LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
HOUSING FOR HEALTH

REGISTERED NURSE
STANDARDIZED PROCEDURES

PILOT PROTOCOLS UNDER REVIEW FOR COUNTYWIDE STREET-BASED ENGAGEMENT

NOTICE

These pilot protocols are being developed by Housing for Health as a tool for use by healthcare clinicians working with Street-Based Engagement Services.

The protocols are in the pilot phase and have not yet been approved for use by administration.

The goal is to have all teams review the attached protocols and provide feedback. After review, comments and suggestions will be incorporated and administrative review will occur. A final version of the protocols and standardized procedures will then be redistributed to all Street-Based Engagement Teams for voluntary adoption.

Please review and provide feedback! Please contact me with any questions or comments.

Thank you!
Shannon

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GENERAL STATEMENT OF PROCEDURE

The following guidelines describe the steps to follow for all Standardized Protocols for Registered Nurses who are working in the community as part of street-based outreach and engagement teams.

1. Document encounter in S.O.A.P. format, including protocol followed under assessment, time seen, completion/discharge time, and name with title.

2. Collect data thoroughly and consistently.

3. Perform physical exam pertinent to presenting problem.

4. Consult medical back-up as necessary.

5. Connecting the client with a regular clinic is a priority of the engagement process. Ideally, medical and nursing care should be transitioned from street-based to clinic-based care as soon as feasible for the respective client.

6. Provide every client with next primary care clinic appointment and encourage appointment adherence. If client is not scheduled, assist in scheduling client for clinic appointment in appropriate timeline.

7. Refer client to medical home if not yet assigned.

8. Consult regularly with assigned provider and/or medical back-up that oversees your team utilizing verbal orders when appropriate.
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## Appendix
CALL 911/ EMERGENCY RESPONSE

Nursing staff must call 911 when assessing a client or potential client who presents with:

1. Unresponsiveness
2. Signs of recent head trauma
3. Cardiac Arrest
4. Chest Pain
5. Grand mal seizure > 2 minutes or multiple seizures
6. Abdominal and/or chest wounds
7. Vomiting frank red blood or coffee ground emesis
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16. Heart rate > 140
17. Blood glucose < 60 and stuporous or obtunded
18. Respiration less than 8 or greater than 24 per minute
19. Audible wheezing and respiratory distress
20. Oxygen saturation less than 90%
21. Temperature < 93º F (33.9º C) tympanic

Outreach team management should be alerted immediately of all critical emergencies involving cardiopulmonary resuscitation (CPR), AED/defibrillator use, and/or resulting in client death.

Staff may contact management at any time with questions regarding client care, staff safety, or operations.
CONTACT MEDICAL BACK-UP

What is Medical Back-up:

During street engagement encounters, a client or other individual may present with a clinical scenario necessitating medical assessment or evaluation. Medical back-up may include team providers (NPs, PAs, MDs), emergency department attending-on-duty, and 911. The particular clinical scenario and team on the scene will often dictate which medical back-up is appropriate as stated in the protocols.

How to Contact Medical Back-Up:

During outreach hours, consult with the assigned provider on duty, typically referred to as ‘medical back-up’.

If unavailable and situation does not necessarily warrant a 911 call, contact the local ED and ask for attending on duty (AOD).

Procedure:
Nursing staff must state “I am calling from the ______________ Street Outreach Team” and be prepared to give the following information as able:

- Client age,
- Gender,
- Current presentation and reason for calling,
- Current level of consciousness,
- Orientation,
- Ability to ambulate,
- Ability to take PO fluids,
- Relevant medical history.

If on scene staff feel the client should be transferred to an ED or clinic, nursing staff should state that: “According to our protocols, this patient requires urgent evaluation. Should this patient be sent by 911, transport (code 2) ambulance, or our non-clinical transport van?”

At times medical back-up is not available and there is concern for client safety, err on the side of the higher level of care and/or transportation.

Please see individual protocols for indications to contact the Medical Back Up.
CLIENT REFUSAL OF MEDICAL SERVICES

Scenario:

A client may present with a clinical need requiring assessment or medical attention at the emergency department. This may be determined via the attached protocols and/or clinical judgment of staff.

During certain encounters, a client may verbally state they are not in need of additional medical services. This can happen with either a current or prospective client. Examples may include (but are not limited to): decreasing oxygen saturation, symptoms of cardiac instability, suspected systemic infections, post-fall confusion, or severe undertreated wounds.

If staff feel the client is at risk of decompensation or worsening condition, and the client is still refusing care, medical back-up should be contacted for onsite assessment. Emergency medical staff (paramedics, EMTs, supervisors/captains) can offer additional support in negotiating a plan of care with the client.

Procedure:
Contact medical back-up or 911 directly as indicated in the related protocol. Depending on the situation, you may or may not need immediate response to engage with the client and this can be determined on a case-by-case basis.

- Provide information as appropriate for medical back-up call
- Inform dispatch that the client is at risk for worsening condition (be specific to the scenario), but is currently refusing treatment.
- Upon arrival of EMS, provide your report and indicate your clinical concerns regarding the client.
- EMS should assess client at this time. If client still refuses transport to further care, determine with EMS if:
  1. Additional support is needed to encourage/order participation (police or sheriff). In this case, EMS or Outreach staff should contact 911 dispatch for further support. Or,
  2. Client has capacity to refuse transport. If it is determined the client can refuse transport:
     - Have EMS complete an AMA form. Keep a copy.
     - Document specifically how capacity was determined.
TRIAGE & TREATMENT OF ILLNESS BY THE REGISTERED NURSE

The Registered Nurse (RN) may collect a history of present illness and complete a nursing assessment that is appropriate to the specific complaint. Additionally, the RN may dispense medications and complete procedures following standing nursing protocols, written orders, verbal or phone orders. Providers on scene with the RN (including NP, PA, MD/DO staff) will act as medical back-up. If no providers on-site, a designated provider off site should be available for phone consultation.

PROCEDURE

1. The RN will collect a history of present illness and complete a nursing assessment that is appropriate to the specific complaint.
   a. Both Subjective (History/ Symptoms) and Objective (Physical Assessment) exam should be completed
   b. This may be a limited assessment for minor complaints.
   c. The RN will use sound nursing judgment in observing for signs of more serious illness and will expand her/his assessment as indicated.

2. After the assessment, the RN will decide on the level of severity of the client’s condition and choose appropriate actions. Decision-making will fall into one of the following categories.
   a. Mild Complaint/Illness
      i. Appropriate nursing care
      ii. May medicate prn per orders/protocols
   b. Complaint that needs referral to Medical Back-up
      i. Immediate nursing actions based on nursing judgment, protocols, and orders
      ii. Either immediate referral to provider or evaluate need for referral to Urgent Care Clinic if provider not available for on site evaluation
   c. Complaint that requires phone consult or possible referral to outside provider
   d. Emergent Situations/Serious Illness
      i. Based on her/his judgment, the RN may make a decision for immediate referral to the Emergency Department. The RN will determine the most appropriate method of transport (by car/van, non-emergent EMS ambulance, versus 911 transport).

3. After appropriate assessment including drug allergies, medication reactions, and medical contraindications to receiving medications, the RN may administer appropriate doses of medications which are either over the counter or as listed in the nursing protocols.
   a. The RN should contact medical back-up to request any medication order beyond over the counter or standing orders.

4. The RN will document all nurse visits on the appropriate forms.

5. The RN will monitor for frequent/repetitive clinical needs that may indicate the need for additional medical workup, counseling or referral; identified problems will be addressed with medical back-up.
ABDOMINAL PAIN

Abdominal pain can be caused by something simple such as gas or indigestion, or may be a serious life threatening condition like internal bleeding. Careful assessment and observation must be done.

See related protocols *Nausea & Vomiting, Constipation, and/or Diarrhea* as appropriate.

Subjective information
- Client complains of abdominal pain, nausea, vomiting, diarrhea, blood in emesis or stool, constipation
- History of ulcers, constipation, gallbladder problems, recent abdominal trauma, pancreatitis, HIV/AIDS, GI bleeding
- Menstruating or pregnant, abnormal vaginal discharge, unprotected sex
- Poor intake over past few days
- Medications (particularly ASA, NSAIDS)

Objective information
- Vital Signs
- Abdominal guarding, absent bowel sounds, abdominal distention or rigidity

Plan
1. Evaluate vitals signs. Assess for shock related to internal bleeding, including hypotension (BP <100/60) or tachycardia (HR >110).
2. Call 911 if vomiting frank blood or coffee grounds, passing black tarry stools (melena), or bright red bloody stools (hematochezia).
3. Abdominal pain: If patient complains of abdominal pain offer fluids and reassess in 30 minutes. If pain is persistent and not improving, and vital signs are within normal limits, send patient to ED via non-emergent transport.
4. Abdominal pain: If pain persists and vital signs are abnormal (see #1), call 911.
5. Pregnancy: Any pregnant women with abdominal pain send via non-emergent transport to ED.
ALLERGIC REACTION

An allergic reaction is a hypersensitive state caused by an antigen-antibody reaction that releases histamine from the body’s storage sites and results in a complex of characteristic conditions, which may include eczema, allergic rhinitis, bronchial asthma or urticarial/ hives. Anaphylaxis is a life threatening allergic reaction which may occur within seconds or minutes following exposure to a specific allergen.

