tooth pain has been evident, any injury to face, swelling, any pus or drainage. Has dental problem limited intake of food? Does jaw pain radiate down arm.	Jaw pain radiating down arm; assess for possible MI, call 911. Mouth injury with bleeding, tooth knocked out and has saved tooth, laceration of tongue, puncture wound of soft palate, send client to ER via cab.	Severe toothache, fever, swelling, inability to eat: client will be seen in clinic.	Moderate pain, no fever, no swelling

Protocol:

S: Record symptoms, onset, any relief with OTCs.

O: Examine mouth and describe dental problem.
If purulence, swelling ————> refer to medical clinic.
Take temperature. If ==> 100' ————> refer to medical clinic.

If "no" to above, continue with nursing protocol.

A: Dental caries/broken tooth/missing filling.

P: May provide tylenol 325 mg. ii q 4 hrs. for pain, #12 if no history of allergy.
Arrange for appointment with CRNP or MD as soon as possible.

Approved by: Natesan — 10/23/95
Vel Natesan, MD — *Date*

Barbara Clark CRNP — 10/26/95
Barbara Clark, CRNP — *Date*

Health Education: Avoid hot or cold foods when tooth is painful. Rinse mouth after eating to prevent further problems. Keep dental appointment - do not miss if toothache improves.

HEALTH CARE FOR THE HOMELESS 111 PARK AVENUE BALTIMORE, MD 21201 app.3/94

TRIAGE GUIDELINES

GENERAL POLICIES:

1. The triage guidelines are designed to assist in determining the acuity and proper action to take for all clients registering at HCH. The goal of the Triage process is to ensure that a reasonable level of care, with respect to the client's presenting problem, is accessible for all clients.
2. The Triage process shall generally take place in the Registrar area. Exceptions are those rare occassions when clinic staff are alerted to the presence of an ill client in another area of the building or surrounding premises. The Triage Nurse may take the client to a second floor examining room if necessary to complete the assessment.
3. The Triage process shall be implemented by the Triage Nurse or by the Registrars. Registrars may independently triage those clients who present with clear Level I requests (see below). If the Registrar finds, upon closer questioning of the client, that a more acute problem is present, she shall consult with the Triage Nurse.
4. When the Triage Nurse is in doubt as to the level of acuity, the client should be assigned to the next higher (more acute) triage level.
5. The triage level may only be changed by the Triage Nurse, and only upon reassessment of the client.
6. The Triage Nurse will, in accordance with the procedure for Registration, scan the computer screen for Registration for any acute or urgent entries, as recorded by the agency Receptionist. Any apparent emergency clients shall be immediately triaged, rather than waiting to be called in order of registration.
7. The triage level is determined by an assessment of the level of acuity, based on the following guidelines. It is not based upon the volume of clients in the clinic or waiting to be seen, the time of the day, nor on the staffing pattern for the day. Subsequent actions may be affected by these factors, but is essential that all clients be given proper attention and either care or referral that is appropriate for the assessed level of acuity.

TRIAGE LEVELS:

The client will be assigned a triage level based on the assessment. The subsequent action shall generally be based on the following:

Level 1: The asymptomatic client with routine, non-urgent need. Arrangement shall be made for the next available appointment or the need shall be immediately met.

Level 2: The asymptomatic or mildly symptomatic client with non-urgent need, but who is vulnerable to develop problems if not seen within the next few days. Arrangements will be made to see the client the same day or have him return to be seen within the same work week, or the next day for reassessment if appropriate.

Level 3: The symptomatic client with non-emergent need. Arrangements will be made to see the client on the same day, or refer to another appropriate facility.

Level 4: The symptomatic client with emergent need. Transport to the nearest hospital by ambulance will be arranged. The Triage Nurse may call upon a provider in the clinic to assist in care needed until the paramedics arrive. Agency Emergency Procedures shall be followed when indicated.

The following lists of presenting symptoms may not be all-inclusive and are meant to provide <u>general</u> guidance to the Triage Nurse. The client will often present with symptoms that span one or more levels, or with one symptom that is definitive in determining the level of acuity. The Triage Nurse shall use her best clinical judgement and consult with a clinic provider in those cases for which assessment is ambiguous or questionable.