Subjective (History/Symptoms):
- History of exposure to known allergen
- Recent injection/ oral medication
- Itching/ rash/ hives
- Shortness of breath/ wheezing/ chest tightness
- Swelling of hands, lips, tongue
- Dizziness
- Palpitations
- Abdominal pain/ nausea/ diarrhea

Objective (Physical Assessment)
- Document onset, duration, overall general appearance, note distress
- Vital Signs: paying particular attention to respiratory rate and quality/rate/depth
- Note: Rash/Hives, swelling of hands/lips/tongue, Stridor/ Hoarseness (indicative of laryngeal edema), wheezing, hypotension, weak thread pulse, pallor

Plan

Mild symptoms: (Hives, Rash, Allergic Rhinitis)
- Diphenhydramine (Benadryl) 50 mg PO, then QID PRN x 2 days.
- Monitor Symptoms. If symptoms unresolved within 2 days, recommend client visit urgent care or primary care clinic. Notify Medical back-up or Primary Care Provider for additional orders.
- Update patient’s allergy record

Moderate to Severe symptoms: (Brochospasm, Altered Mental Status, Hypotension SBP<90, swelling of hands/ lips/ tongue, severe SOB, stridor/ hoarseness)
- Activate EMS/ call 911
- Epinephrine 0.3 mg IM x 1
- Be prepared to initiate CPR
- Continue to monitor VS
- Notify Medical Back-up
- Update patient’s allergy record
- If able to follow-up: Evaluate signs/ symptoms, refer to primary or urgent care clinic if condition does not respond to treatment in 2 days
ALTERED MENTAL STATUS

Alterations in mental status reflects a disturbance in cerebral functioning can be presented by a change in level of consciousness, agitation, impaired attention/concentration/ thinking, incoherent speech, and or hallucinations. Changes in mental status can be a result of but not limited to medical conditions, substance intoxication, medication side effect, infections or head injury. The condition typically develops over a short period of time. An acute mental disorder like delirium which presents with confusion, disorientation and restlessness can be reversed if the underlying cause is treated. This can be associated with central nervous system, metabolic, and/or cardiopulmonary disorders, systemic illnesses, and sensory deprivation or overload.

Assessment:

Subjective Information (If Possible):
1. (Patients) Person, place, thing- Is the information accurate?
2. Able to answer yes or no questions- can they answer simple questions?
3. Patient Hx:
   a. alcohol or drug use, chronic illnesses (seizures, diabetes, hypertension, liver, kidney, or cardiac disease), trauma

Objective Information:
1. Confusion and disorientation:
   a. Glasgow Coma Scale <13 (see Appendix)
   b. AVPU (Alert, Verbal, Pain, Unresponsive)
2. Focused exam to include:
   a. PERRLA
      i. Pupils dilated: may indicate cardiac arrest, stimulants, hallucinogens, etc.
      ii. Constricted: may indicate CNS disorder or opiate ingestion
      iii. Unequal: may indicate stroke or head trauma
   b. Vitals: RR, BP, Pulse, Temp and O2
   c. Glucose Finger Stick (See Hypo/ Hyperglycemia Protocol)
   d. Assess for head trauma such as contusions or abrasions
   e. Hydration status

Plan:
1. Obtain a finger stick blood glucose (*see related Hypo-Hyperglycemia Protocol*)
   a. If AMS accompanied with weakness, sweating, rapid pulse, anger, or anxiety, consider hypoglycemia
   b. If AMS accompanied with weakness, lethargy, abdominal pain, nausea, consider hyperglycemia
2. Pupils unequal upon exam, with signs of altered mental status without prior documentation indicating unequal at baseline (*Anisocoria*), should be treated as a medical emergency. Contact 911.
3. If patient does not have history of mental illness or similar behaviors in past, and has a blood glucose within normal limits (>70 and <400), **evaluate orientation**.
   a. If the patient cannot answer simple yes or no questions about him or herself, is totally unresponsive, unable to follow simple commands, or severely disoriented, **call 911**.
4. If patient has head trauma and presents with red or purple bruises anywhere above the clavicles, lacerations, dried blood or with unequal pupils, paralyzed limbs, **call 911. See Head Trauma protocol**.
5. Suicidal or violent threats must be taken seriously, **call 911**.
ANIMAL BITES

Many wounds are often ignored until signs of pain swelling or drainage appear. Clinical manifestations of infections usually occur after 24 hrs. and consist of fever, erythema, swelling, tenderness, purulent drainage. Common animal bites include:

Dog- cause minor wounds such as scratches or abrasions or complicated wounds such as deep lacerations, deep puncture wounds, tissue avulsions, and crush injuries. Lethal wounds involve head, neck or direct penetration of vital organs and require extra precautions with ABC’s and immobilization.

Cat- cause wounds with their teeth or claws usually in the upper extremities or the face. They can result in deep puncture wounds because of long, slender, and shaper teeth, with wounds more susceptible to bacteria below the periosteum. Cat bites can often transmit the highly pathogenic Pasteurella bacteria.

Rodent- bites of most small animals such as squirrels, rodents, and rabbits are treated the same as cat bites.

Human- Occlusive wounds are made by teeth closing over and breaking the skin. Clinched fist or fight bites are skin over a joint that strikes a tooth. It can damage the skin and the underlying structures. They are not bites but similar to bite wounds. Skin that brakes over the bite wounds are prone to infection because of the proximity of the skin over the knuckles to the joint capsule. These types of wounds place people at risk for deep soft tissue infection, septic arthritis, and osteomyelitis.

Subjective Information:
- What caused the bite?
- Type and size of the animal? Possibility of rabies (animals with fur)?
- How did it happen?
- When did it happen?
- How has the client treated the injury thus far?
- Preexisting conditions which may have weakened the immune system

Objective Information
- Assess wound site:
  - note the structures involved
  - Damage may include fractures, lacerated tendons, blood vessels, nerves damage to the joint space or body cavity
  - Examine for foreign bodies such as teeth or broken bone.
  - Assess distal neurovascular function including circulation and palpable pulses

Plan:

1. Immediate injuries:
   a. Safety is the first priority. If the animal is on site, call for support to remove client to a safer environment or to secure offending animal. Appropriate entities to assist include:
      a. Animal control
      b. Law enforcement
      c. Fire department
   b. Do not attempt to make contact with offending animal
2. Bites (<24hrs)
   a. All bite injuries should be referred to urgent care or other clinic. If unable to refer client to clinic or other medical setting, proceed with following care.
   b. Clean thoroughly with irrigated water, soap and water, or sterile saline.
   c. All bites to the hands must be referred to a higher level of care, either clinic or ED. Contact medical back-up for instruction.
   d. For puncture wounds:
      i. Superficially irrigate the wound avoiding high pressure irrigation.
      ii. Remove gross wound contaminants (such as teeth or broken bones). Place large items in biohazard bag and do not immediately dispose. Provide to medical teams providing secondary care. These items may be also provided to officers in case of human-to-human bite.
      iii. Avoid removal of deep tissue.
   e. Cover wound with non-adherent dry dressing, and advise patient to keep dry and clean for 24-48 hours.
   f. If there is bleeding a clean towel or non-adherent dressing should be used to press the wound to slow or stop the bleeding.
   g. If bleeding does not stop after applying pressure for 15 minutes, call 911.
   h. Red, painful, swollen, and warm injury sites indicate possible infection. Contact medical back-up for further instruction.

3. Bites (after 24hrs)
   a. Any damage to circulation or lack of distal pulses requires immediate medical intervention. Contact 911.
   b. Red, painful, swollen, and warm injury sites indicate possible infection. Irrigate with normal saline and cleanse wound site. Re-evaluate once wound is clean.
      a. Refer to Wound Protocol as appropriate.
   c. If infection is complicated: cellulitis, soft tissue abscess, septic arthritis, necrotizing soft tissue infection, and osteomyelitis, refer to medical back-up.
ATHLETE’S FOOT

A superficial infection of the feet caused by fungi of the dermatophyte group. The fungi invade dead tissues of the skin, usually producing mild or no inflammation and creating scaly lesions with raised borders or maceration. A stronger immunologic reaction to the fungus causes itching, redness and/or erosion. The condition may be acute or chronic, usually affecting the interdigital web space and soles of the feet.

Contributing factors include tight, ill-fitting shoes, nonporous socks, sweaty feet, and walking barefoot in public showers or on damp floors.

Cellulitis and lymphangitis may be seen if bacterial superinfection occurs.

Subjective:
- Document onset duration, frequency of occurrences, and the nature of symptoms
- Contact with or sharing shoes/socks with person with athlete’s foot
- Self-care history including access to hygiene facilities and ability to wash/dry feet on a regular basis

Objective (Wear gloves for examination):
- Maceration between toes
- Mild erythema in affected areas
- Scaling and cracking of the skin
- Edema and erythema
- Difficulty walking
- Scaling thickening and cracking on the sole and heel that may extend over the side of the feet in a “moccasin” distribution
- Toenails may be brittle, discolored, and abnormally shaped.

Plan

1. Mild Symptoms:
   - Foot soak/wash with soap and warm water.
   - Clotrimazole cream 1%: apply sparingly to affected area BID x 2 weeks or anti-fungal foot powder apply to affected area BID x 2 weeks
   - If any symptoms of secondary infection or if interdigital blistering – refer to Medical back-up
   - Provide supplies as needed – foot soak basin and clean socks.
   - As able, client should wash feet daily and dry thoroughly. Vinegar soaks for 20-30mins (one cup vinegar to 2 quarts water) can be recommended as appropriate.
   - Severe symptoms or those that are difficult to resolve may be treated with oral medications including intraconazole (Sporanox), fluconazole (Diflucan), or terbinafine (Lamisil). Refer to urgent care or contact medical back-up for additional assessment.