BAL-1-2

CATEGORY I: HEALTH CARE AND ENVIRONMENTAL MANAGEMENT

LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Needs Rx referral Needs to make appt for routine visit within next month; no present problem	Lost meds for chronic condition; can safely wait a few days to see provider (e.g. arthritis, back pain)	Lost meds for acute condition, unable to access regular source of care; lost meds for chronic condition that could become unstable without meds (e.g. CAD)	
Needs papers completed; able to access regular or other provider Requests routine HIV testing and counseling	Needs papers completed within week; has HCH provider		
Known HIV+ with recent CD4 count >500; with CD4 count <500 but has enough meds to last until appt. available; asymptomatic	Known HIV+ without source of health care; asymptomatic	Known HIV+ without source of health care; symptomatic	
		Self-care deficit resulting in injury or illness;	
	hx. of recent physical abuse, asymptomatic; now in safe environment	Hx. of recent physical abuse, plans to return to same environment	

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CATEGORY II: NEUROLOGICAL

LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Has hx. of seizures, is asymptomatic; has meds to last until appt. available	Running out of seizure meds within a few days; asymptomatic	Has run out of seizure meds or has had seizure within last 48 hours and did not receive or complete plan of care (e.g. from ER)	Active seizure state or post-ictal; seizure within 6 hours without care; experiencing aura; febrile, hallucinating, severe tremors
c/o minor headache, relieved by OTC meds; vital signs WNL; no hx. of trauma	c/o recurring headaches, eased by OTC meds; vital signs WNL; no associated symptoms; no hx. of trauma	c/o headache, not relieved by OTC meds; holds head, photophobia, nausea	c/o headache: appears in acute distress; nuccal rigidity; hx of recent head trauma; diastolic BP>115
	c/o dizziness; no syncope; able to carry out ADL's; vital signs WNL	Witnessed syncope; alert & oriented now; c/o numbness & tingling of extremity; no facial droop; mild headache; hx of HTN; no change in mental status, speech, or ability to understand	Sudden onset of decreased ability to use any part of body; change in mental status; new onset facial drooping; new onset of aphasia; may be confused
	Minor head/neck injury; no LOC; no neuro deficits; no spinal tenderness; no vomiting; vital signs WNL	Minor injury to head/neck; questionable LOC; alert & oriented now; able to move all extremities; PERRLA; no neuro deficits;	Major trauma to head/neck; change in level of consciousness; unable to walk; vomiting; double vision; combative; unequal grips; witnessed LOC

BAL-1-4

CATEGORY III: SENSORY

LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Requests routine eye or hearing exam; asymptomatic	Lost glasses or hearing aid, causing inability to carry out ADL's or safety concerns		
	c/o reddened, itchy eyes; no vision loss or discharge	c/o reddened itchy eyes, periorbital edema or discharge	Sudden loss of vision
	Chronic eye pain	Foreign body sensation in eyes, with or without hx. of trauma	Chemical/toxic splash in eyes
		Corneal abrasion	Corneal ulcer
		Cold injury to external ear	Amputation external ear
	Gradual hearing loss; no hx. of trauma	Gradual hearing loss with hx. of trauma; acute onset of decreased hearing (feels like ears blocked)	Sudden onset of total deafness
		Foreign body in ear; c/o mild to moderate pain	Foreign body in ear with severe pain
		Ear drainage	Bloody drainage in ear with hx. of recent trauma
	Tinnitus, no fever, no hx. of ASA ingestion, no vertigo	Tinnitus, fever	Tinnitus; hx of ASA ingestion, vertigo
	Chronic pain; running out of meds; mild pain of known origin, relieved by OTC meds	Moderate to severe pain	Incapacitating pain of any origin

CATEGORY IV: CARDIOVASCULAR

LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
		Chest pain suggestive of non-cardiac nature: pain with respirations, cough, fever, increases with movement	c/o chest pain, sudden onset. pallor, diaphoresis, SOB, nausea. Chest pain at rest Has pacemaker: c/o syncope or weakness
		Edema, increased SOB on exertion, with or without hx cardiac disease; 60<pulse<120	pulse rate >150 or <45; irregular pulse, rapid, new onset; c/o dizziness, syncope, hypotensive, impaired mentation
Wants BP check; no hx of HTN	Running out of BP meds in next few days; BP currently WNL	Ran out of BP meds; in no acute distress; BP <200 systolic, 115 diastolic	HTN with weakness, neuro deficits, chest pain; BP >200 sys., 115 dias. Sickle cell crisis or hx sickle cell, c/o moderate to severe pain; may be febrile, nausea/vomiting
	Running out of coumadin; asymptomatic	Needs coumadin; on coumadin and has signs of mild bleeding. c/o leg pain, swelling or erythema, with or without hx. of thrombophlebitis;	On coumadin; severe bleeding c/o leg pain with decreased circulation, calf pain, +Homan's sign, erythema. May be pulseless, cold, cyanotic extremity, SOB