2. Signs/ Symptoms of Infection:
   - Any indication of infection, including red streaks on limb, co-occurrence of fever, or wounds that are red, hot, swollen, or purulent should be seen in urgent care or the ED. Non-emergent transport can be used as available.
BRADYCARDIA

Low pulse or bradycardia may be due to a drug effect, heart problem, syncope, or may be normal in athletic persons.

Subjective information
- Current cardiac and/or other medications (e.g. atenolol, metoprolol, clonidine)
- Past history of pulse abnormalities
- Fatigue, dizziness

Objective information
- Pulse rate <60
- Regular or irregular pulse
- Abnormal characteristics ie. weak, thready or bounding pulse

Plan
1. Any client with a pulse <60 should be referred to medical back-up and/or the emergency department. Contact medical back-up for advice on transport method and location.
2. Clients with a pulse <60 accompanied with dizziness, syncope, or other signs of altered mental status (see Altered Mental Status protocol) should be referred to the ED via 911.
3. Refer to medical provider for evaluation during working hours.
CHEST PAIN

Complaints of chest pain must be taken seriously. The patient who describes chest pain represents an immediate challenge, as the symptom is often of benign etiology, but it may indicate imminent catastrophe. Try to gather as much information as possible including patient history.

Subjective and Objective Information

- The patient with myocardial ischemia may feel chest "pain." Other descriptions include squeezing, tightness, pressure, constriction, strangling, burning, heart burn, fullness in chest, band-like sensation, knot in the center of chest, lump in the throat, ache, heavy weight on chest, and toothache (with radiation to lower jaw).
- Acute chest pain with a classically ripping or tearing quality may indicate acute aortic dissection. This is a significant medical emergency with a high risk of death. Symptoms typically include severe, sharp or "tearing" posterior chest or back pain or anterior chest pain which can radiate in the thorax or abdomen. It is most commonly seen in patients with severe hypertension or recent cocaine use.
  - Note: If dissection suspected, provide oxygen but do not administer other medications such as aspirin.
- History – Has patient had this symptom before, if so what was cause and resolution.

“PQRST” Assessment

Nurse should assess the subjective information for presence of Pain; Quality of Pain; Region/Radiation; Severity; and Temporal characteristics.

Other information to obtain:
- Past Medical History
- Associated Symptoms– diaphoresis, shortness of breath, dizziness, anxiety/feeling of doom
- Medications
- Vital Signs
- Skin signs

Assessment and Plan

1. The client complaining of chest pain requires an emergency medical assessment and 911 should be called – unless the chest pain is clearly benign such as a documented muscle sprain or heartburn consistent with client’s typical heartburn.

2. Medications: Clients with active chest pain should be provided (prioritizing administration in order listed):
   a. Oxygen: 4 L/min via nasal cannula (if at facility with access to oxygen)
   b. Aspirin: 162-325mg to be chewed PO x 1 except when primary complaint is “tearing chest pain”
   c. Nitroglycerin: 1 tab (0.3-0.6mg) sublingually x 1 except when primary complaint is “tearing chest pain”. Must have SBP >110mmHg to administer. Nitroglycerin administration may be delayed per clinical judgment until EMS arrival to ensure IV access.

3. Upon EMS arrival, report medications provided and hand off further treatment.
4. Document
COLD/ UPPER RESPIRATORY INFECTION

An acute respiratory tract infection, with major involvement in any of the airways, including the nose, paranasal passages, throat, larynx, and often the trachea and bronchi. A self-limited viral syndrome caused by any of the over 200 viruses which is managed symptomatically.

Subjective

- Assess onset, duration and nature of symptoms (sore throat, nasal congestion, rhinorrhea, sneezing, cough, nature of sputum, aches, pains, fever, chills, fatigue, headache, ear pain, shortness of breath).
- Document pertinent past medical history including chronic obstructive disease, pneumonia or flu
- Self-care history

Objective

- Document overall general appearance, vital signs. Note distress as applicable.

<table>
<thead>
<tr>
<th>ASSESSMENT: Note the absence or presence of the following symptoms to guide intervention options.</th>
<th>EXCLUSIONARY CRITERIA: If any of these are present, consult medical back-up and/or the relevant additional protocols.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red eyes</td>
<td>Fever &gt;100° F (38° C)</td>
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<tr>
<td>Tearing, discharge</td>
<td>Elevated blood pressure</td>
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<tr>
<td>Runny nose</td>
<td>Elevated heart rate</td>
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<tr>
<td>Nasal congestion</td>
<td>RR &gt;24 and/ or O2 sat. on RA &lt;94%</td>
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<tr>
<td>Sneezing</td>
<td>Neck stiffness</td>
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<td>Throat redness, swelling</td>
<td>Exudate in throat and/or on tongue</td>
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<tr>
<td>Quality of cough</td>
<td>Abnormal breath sounds</td>
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<tr>
<td>Auscultate chest</td>
<td>Swollen glands</td>
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<td>Palpate sinuses for pain</td>
<td>Ear Pain</td>
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<td>Sinus pain with purulent drainage</td>
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<td>Shortness of breath</td>
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<td></td>
<td>Uncontrolled asthma</td>
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<tr>
<td></td>
<td>Cold symptoms for &gt;7 days</td>
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<td></td>
<td>Untreated +PPD or +QFT</td>
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</tbody>
</table>

Plan

1. Medical back-up consultation as needed

2. For nasal congestion/ sinus pressure:
   a. **Pseudoephedrine hydrochloride**: 30 mg tablet every 6 hours x 2 days
   b. Consult with Medical back-up for patients with HTN
   c. Contra-indicated for patients also taking MAOIs

3. For chest congestion/ cough:
a. **Expectorant/ Suppressant cough syrup:** Guaifenesin / Dextromethorphan syrup (Robitussin DM, Mucinex DM). One adult dose (varies based on brand): typically every 4-6 hours x 2 days PRN cough. Note 24 hour dosing limits.

4. For non-hacking coughs with thick mucus:
   a. **Expectorant syrup:** Plain Guaifenesin cough syrup. One adult dose (varies based on brand) every 4-6 hours PRN cough. Note 24 hour dosing limits.

5. For fever/ pain:
   a. **Acetaminophen (Tylenol):** 325 mg 1-2 tabs every 6 hours PRN x 2 days for fever/ pain. NTE 12 tablets (4 gm) in 24 hour period.
   b. Consult medical back-up for patients with liver disease

6. Sore throat: **Cepacol** throat lozenges

7. Depending on symptoms, consider: **Saline nasal spray; multi-vitamins; Vitamin C**

8. Assure that clients with Asthma/ COPD have access to prescribed medications and refills
CONSTITUTION

An abnormal infrequency of bowel movement, or the passage of hard, dry fecal matter. The normal frequency of bowel movements varies from 3/day to 2/week. Contributing factors to constipation are variable and include: lack of privacy, mobility impairment, inactivity, poor nutrition, dehydration, opioid use, anxiety, painful hemorrhoids, anal fissures, and recent anesthesia.

Subjective (History/Symptoms):
- Document frequency and consistency of stools, last bowel movement, abdominal pain, rectal pain and/or bleeding, abdominal fullness (bloating), flatulence, indigestion, vomiting, previous history of constipation.
- History of constipation
- Medical history including current medications, such as antacids, antidepressants, opiate pain medications, some cold medications including antihistamines, or cardiac medications (including some cholesterol or blood pressure medications).

Objective (Physical Assessment):
- Document general appearance, vital signs. Note areas of distress.
- Perform abdominal exam as able:
  - Symmetry
  - Abdominal distension
  - Presence or absence of bowel sounds in all four quadrants
  - Rigidity or tenderness
- Prescription for opiate medications

Intervention:

Mild Symptoms (complaints of constipation lasting < 2 days, normal VS, mild abdominal discomfort, no vomiting). One or more of the following medications can be provided. As able, start from top and work down. Do not provide all three interventions at one time.
- Metamucil 1-2 tsp (or 2 wafers) in 8 oz water once daily x 2 days
- Docusate Sodium (Colace) 250 mg, continue twice daily x 2 days if no BM
- Senna 8.6 mg 1-2 pills once at bedtime, continue x 2 days if no BM
- Monitor symptoms. If symptoms unresolved or worsen in 2 days, notify primary care or medical back-up.

Moderate-Severe Symptoms (severe abdominal pain with cramping, nausea, vomiting, and/or distention, no BM x 24 hours after enema, fever, heart palpitations, vomiting with sediment of feces, absence of bowel sounds, history of Crohn’s Disease or Ulcerative Colitis)
- Refer to Urgent Care, Primary Care, or EMS as appropriate
- Notify Primary Care Provider as appropriate
- Notify medical back-up or client’s primary care provider if frequent symptoms (recurrence of constipation every 2-3 weeks)
- Confirm clients prescribed opiate pain medication or other medication affecting constipation are also prescribed stool softeners
Cough

A cough can result from numerous conditions such as the common cold, allergies, gastroesophageal reflux (GERD), chronic bronchitis, or tuberculosis. Cough without additional symptoms may indicate exposure to tuberculosis, particularly as individuals without homes are at risk of contracting tuberculosis and exposing others if they have active disease. Persons with active substance use disorders, poor nutrition and/or immuno-suppression (e.g. HIV infection) are susceptible to reactivation of latent TB. Though presence of a cough is likely due to another condition than tuberculosis, take relevant precautions to decrease risk of exposure to others.

All homeless persons and staff who work with the homeless population should have screening for tuberculosis regularly.

Subjective Information
- History of tuberculosis (TB) exposure
- Complaints of cough > 2-3 weeks, unexplained weight loss, night sweats, weakness/ fatigue
- Stated history of +PPD (TB skin test) or +QFT (QuantiFeron)
- Incomplete TB treatment

Objective Information
- Persistent coughing
- +PPD or +QFT (QuantiFeron)
- Hemoptysis (bloody cough)
- Clinical alert stating exposure to tuberculosis

Plan
1. Clients with intermittent cough: place a mask over client nose and mouth and alert medical back-up for evaluation (See also Cold/ URI protocol). If no provider available, refer client to primary care or urgent care.

2. Clients with persistent cough and/or additional signs or symptoms of active TB require urgent evaluation. Place mask on client. Alert medical back-up and/or transport client to urgent care or primary care. If no provider or clinic available, consider transport to emergency department via non-emergent transportation. See “Client Refusal of Medical Services” as appropriate, if a higher level of care is needed and refused. Additionally, if TB is suspected, contact LA County Public Health Department for further instruction.

3. Clients with hemoptysis, cough with fever, or difficulty breathing (see Shortness of Breath protocol) require urgent evaluation. Contact 911 for transportation.

4. Staff has the option of wearing a mask as appropriate.
DENTAL PAIN

Toothache - A painful tooth or an acute suppurative process (of pus) of the tissues encompassing or surrounding the root of a tooth that can often be the result of dental abscess or trauma. Dental abscess may be dental or periodontal in origin. Pain level can vary: a normal appearing tooth may be the source of much pain, and a broken rotted tooth may be painless. Teeth with acute abscesses are generally extremely sensitive to the tap of an instrument. Complications of chronic abscess may include fistulas, cellulitis, and osteomyelitis.

Subjective (History/Symptoms):
- Duration and severity of symptoms
- Quality of pain (i.e., dull, throbbing continuous)
- Gingival or facial swelling
- Fever and/or chills
- Difficulty eating with sensitivity to hot/cold/sweet/pressure
- Bad taste in mouth
- Difficulty swallowing

Objective (Physical Assessment):
- Localized inflammation, intra-oral or facial swelling
- Loose teeth, broken teeth, or dental caries
- Foul breath
- Tenderness with percussion (tap tooth with a tongue blade)
- Drooling
- Note presence of fever, facial or jaw swelling, or enlarged lymph nodes

Intervention (Based on signs and/or symptoms):
1. No facial swelling, minimal discomfort and no elevated temperature:
   - Provide **Acetaminophen** 325 mg po, 2 tabs qid x 3 days
   - Dispense **Oil of Clove** and instruct to apply locally as needed
   - Refer client to dentist or dental clinic

2. ANY facial swelling and/or moderate pain:
   - Consult with medical back-up
   - Assist client in obtaining an urgent dental appointment/plan.

3. Facial swelling, difficulty swallowing or drooling, moderate to severe pain, or fever:
   - Consult with medical back-up or refer client to urgent care or ED as appropriate. Facial swelling can increase rapidly and may require IV antibiotics.

Patient Education:
- Advise warm water mouth rinses prn.
- As able, avoid extremes of hot and cold foods and liquids.
DERMATITIS, (ATOPIC) ECZEMA

Atopic dermatitis is a chronic, pruritic, inflammatory skin disease that affects the epidermis, the first line of defense between the body and the environment. It causes dry, itchy, scaly, red skin, erythema, oozing and crusting, and lichenification. It occurs most often in infants and children, but can also be found in adults. The skin may become thickened and darkened, or even scarred from repeated scratching. There is known cause or cure. The focus is on controlling the symptoms by restoration of skin barrier function and hydration of the skin, patient education, Rx treatment for inflammation and itching, reducing or eliminating exacerbating factors.

Subjective
- Med Hx: particularly asthma, allergic rhinitis, hay fever, family history of eczema
- Scratching: Is there intense scratching throughout the day? Is it worse at night? Does it impact daily activities?
- Assess what triggers or exacerbates client symptoms: emotional distress, hot or cold climate, food allergies, tobacco smoke, soaps, detergents

Objective
- Distribution of lesions: Neck and/ face, flexor surfaces (folds), hands feet, upper chest, genital areas, axilla
  - Infants: red scaly, and crusted areas are found on the front of the arms, legs, cheeks, or scalp (diaper area usually not affected).
  - Children and adults commonly affects the back of the neck, elbow creases, and back of the knees, and can sometimes include the face, wrist, and forearms.
- Skin Assessment can be evaluated and monitored with specific tools: SCORAD index (incorporates objective and subjective data), or EASI (utilizes objective information estimates of disease extent and severity).
  - Mild
    i. areas of dry skin, infrequent itching (with/without small areas of redness)
    ii. little impact on everyday activities, sleep, and psychosocial well being
  - Moderate
    i. Areas of dry skin, frequent itching, redness (with or without excoriation and localized skin thickening.
    ii. Moderate impact on everyday activities, psychosocial wellbeing, frequently disturbed sleep
  - Severe- (20% general skin involvement; 10% skin involvement affecting eyelids, hands, and intertriginous areas that do not respond to therapy).
    i. Widespread areas of dry skin, incessant itching, redness (with or without excoriation, extensive skin thickening, bleeding, oozing, cracking, and alteration of pigmentation)
    ii. Severe limitation of everyday activities and psychosocial functioning, nightly loss of sleep
  - Infected (at risk for cutaneous bacterial, viral, and fungal infections)
    i. Superinfection: weeping, pustules, honey colored crusting, worsening of dermatitis, or failure to respond to therapy
    ii. Presence of vesicles and punched- out erosions may be a sign of eczema herpeticum, a life threatening condition which can affect, eyes, lungs, brain, liver
Plan:

1. Restoration of Skin Barrier Functions and Skin Hydration
   a. Mild
      i. Apply emollients (thick creams) such as Eucerin or Cetaphil or ointments such as petroleum jelly, Aquaphor, and Vaseline BID or as needed
      ii. Low potency topical corticosteroid cream or ointment (hydrocortisone)  
          1. Should be applied after bath or cleansing
   b. Moderate
      i. Apply medium to high potency corticosteroid creams (flucoinolone, triamcinolone, betamethasone)
   c. Severe
      i. May require referral for phototherapy or systemic immunosuppressant.
   d. Bathing (arrange access to bathing, if possible)
      i. Lukewarm baths can hydrate, cool the skin, and relieve itching
      ii. Use unscented mild soap

2. Skin Irritation
   a. Apply topical Steroids such as corticosteroids, hydrocortisone once or twice daily to prevent thinning of the skin.
   b. Oral steroids may be prescribed. Contact medical back-up, urgent care, or primary care.

3. Control Itching
   a. Over the counter oral antihistamines such as Zyrtec or Claritin (non-drowsy) or Benadryl or Atarax (cause drowsiness)
      i. Follow dispensing guidelines as indicated on the package
   b. Wet dressing- to temporarily soothe and hydrate the skin to reduce itching, redness, loosen crusted areas, and prevent injury from scratching.
      i. A clean dampened cotton garment can be worn over the affected area and covered with a dry garment.
      ii. It can be worn overnight or changed twice daily

4. Eliminate Aggravating factors
   a. Heat, perspiration, dry environments, emotional stress or anxiety, rapid temperature changes, exposure to certain chemicals or cleaning solutions, wool or synthetic fibers, dust, sand, and cigarette smoke aggravate the symptoms and should be avoided or eliminated whenever possible.
DERMATITIS, CONTACT

Allergic contact dermatitis (ACD) is immune mediated inflammatory skin rash. The inflammation of the skin presents itself by different degrees of edema, erythema, and vesiculation. It affects people who have been previously sensitized to a contact such as poison ivy, latex, or topical antibiotics. It is an inflammation of the skin that is manifested in differed degrees of edema, erythema, and vesiculation.

Irritant contact dermatitis (ICD) is a localized inflammatory skin response to a chemical or physical agent that increases skin permeability and trans-epidermal water loss. It is considered the most frequent cause of hand eczema and the most at risk are those with “wet work” exposures such as food handlers, healthcare workers, cleaners, and house keepers. The face, hands, and finger webs are areas more prone to irritation. Environmental factors such as temperature, air flow, humidity, and occlusion affect the skin's response to the irritant.

Subjective
1. Review client’s contact with chemicals, and activities, including hobbies and or occupation, products used, or a change or addition of a chemical (such as a soap)
2. Medical Hx: does patient know of allergies? Have they symptoms happened before? When? How long do symptoms occur after exposure? What is usually seen or felt?
   a. Itching, burning, stinging or pain
3. History of irritant exposure
   a. Onset of symptoms within minutes or hours? Or within weeks?
   b. Pain, burning, stinging, or discomfort exceeding itching
   c. Investigate if other persons were affected by the same irritant
   d. Exposure to multiple irritants

Objective
1. Allergic CD
   a. Erythema and edema
   b. Bullae and vesicles, with distinct boarders
   c. Appears to spread with time
2. Irritant CD
   a. Erythema, hyperkeratosis, or fissuring with no distinct borders.
   b. Glazed, parched, or scalded appearance of the skin.
   c. Healing process proceeds without plateau when irritant is removed.
   d. Affects only point of contact.