BAL-1-6

CATEGORY V: RESPIRATORY

LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Hx. of asthma or COPD; asymptomatic; has enough meds to last until appt. available	Running out of meds for asthma or COPD; asymptomatic	Has run out of meds for asthma or COPD; wheezing but able to converse (with or without hx. of asthma)	Severe resp. distress or arrest; wheezing and using accessory muscles; cyanosis; resp rate >30 or <12; color pale or dusky; severe pulm congestion
	Cold/flu-like sx., cough, productive for clear/white sputum;no fever; no chest discomfort; resp. rate <24	Cough productive for yellow, green, rusty, or bloody sputum; fever, night sweats; mild to moderate resp distress; resp rate 24-30	
Requests TB test; asymptomatic; no Hx of frank exposure to TB	Needs TB test to obtain housing; on prophylaxis for TB and is running out of med; recent hx of known exposure to TB	Has active TB & has run out of meds	
		Blunt trauma to chest; no resp distress or peripheral signs of hypoxia; resp rate <30	Penetrating or blunt chest trauma; hypoxia; color poor; unequal chest expansion; crepitus;

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CATEGORY VI: NUTRTION/METABOLIC

LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Requests glucose check; asymptomatic; no hx. of diabetes, or is diabetic and has enough med to last until appt. available	Diabetic; running out of meds; asymptomatic, or c/o fatigue but chemstrip <250	Diabetic; has run out of meds; aysmptomatic or symptomatic but alert & oriented; may have vomiting /diarrhea	Diabetic; change in mental status; decreased resp. rate or kussmaul resp.
	c/o vomiting &/or diarrhea relieved by OTC med; vital signs WNL, no orthostasis; afebrile; c/o heartburn, indigestion, or gas after meals, no associated symptoms	c/o vomiting or diarrhea unrelieved by OTC med; fever present; signs of dehydration but no orthostasis; mild or non-acute abd. pain	c/o vomiting &/or diarrhea; severe abd. pain; hematemesis; vital signs abnormal, hypotension or orthostasis; rigid, board-like abdomen
Needs list of soup kitchens	c/o and appears malnourished; able to eat	Unable to eat or take fluids; may be due to recent surgery, jaw-wiring, etc.	Unable to eat or take fluids; weakness, orthostasis, abnormal vital signs
		Dysphagia without resp. distress	Dysphagia with resp. distress

BAL 1-8

CATEGORY VII: ELIMINATION

LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
	c/o mild rectal itching, non-thrombosed hemorrhoids	Rectal bleeding, small amount; tarry stools; painful hemorrhoids; vital signs WNL	Copious amt. bright red blood per rectum; hypotension, tachcardia; rectal prolapse
	Constipation for 1-2 days; mild discomfort	Constipation, recent abd. surgery; moderate pain	Constipation with severe abd. pain
	Diarrhea for 1-2 days, relieved by OTC meds; no pain; vital signs WNL	Diarrhea with abd. pain; orthostasis or other abnormal vital signs; signs of dehydration; fever	Severe diarrhea with severe abd. pain, orthostasis or other abnormal vital signs
		Dysuria, frequency, urgency, burning; vital signs WNL.	Gross hematuria; severe flank pain; positive orthostasis suggestive of renal colic
	Difficulty starting stream of urine but able to void	Unable to void; penile swelling;	Unable to void for >12 hours in severe discomfort
			Dialysis pt. altered mental status, seizure, syncope, cardiac chest pain, bleeding, fever>102, bleeding, abd. pain, nausea/vomiting
	Abd. distended, asymptomatic, able to move bowels	Abd. distended, no resp.distress, has not moved bowels; can void	Abd. distended, resp. distress, unable to void

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CATEGORY VIII: REPRODUCTIVE/SEXUALITY

LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Requests condoms; asymptomatic	Positive STD contact; asymptomatic	Positive STD contact with urethral or vaginal discharge	
	Vaginal discharge without discomfort; no known STD contact	Vaginal discharge with mild to moderate pain or discomfort	Vaginal discharge with severe abd. pain, abnormal vital signs
		Penile discharge, rash, or lesion	
	Intermittent but not current swelling of testicle; no pain	Testicular pain with or without swelling	Testicular swelling with sudden onset of severe pain
	Painful normal menses, needs OTC med	Painful menses, unrelieved by OTC med	Severe vaginal bleeding
	Requests pregnancy test; no associated sx.	Pregnant with no prenatal care; having pain, discomfort, or edema	Pregnant, vaginal bleeding or severe pain
	Rape victim in past; no acute physical or emotional distress, requesting counseling	Rape victim >48 hours, no acute distress.	Rape victim within past 48 hours
		Genital trauma, no acute distress; swelling, hematoma, or laceration; signs of STD	Genital trauma with significant bleeding
		foreign body in vagina, anus, or penis; has or has not been removed; mild to moderate discomfort, no bleeding	Foreign body in vagina, anus, or penis with severe bleeding or discomfort; has not been removed or was removed with significant bleeding

BAL 1-10

CATEGORY IX: STRUCTURAL INTEGRITY

LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
	old extremity injury/deformity, now causing some discomfort; able to bear wt/use extremity, sensation & circulation intact	New extremity injury; no gross deformity; circulation, motor skill, and sensation intact; may have edema/ecchymosis; pain	New extremity injury with deformity; pain severe; circulation, motor skill, or sensation deficit; appears shocky
		Laceration, superficial; circulation, motor, and sensation intact; hemostasis achieved by direct pressure	Laceration, deep/extensive or unable to achieve hemostasis; significant crush/avulsion injury; trunk lacerations associated with evisceration; partial/complete amputation;open fracture
		Uncomplicated bite with skin breakage	Bite resulting in tear or laceration of face; snake bite; bite resulting in allergic rxn. nonresponsive to treatment; resp. distress
		Abscess, cellulitis, wound infection	Cellulitis/ infection of the face or periorbital area
		Thermal injury, first degree burn, less than 10% total body surface area	Extensive first degree burn; all second/third degree,electric/ chemical burns; circumferential burns; burns on hands, face, genitalia

CATEGORY IX: STRUCTURAL INTEGRITY

LEVEL 1	LEVEL 2 Scratchy throat without fever, swollen glands, or any other symptoms	LEVEL 3 Sore throat , swollen glands, fever; can swallow liquids	LEVEL 4 Sore throat with stridor, drooling; difficulty breathing; unable to take liquids with orthostasis; bleeding S/P nasopharyngeal surgery; hoarseness with hx. of injury to larynx
	Mouth sores; not HIV+	Multiple mouth sores, HIV+;	Multiple mouth sores; unable to take fluids; signs of dehydration
		Bleeding gums; not on coumadin	Significantly bleeding gums; on coumadin; frank bleeding of mouth or pharynx
Needs dental referral for dentures; no current problems with gums	Mild toothache, relieved with OTC meds; no fever, no swelling	Toothache, fever, swelling; moderate pain; tooth knocked out and has not saved tooth	Multiple teeth knocked out; mouth injury with bleeding; tooth knocked out and has saved tooth; laceration of tongue; puncture wound of soft palate
	Mild skin rash, mild pruritis; no drainage; able to sleep	Moderately-severe skin rash, pruritis, unable to sleep; draining lesions, ulcerations; surrounding erythema/swelling	
		Allergic reactions	Allergic reaction with resp distress

BAL-1-12

CATEGORY X: MENTAL HEALTH AND EMOTIONAL RESPONSES

LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
	Depressed with change in ADL, eating, sleeping habits; no suicidal or homicidal ideation; staying in stable shelter	Suicidal or homicidal ideation without a plan; depression as in LEVEL 2 but has unstable shelter; hallucinating; can safely wait for Mental Health on-call provider to assess	Suicidal or homicidal ideation with plan; body movements may be slow and decreased or rapid and agitated; may have impaired perception of reality
	Displays signs of anxiety; mild transient displays of anger	Frustrated but in control of behavior; in some contact with reality; can safely wait for Mental Health provider to assess	Unable to control anger; impaired perception of reality; real or potential danger to self or others

CLN 2

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.