Plan:
1. Identify and create plan to try and eliminate contact with irritants or allergies
2. Goal is restoration of skin barrier and hydration
   a. Mild
      i. Apply emollients (thick creams such as Eucerin or Cetaphil) or ointments (such as petroleum jelly, Aquaphor, or Vaseline) BID or more frequently as needed
      ii. Low potency topical corticosteroid cream or ointment (hydrocortisone)
         1. Should be applied after bath or cleansing, ideally BID
b. Moderate or Severe symptoms with skin inflammation
   Medium to high potency corticosteroid creams (fluocinolone, triamcinolone, betamethasone) or other prescription medications may be indicated. Contact medical back-up for orders. If there is a lot of swelling or a rash covering much of the body, consult with medical back-up or refer client to urgent care/ ED.

3. Control Itching
   a. Recommend or provide over the counter oral antihistamines such as Zyrtec or Claritin (non-drowsy) or Benadryl or Atarax (cause drowsiness)
      i. Follow dispensing guidelines as indicated on the package
   b. Wet dressing- to temporarily soothe and hydrate the skin to reduce itching, redness, loosen crusted areas, and prevent injury from scratching.
      i. A clean dampened cotton garment can be worn over the affected area and covered with a dry garment.
      ii. It can be worn overnight or changed BID
DIARRHEA

Diarrhea is oftentimes viral in cause, though both bacterial and viral conditions can be severe. The most important goal of therapy is to prevent dehydration. Co-occurring conditions, such as abdominal pain, can be caused by benign conditions such as gas or indigestion, or may be a serious life threatening condition such as internal bleeding. Careful assessment and observation must be done.

See related protocols Nausea & Vomiting and/or Abdominal Pain as appropriate.

Subjective
- Client complains of abdominal pain, nausea, vomiting, diarrhea, blood in emesis or stool, constipation
- Nature of stools (watery, bloody, fatty, etc), frequency, onset/ duration
- History of constipation, gallbladder problems, pancreatitis, HIV/AIDS, GI bleeding
- Menstruating or pregnant, abnormal vaginal discharge, unprotected sex
- Client report of recent diagnosis of shigella, c-diff (clostridium difficile)
- Rectal pain
- Stimulant use

Objective
- Vital Signs (including orthostatic BP if any signs/ symptoms of dehydration)
- Assess for shock related to internal bleeding, including hypotension (BP <100/60) or tachycardia (HR >110).
- Bloody stool or melena
- Signs of Dehydration (low blood pressure, sunken eyes, decreased skin turgor, infrequent or dark urine)
- Assess for history of transmissible disorder such as c-diff or shigella. If any recent history of un- or undertreated infectious process, contact medical back-up for likely transport to ED or urgent care for further evaluation.

Plan
1. Mild Symptoms: (diarrhea lasting < 2 days, no observed blood in stool, normal vital signs, no vomiting)
   a. Bismuth Subsalicylate (Pepto Bismol) PO as directed x 2 days. Note: Pepto Bismol can darken stool
   b. OR
   c. Loperamide (Immodium) PO as directed x 2 days
   d. Contra-indicated if possible cause of diarrhea is Clostridium Difficile (C-Diff) occurring after recent (within last 4 weeks) antibiotic treatment. Treatment with Loperamide can actually worsen condition.
   e. Encourage increased PO fluid intake. Monitor Symptoms x 2 days. If symptoms unresolved, notify medical back-up

2. Moderate-Severe Symptoms: (watery stools lasting more than 2 days, altered mental status, vomiting, fever, blood in stool, evidence of severe dehydration: hypotensive, orthostatic hypotension, tachycardia, oliguria/ anuria, dry mucous membranes, decreased skin turgor)
   a. Refer to medical back-up, Urgent Care, Primary Care, or EMS as appropriate
HAYFEVER / ALLERGIC RHINITIS

Allergic rhinitis is the inflammation of the mucous membranes due to inhaled allergen causing edema, nasal obstruction, rhinorrhea, cough, sore throat, sinus pressure, itchy/watery eyes, itchy nose/mouth/throat, swollen/blue color under eyes. Symptoms present without a fever, persist as long as exposure to allergen, and can be chronic, depending on cause. An allergic reaction may become more severe, including signs of an upper respiratory infection or cardiac compromise.

Subjective:
- Onset/duration/severity of symptoms
- Past history of seasonal rhinitis
- Sinus pressure, sore throat, headache

Objective:
- General appearance/distress, including: difficulty breathing, tearing/affected eyes, rhinitis, sneezing, nasal congestion, throat redness
- Lung Sounds (including wheezing, stridor or diminished lung sounds)
- Presence of a fever

Plan

Mild symptoms:
- Diphenhydramine (Benadryl) PO: Adults 25-50 mg PO every six hours, NTE 300 mg/day for 2 days.
- Advise patient to avoid alcohol while taking diphenhydramine

Moderate/Severe symptoms:
- May indicate a worsening condition or more systemic allergic reaction, including presence of a fever, significant exudate,
- If any cardiac or advanced respiratory symptoms are present (hypotension; palpitations; chest pain; respiratory; difficulty breathing; bronchospasm, wheezing), contact medical back-up.
- If airway is compromised (rapid respiratory rate, low oxygen saturation, tripod positioning), contact EMS.
HEADACHE

Headache is one of the most common medical complaints. Primary headaches include migraines, tension-type headaches, cluster headaches. Secondary headaches may be due to neurologic or systemic conditions, and can originate from mild (dehydration, mild withdrawal) or severe (hemorrhage, stroke, increasing blood pressure) conditions.

**Subjective**

1. Frequency, duration, severity of pain
   a. Does anything aggravate or worsen the headache?
2. Pain location: is it unilateral, bilateral, periorbital, occipital?
   a. Does it radiate? Is there neck stiffness associated with it?
3. Associated symptoms:
   a. Nausea/Vomiting
   b. Visual disturbances
   c. Weakness/numbness
   d. Fever
   e. Dizziness
4. Med Hx: Hx of headaches, migraines, presence of co-existing conditions (hypertension, asthma, depression, anxiety, hx of heart disease or stroke)
5. Evaluate nutrition: last meal or non-alcohol fluid intake

**Objective**

1. Vital sign assessment, particularly elevated BP or pulse
2. Neuroexam:
   a. Mental status: alert, oriented
   b. Eyes: Tearing, red
   c. Pupils: PERRLA?
   d. Facial symmetry and weakness
   a. Posture, range of motion
   b. Hand grips: equal in strength?
4. Gait, balance, coordination: Normal, weak, uncoordinated

**Plan:**

1. Mild symptoms
   a. Recommend or offer over-the-counter pain reliever: aspirin, acetaminophen, NSAIDS
      i. Do not provide these medications for clients with gastritis, active or chronic alcohol consumption, ulcers, liver disease, kidney disease, and bleeding conditions
      ii. Avoid alcohol while taking acetaminophen or ibuprofen
   b. Provide oral fluids in cases of dehydration
2. **Clients with the following symptoms indicate a condition requiring consultation with medical back-up.** If medical back-up or urgent care is not available, consider transfer to ED.
   a. New onset or major change in pattern and systemic illness (cancer, HIV, etc.)
   
   b. New, throbbing headache in patients over 50 years of age (temporal arteritis, an inflammation of the arteries providing blood to the head and brain)
      i. Co-occurring symptoms in temporal arteritis include jaw claudication, visual loss, double vision, shoulder or hip pain and stiffness
   
   c. Papilledema (optic disc swelling) without alteration in LOC and no focal neurological signs

3. **Patients with the following symptoms indicate a possible emergency. Contact 911.**
   a. Patients with a sudden or severe headache (thunderclap headache)
   b. Headache with fever and neck stiffness (Meningismus)
   c. Papilledema (optic disc swelling) with altered level of consciousness and/or focal signs
   d. Non-reactive, mild dilated pupil, acutely inflamed eye, visual disturbance with pain and nausea (acute angle-closure glaucoma)
HEAT-RELATED ILLNESS

During extreme heat, sweating itself may not be enough for the body to cool itself. A person’s body temperature rises faster than it can cool down. Heat related illnesses can affect anyone but is common among athletes, elderly, people with pre-disposing medical conditions (diabetes), and people who take a variety of medications. Levels of high humidity, and dehydration are other risk factors. HEAT STROKE and HEAT EXHAUSTION are two of the common illnesses associated with extreme heat.

HEAT STROKE
Classic heat stroke (non-exertional) affects older individuals with an underlying condition (cardiovascular disease, neurologic/psychiatric disorders, obesity, physical disability, extremes of age, use of alcohol or cocaine, diuretics or beta blockers). Exertional heat stroke usually occurs with youthful healthy individuals who exercise in extreme heat conditions.

Subjective
- Medical history
  - Preexisting conditions
  - Drug use (Rx and Illicit)
  - Muscle cramps
- History of symptoms
  - Neurological changes: Dizziness or weakness, confusion loss of consciousness (often goes unnoticed and patient collapses)
  - Losing consciousness (passing out)
  - Muscle weakness

Objective
- Vitals: HR (may be tachycardic), BP (may be hypotensive/ normotensive), High body temperature, 104 °F or higher, RR (may be tachypneic)
  - Note some temperature readings with heat stroke may not exceed 40-degree C, especially if cooling measures were initiated.
- Hot, dry or damp skin often with lack of sweating (especially in classic heat stroke)
- Confusion, altered mental status or seizures
- Decorticate posturing
- Crackles due to pulmonary edema, excessive bleeding, slurred speech, irritability, agitation

Plan
1. See related protocols as appropriate including Altered Mental Status, Headache, or Musculoskeletal pain
2. If physical assessment indicates heat stroke, contact 911.
   a. If safe and possible, move person to a cooler place
   b. Maintain airways, breathing, and circulation
   c. Help lower the person’s temperature with cool cloths or a cool bath
   d. Apply ice packs to axillae, neck, and groin
   e. Do not give the person anything to drink if they are altered
HEAT EXHAUSTION

Inability to maintain adequate cardiac output due to strenuous physical exercise and environmental heat stress. Acute dehydration may be present.

Subjective
- Tired
- Headache
- Losing consciousness ("I feel like I am passing out")

Objective
- Vitals: HR (tachycardia, weak pulse), RR, BP, T (usually 101°F to 104°F)
- Heavy sweating, "prickly heat" sensations
- Cool, pale, and clammy skin
- Headache, nausea and/or vomiting
- Muscle cramps and/or abdominal cramps
- Weakness

PLAN
1. If safe and possible, Move to a cool place
2. Loosen clothing
3. Place patient supine with feet elevated above the level of their head
4. Place cool wet clothes on body
5. Allow for a sip of water
6. If rapid improvement does not occur, call 911*
_procedures_ PILOT DRAFT, November 2017

**HYPERTENSION**

Elevated blood pressure may be due to essential hypertension, stress, pain, agitation, effect of drugs, or various medical conditions. Often hypertensive persons are asymptomatic. The constellation of headache, confusion, and/or chest pain with SBP>180 and DBP>110 may represent malignant hypertension, a medical emergency.

**Subjective information**
- Co-occurring symptoms including: headache, chest pain, confusion, dizziness, irritability, blurry vision
- Past history of elevated blood pressure, myocardial infarction or stroke/ transient ischemic attack
- Current antihypertensive/cardiac medications (confirm date/ time last taken)

**Objective information**
- Systolic blood pressure greater than 160
- Diastolic blood pressure greater than 90
- Note: recheck blood pressure on both arms as able for abnormal blood pressure.

**Plan**
- If client presents with Systolic BP greater than 180 and/or Diastolic BP greater than 110 with a complaint of headache, chest pain, confusion, dizziness, blurry vision, diaphoresis or irritability, contact 911 for assessment and transport to ED.

- If client’s SBP is 160-189 or DBP is 90-109 and is asymptomatic, discuss client history of elevated blood pressure including typical range. Offer rehydration with 1 liter of water. Consult with medical back-up.

- Confirm if client has medication prescribed for hypertension and available on person. If client has not yet taken their medication, evaluate prescription and encourage client to take as directed. Consult medical back-up for follow-up evaluation.

- Encourage client to visit urgent care or primary care provider for follow-up and bring in all medications for review, as appropriate.
HYPO/ HYPERGLYCEMIA

Identification of diabetes and prevention of hypoglycemia are the main objectives of care. Hypoglycemia in general is less well tolerated and more rapid in onset than hyperglycemia. Persons with frequently higher blood sugars are also prone to dehydration due to excessive diuresis. Persons with alcohol use disorders tend to deplete their sugar stores and the lack of sufficient gluconeogenesis leaves persons more prone to hypoglycemia.

Subjective (If Possible)

- **Medical history**: individual or family history of diabetes
- Previous occurrences of hypo- or hyperglycemia: known cause for client and resolution
- Any medications for diabetes prescribed including insulin or oral medications
- Last time clients checked their FSBG or took insulin
- Confirm when and what the client last consumed for food or drink (may affect FSBG results if <2hrs)
- **Specific symptoms:**
  - **Hyperglycemia**: Has the patient experienced any polyuria, polydipsia, dry mouth, or weight loss? Is their stomach pain? Has the patient felt weak, loss of focus, or blurred vision?
  - **Hypoglycemia**: Has the patient experienced hunger, restless sleep, fatigue, headache, confusion irritability?

Objective

- **Level of consciousness, ability** to answer simple yes or no questions
- Finger stick blood glucose.
  - **Hypoglycemia**, FSBG < 70 mg/dl
    - Typical symptoms include: weakness, sweating, rapid pulse, anger, anxiety, tremor, decrease in level of consciousness.
  - **Hyperglycemia**, FSBG > 250. Blood glucose levels stay higher than 140 mg/dl (before meals), some can be > 400 and accompanied with dehydration
    - Typical symptoms include: frequent urination, thirst, abdominal pain, nausea, vomiting; decreased skin turgor, tachycardia; hypotension (severe)

Plan

1. **Hypoglycemia (FSBG <70)**
   a. **FSBG <60 and stuporous/ obtunded, call 911**
      i. Use glucagon pen while waiting. If no glucagon, a small amount of glucose gel may be administered orally. Put on gloved finger and rub inside cheeks and on gums.
   b. FSBG 60-69, give nutritional snack or oral glucose and recheck in 30 minutes.
   c. FSBG 50-59, give glucose and nutritional snack.
      i. Recheck at 20 minutes and 60 minutes.
      ii. If FSBG does not elevate above 69, contact medical back-up for orders
   d. **All persons stuporous/obtunded or unable to comply with oral glucose shall be referred to the ED via 911 for evaluation** (also see Altered mental status protocol).
      i. Administer glucagon pen while awaiting 911.

2. **Hyperglycemia (FSBG >250).**
   a. Encourage fluids and use of medications and insulin as directed. Assist client to self-administer medications as appropriate. As able, confirm with client their typical FSBG reading.
   b. For FSBG >400 and alert/ oriented, contact medical back-up.
   c. For FSBG “High”, >500, or any signs of altered mental status, contact 911.
HYPOTENSION

A systolic blood pressure less than 90 is not a normal finding; however, in some individuals a reading of 90 can be normal. Hypotension is most often a result of dehydration in this setting; it may also be due to blood loss, drug effect, opiate use, cardiac disorders, or hypothermia.

**Subjective**
- Dizziness, especially when standing or getting up quickly
- Use of any antihypertensive medication
- Use of diuretics
- Recent illness, PO intake

**Objective**
- Systolic blood pressure less than 100
- Diastolic blood pressure less than 60
- Evidence of blood or fluid loss (N/V/D, tarry stools, quality of emesis)
- Note: recheck blood pressure on both arms as able for abnormal blood pressure.
- Check orthostatics.

**Plan**
- Manually recheck blood pressure immediately if SBP less than 100 or DBP less than 60. Confirm with client their typical blood pressure.
- Interventions depend on systolic blood pressure:
  - SBP < 80 without alteration to mental status, contact medical back-up
  - SBP < 90, and client is unresponsive or unable to take PO fluids, call 911.
  - If SBP is 80-99 and client is alert and able to take PO fluids, give oral rehydration of 1 liter or more and recheck in 30 minutes. If SBP less than 90 after 30 minutes, contact medical backup.

- Though clients on medications should be encouraged to comply with their prescription medication regimen, a client with hypotension on anti-hypertensive medications should not take these medications until provider evaluation. Check with primary care as able or medical back-up for further instructions.
HYPOTHERMIA

A subnormal temperature in those who are living outside is most often as a result of exposure. Rarely will it be a sign of other disorders such as sepsis or hypothyroidism.

Subjective information
- Complaints of feeling cold
- Exposure to cold, especially wet weather
- Inadequate clothing

Objective information
- Temperature less than 97°F (36.1°C) oral or 96.5°F (35.8°C) tympanic bilaterally
- Shivering
- Lethargic
- Damp or inadequate clothing
- Body is cold to touch
- Diminished level of consciousness

Plan
1. As able, bring client indoors. Provide radiant heat, dry clothes, blankets, warm liquids (note: never force fluids on a client with diminished level of consciousness).
2. Recheck temperature every 1 hour until 97°F (36.1°C) oral or greater.
3. If temperature does not improve over 2 hours, and client is alert and oriented, send to emergency department via non-emergent transportation. For altered level of consciousness, refer to Altered Mental Status protocol.
4. Call 911 if temperature is less than 93°F (33.9°C) and client has a diminished level of consciousness.
5. If temperature < 93°F (33.9°C) and client is fully alert and oriented however you are unable to place client indoors, call medical back-up.
LICE, Head or Body

Lice infestation most commonly occurs in hairy parts of the body. There are two forms, head lice and body lice, which can be observed by visual assessment. Head lice are extremely contagious and difficult to successfully treat.

Body lice saliva can produce an intensely irritating small red popular rash in sensitized persons and later wheals. In addition to other conditions, body lice can infect their host with Bartonella also known as Trench Fever. Early signs of infection are fever, fatigue, headache, poor appetite, and an unusual, streaked rash. Swollen glands are typical, especially around the head, neck and arms. Other symptoms may include lymph node enlargement, gastritis, abdominal pain, sore throat, sore soles, and tender subcutaneous nodules along the extremities.

Subjective:
- Itching or report of rash on head, neck, axilla, waist, hands, genital area, etc.
- History of allergies

Objective (Wear gloves for examination):
- Live lice on body or in seams of clothing
- Nits and lice in hair
- Excoriations
- Cannot stop scratching
- Diagnosis from medical provider indicating active scabies or lice

Plan:
- In clients with possible symptoms of Trench fever or other infection, refer to medical back-up.
- Intervention removing bugs depends upon the ability of the client to find or be placed in a clean environment. A treated client, who then returns to an infected area, will likely be immediately re-infected with lice. Thus, treatment should be reserved primarily for clients once able to transition to a clean environment.
  - If client warrants treatment, use best judgment regarding safety of fellow staff and risk for infection.
- Lice treatment:
  - Remove all clothing and belongings from client.
  - Wash all clothes with hot water and dry at least 30 minutes in high heat dryer.
  - Have client shower and wash thoroughly with staff supervision. Body lice require no further treatment than a shower and removal of infected clothing/belongings.
  - Head lice: Treat all clients with head lice with 1% permethrin shampoo.
    - Note: Do not treat with permethrin unless the combing process will be completed by a staff member. Shampoo alone is not effective.
    - Leave lotion on for 10 minutes. After ten minutes, comb through all hair with comb provided in permethrin packet.
    - After combing, wash thoroughly with soap and water.
    - Inform client that treatment should be repeated in 7-10 days. Client should follow-up with primary care or urgent care.
  - Permethrin may exacerbate pruritus, edema, and erythema. Consider medical assessment if possible infection is present.
  - Client should be returned to clean bedding. Any bedding used by client before shower should be washed or disposed of immediately.
MENSTRUAL CRAMPS (DYSMENORRHEA)

Painful menstruation is classified as primary (excess prostaglandin production on ovulatory cycle) or secondary (associated with other conditions including endometriosis, fibroids, adenomyosis, PID, and IUDs). Often described as a dull ache or a sense of pressure in the lower abdomen that can be constant or intermittent. Ache may radiate to hips, lower back, and thighs.

Subjective:
- Onset/ duration/ severity of symptoms
- Date of last menstrual period and past history of dysmenorrhea, fibroids, or other gynecological conditions
- Confirm if current menstrual bleeding is typical for client
- Concomitant symptoms including nausea, vomiting, diarrhea, headache, dizziness
- Confirm recent pregnancy (<7 days ago), or induced or spontaneous abortion

Objective:
- Evaluate vital signs, in particular evaluate for signs of excessive bleeding or dehydration, including hypotension, orthostatic hypotension, or tachycardia.
- Document general appearance/ distress
- Fever (risk for infection)

Plan:
For clients without recent pregnancy or abortion, without fever or signs of excessive bleeding:
- Ibuprofen 200-600 mg PO, twice-daily PRN pain for three days.
- Advise client to present to urgent care or primary care provider if there is an increase from normal bleeding, or the symptoms do not improve in three days.

For clients with recent pregnancy or abortion, without fever or signs of excessive bleeding:
- Confirm any complications experienced during birth or abortion, such as birth outside medical facility, departure against medical advice, incomplete evacuation of tissue
- Consult with medical back-up

For clients with fever or signs of excessive bleeding:
- Confirm any complications experienced during birth or abortion, such as birth outside medical facility, departure against medical advice, incomplete evacuation of tissue
- Consult medical back-up
MUSCULOSKELETAL PAIN/ Non-traumatic

Muscle or joint pain sometimes with accompanying swelling, stiffness, inflammation, with no known precipitating traumatic cause. Pain may be due to osteoarthritis, undiagnosed infection, degenerative joint disease, obesity, positioning during sleep, gait, posture, and more.

Subjective

- Describe the pain in detail including characteristics of symptoms
  - Provoking factors: what improves the condition? What makes it worse?
  - Quality: Sharp, dull, cramping, etc
  - Region/ Radiation: Where is the pain? Is it radiating? Where?
  - Severity: Mild, Moderate, Severe? Use Pain Scale (1-10)
  - Time: When did it start? Consistent or intermittent? Getting worse or better with time?
- Other concomitant symptoms, illness, or injury during past several weeks (e.g. sore throat, constipation, fall, etc.)
- Document systemic symptoms such as fever, chills, malaise, insomnia, etc.
- Review current medications and adherence

Objective

- Vital Signs, particular respiration rate/ depth/ quality and any fever
- Note: posturing, guarding, disuse of affected area, tenderness, swelling, redness, pain with movement, impaired range of motion, numbness, weakness

Plan

1. Mild-Moderate Symptoms: (Extremity, joint, back pain and/ or stiffness, normal vital signs, and no other symptoms of illness or distress)
   - As feasible, recommend rest, elevation, heat and/ or ice to affected extremity
   - Recommend or provide ONE of the following medications as appropriate:
     - Acetaminophen (Tylenol) 325 mg PO, 1-2 tablets now, and then 1-2 tablets every 6 (six) hours PRN x 2 days.
     - Ibuprofen 200 mg, 1-2 tablets now, and then 1-2 tablets every 6 (six) hours PRN x 2 days.
     - NTE 12 tablets (4 grams) in 24 hour period

2. Severe Symptoms (Sudden onset, nausea/ vomiting, tachycardia, HTN, fever, debilitating pain, recent trauma resulting in possible fracture/ head injury)
   - Refer to Medical back-up, Urgent Care, Primary Care, or EMS as appropriate

3. Low Back Pain:
   a. Requires UA chemstrip to rule out acute kidney process or infection
   b. Contact medical back-up or bring client to urgent care or primary care
      - Encourage client to increase PO fluids
NAUSEA and VOMITING

Abdominal pain can be caused by a benign condition such as gas or indigestion, or may be a serious life threatening condition including internal bleeding or alcohol poisoning. Careful assessment and observation must be done.

Subjective:
- Client complains of abdominal pain, nausea, vomiting, diarrhea, blood in emesis or stool, constipation
- History of ulcers, constipation, gallbladder problems, recent abdominal trauma, pancreatitis, HIV/AIDS, GI bleeding
- Poor intake over past few days
- Medications (particularly ASA, NSAIDS)

Objective:
- Vital Signs (particularly low or orthostatic BP)
- Abdominal guarding, absent bowel sounds, abdominal distention or rigidity
- Signs of Dehydration (low blood pressure, sunken eyes, decreased skin turgor)
- Bloody or coffee ground emesis, bloody stool or melena

Plan
1. Evaluate vitals signs. Assess for shock related to internal bleeding, including hypotension (BP <100/60) or tachycardia (HR >110).
2. Call 911 if vomiting frank blood or coffee grounds, passing black tarry stools (melena), or bright red bloody stools (hematochezia)
3. Nausea: If nausea persists have client take slow sips of water; reassess in 30 minutes. If it persists, contact medical back-up or recommend client be evaluated in urgent care or primary care clinic.
4. Emesis: If patient vomits, assess for nausea and have client sip fluids and reassess in 30 minutes. If emesis persists longer than 60 minutes or if patient is unable to hold down any fluids, consult with medical back-up and/or send to ED via non-emergent transport.
OPIATE OVERDOSE/ DEPRESSED RESPIRATIONS

The exposure to opioids falls under several categories: therapeutic use, recreational use, intended self-harm, and “Body stuffing” in attempt to hide drugs. Opiates are usually prescribed for their analgesic properties and to reduce pain such as (oxycodone, morphine, and hydrocodone). They also include non-prescribed drugs such as heroin or fentanyl. Persons released from prison or with a long period of sobriety are at higher risk of opioid overdose because of lost tolerance during incarceration or treatment.

Subjective
- Patient states s/he has taken oral, inhaled or injected opiates

Objective
- Difficult or unable to arouse
- Not oriented, inability to answer questions
- Pinpoint pupils
- Vital sign abnormalities may include:
  - Respirations < 8 bpm and decreased tidal volume. Crackles may indicate aspiration or acute respiratory distress.
  - Low to normal HR
  - Mild hypotension
  - Hypothermia (often due to exposure)
- Decreased bowel sounds
- Look for signs of trauma, particularly on the head
- Possession of syringes, opiate medication, empty medication bottles

Plan
1. Attempt to arouse client using pain (sternal rub, trapezius pinch). Check ABCs and provide CPR / rescue breathing as warranted. Utilize team members to obtain medications and/or provide CPR.
2. If no provider is immediately available onsite and client remains unarousable, call 911 for a possible overdose.
3. Oxygenation:
   a. For nonresponsive clients or clients with respirations < 4 bpm, utilize an ambu bag and provide rescue breathing every 4-5 seconds.
   b. If oxygen is available, apply nasal cannula at 4 L/min.
4. Medications:
   a. Naloxone:
      i. IM: Provide naloxone 0.4mg IM. May repeat x 1 after 5 minutes for total of 0.8mg IM. IM injections can be administered via needles or automated injector as available.
      ii. Nasal: Administer 1mg/1ml per nostril (total 2mg/2ml). May repeat x 1 after 5 minutes for total 4mg/4ml.
5. Clients receiving naloxone must continue to the ED via EMS, due to the risk of overdose after the naloxone effect diminishes (30-45 minutes).
6. Contact medical backup after calling 911 for additional verbal orders.
SCABIES

An infestation of the skin by mites that burrow into the skin. It is often presented in the sides and webs of fingers, wrists, axillae, areolae, and genitalia. It causes visible lesions 2-15 mm, thin gray, red, or brown lines. They are often not visible because of excoriation or secondary infection. It can be spread from direct and prolonged skin-to-skin contact. It is possible for contamination from wearing or handling heavily infected clothing, belongings, or sleeping in unchanged bedding. Itching begins three to six weeks after primary infestation or within one to three days after re-infestation.

Crusted scabies (Norwegian Scabies) is a form of scabies that occurs in people who are immunocompromised such as people with AIDS, HIV, older adults, and patients with down syndrome. They are poorly defined, crusty red patches or pumps on the skin. If untreated scales become warty, crusts and fissures appear, and lesions begin to smell. The nails are thickened and discolored. They can also be easily spread.

Subjective
- Med Hx:
  - Contact with anyone with scabies
  - Older adult, or person with compromised immune system, cognitive impairment, or inability to scratch (due to physical disability, amputation, etc)
- Is itching widespread and worse at night?
- Itching may be reported as out of proportion to visible changes in the skin
- Any previous diagnosis and/or treatment for scabies

Objective (Wear gloves for examination)
- Assess skin, looking for:
  - Gray skin color
  - Wavy lines in skin 5-10 mm in length ending in pearly blebs or blisters. These are often found in interdigital webs of hands, wrists, shaft of penis, elbows, feet, genitalia, buttocks, waist and axilla.
  - Assess for crusted scabies, which are thick crusted fissures
- Any secondary infection:
  - Signs of general rash, urticaria, eczema, excoriation, impetigo, fever.

Plan
1. Contact medical back-up for:
   a. Suspicion of crusted scabies
   b. Infection
   c. Pregnant patients
2. Treat mites: Permethrin/ Elimite 5% cream: Approved for ages 2+, Pregnancy Category B (clearly indicated to treat obvious infestation. Apply to all areas of the skin from neck and feet and is washed off in shower or bath after 8-14 hrs
3. Treat family members/ living mates: Close contact of a person with symptoms also need to be treated for scabies. contact medical back-up to help decide if it is necessary
4. Wash Items: that have come in contact with infected person (bedding, clothes, towels, even stuffed animals). Place items in plastic bags for at least three days, then machine wash and dry. Ideally, dispose of and replace infested items.
5. **Relieve itching**: antihistamines such as Benadryl or Claritin can be recommended to help control itching and improve sleep.
   a. Patients will not be contagious after one treatment if directions are followed
   b. Rash and itching may continue for 2-4 weeks after treatment
SEIZURE

Seizures are common in persons with idiopathic epilepsy, brain scarring due to previous head trauma, or severe alcohol use disorder that may be due to alcohol use or withdrawal. Seizures can be dangerous if prolonged or recurrent and can be associated with risk for injury.

**Subjective**
- Past history of seizures
- Feeling of imminent seizure
- History of taking anti-epileptic medications

**Objective**
- Witnessed seizure
- Loss of consciousness, urinary incontinence, buccal damage

**Plan**
1. In the event of a seizure, protect the client against injury. Place client in side-lying position.
   a. Note: do not place anything in the client’s mouth. This is dangerous and does not protect client.
2. Obtain vital signs and blood glucose when safe. Refer to appropriate protocols as needed.
3. Continue to monitor the client while emergency transport is notified. Code 2 (non-urgent) transportation is generally sufficient. Note time, length, and type of seizure.
4. In the event of a seizure lasting longer than 2 minutes or the occurrence of multiple seizures: protect client against injury and call 911. A staff member must be present with client at all times until ambulance arrives.
5. For any seizure resulting in head injury, please call 911 and refer to *Altered Mental Status* protocol.
SHORTNESS OF BREATH

Respiratory rate outside acceptable parameters may be due to a number of conditions including pre-existing pulmonary disease, upper respiratory infection, anxiety or panic disorders, or intoxication from drugs or alcohol. Evaluation is critical to determining if the SOB may be controlled, such as reducing anxiety or utilizing previously prescribed inhalers.

Subjective
- Complaint of shortness of breath or difficulty breathing
- History of Asthma, COPD
  o With a history of chronic obstructive pulmonary disease, an oxygen saturation between 88-92% may be appropriate.
- Current medications
- Presence of chest pain or pressure (also refer to Chest Pain protocol)
- Use of tobacco products or other inhaled drugs (crack-cocaine, heroin, meth)

Objective
- Audible wheezing or stridor (high pitched wheezing from upper airway obstruction)
- Gasping for breath
- Oxygen saturation less than 90%
- Respiration greater than 24 or less than 8 per minute
- Slow, shallow breathing or noisy respirations
- Signs of opiate/barbiturate/sedative/hypnotic use (excessive sedation, respiration rate < 8, pinpoint pupils)
- Respiratory symptoms and signs associated with fever

Plan
1. If client is responsive and able to engage, confirm if they have any previously prescribed inhalers, particularly albuterol. If able, secure inhaler and have client use as directed.
   a. Re-evaluate oxygen saturation and respiratory rate after 10 minutes. Contact medical back-up for further instruction.
   b. If you are at or able to bring client to a clinic setting, treatment may be initiated via provider orders and upon securing medication, and may include albuterol inhaler, or albuterol nebulizer and prednisone provided within a clinic setting.
   c. A clinic setting also permits for the ability to evaluate client for
2. If no provider on site or client unable to go to nearby clinic, call 911 if:
   a. Respirations are less than 8 with altered mental status, or greater than 24 per minute;
   b. Client has oxygen saturation less than 90%; or
   c. If patient has audible wheezing or gasping for breath.
   d. Refer to Altered Mental Status protocol as appropriate.
3. If client is alert and oriented with an oxygen saturation between 90-93% and/or respirations between 8-12 per minute, consult with medical back-up.
SO RE THROAT

Sore throat, a symptom of acute pharyngitis (inflammation of throat), may be described as discomfort, pain, burning, scratchiness in back of throat, worse when swallowing. Sore throat can be caused by multiple pathogens including viruses (most common, including Influenza, infectious mononucleosis, and herpes simplex) and bacteria (least common, including Group A Strep), as well as non-infectious causes (including allergies and smoking).

Sore throat is often accompanied with symptoms of fever, headache, malaise, lymphadenopathy (“swollen glands”), and other signs/ symptoms associated with upper respiratory infection (nasal congestion, cough, sinus pain).

Subjective
- Onset, nature, severity, and duration of symptoms
- Associated symptoms such as: presence or absence of cough, fever, malaise, nasal congestion, sinus pain, difficulty swallowing

Objective
- Fever >100 F
- Presence or absence of tonsillar exudate (white or yellow coating on tonsils)
- Cervical adenopathy (swelling of lymph nodes around head/ neck)
- Medical history including increased risk for severe infection (poorly controlled diabetes, HIV+, cancer)
- Swelling of throat, drooling, or secretions

Plan
1. **Low-risk symptoms:** (sore throat without tonsillar exudate, may or may not be accompanied by s/sx of upper respiratory or influenza infection)
   a. Benzocaine/ Menthol (Cepacol) throat lozenges PO, PRN
   b. Acetaminophen (Tylenol) 325 mg 1-2 tabs every six (6) hours PRN x 2 days for fever/ pain.
      NTE 12 tablets (4 gm) in 24 hour period
      o Consult medical provider for patients with liver disease or substance use disorders
      o Avoid alcohol while taking acetaminophen
   c. Monitor Symptoms. If symptoms unresolved within 2 days, notify Primary Care Provider

2. **Moderate to Severe symptoms:** (Difficulty/ inability swallowing, respiratory distress, secretions, drooling, dysphonia (muffled voice), neck swelling, tonsillar exudate)
   - Refer to Urgent Care, Primary Care, or EMS as appropriate
   - Rapid Antigen Detection Test and/ or throat culture indicated to rule in/out Group A Strep when 2 or more of following symptoms present:
      o Tonsillar exudate
      o Tender anterior cervical adenopathy
      o Fever
      o Absence of cough
SUICIDAL CLIENT

Suicidal behavior is associated with many different types of events, illnesses, and life circumstances. Clients who are currently homeless may have one or more risk factors for suicide, including physical illness, chronic pain, major mental health disorders, history of trauma or abuse, family history of suicide, lack of social support, or barriers to care. We must be alert and always assess for potential suicidality, especially if any history of mental illness or previous attempts is known.

Subjective information/ Risk Factors
- Verbal expressions of suicide
- History of past suicide attempts
- History of mental illness, bipolar, schizophrenia, depression, psychiatric medications
- Verbalizes a plan for suicide and the means to carry it out
- Ability to contract to not harm self

Objective information
- Active attempt at harming self.
- New wounds including lacerations, bruising,

Plan

1. If client is attempting suicide or unable to contract for safety, call 911 for 5150 evaluation. Observe client at all times and obtain additional staff support as needed. If safe for staff and other nearby persons, intervene to keep client from self-harm.
2. If client is able to verbally contract to not harm self, engage with client to remove any potentially harmful belongings from area. If one or more team members are 5150 certified, the team member may perform a suicide risk evaluation. Assist in coordinating with emergency response for 5150 transfer and placement as appropriate.
   - 911 should be called for any client attempting suicide or attempting to leave the location while actively suicidal. A staff member should keep visual contact on client at all times, including if 911 has been contacted but not yet arrived.
3. Notify medical back-up and/or social work team members of any suicidal client.
4. You may refer client to crisis intervention services at any time before or instead of 911.

LA County Department of Mental Health
1-800-854-7771
SUTURE REMOVAL

Sutures are appropriate when the depth of the wound extends through the dermis. The amount of time sutures are necessary depends on the type of wound, where it is located, and the healing process of the wound.

Subjective

- Determining the mechanism of injury
- When did it happen? When were they placed
- Why were sutures placed
- How many were placed

Objective

- Assess for signs and symptoms of infection (redness, swelling, exudate, opening wound, tenderness, fever)
- Adequacy of healing (closed, clean edges, no exudate, no bleeding)
- Assess sutures: Can they easily be removed? Are they broken, hard to visualize, embedded?

Plan:

- If the following conditions apply, do not remove sutures and refer to medical back-up or clinic:
  a. Signs of infection present (redness, swelling, fever, drainage, tenderness)
  b. Inadequate healing, client request of premature suture removal, embedded sutures
  c. Post-surgical sutures when surgical or clinic follow up has been recommended or is warranted
- Length of time appropriate for the removal of sutures:
  o Eyelids: 3 days
  o Neck: 3 – 4 days
  o Face: 5 days
  o Scalp: 7-14 days
  o Trunk and upper extremities: 7 days
  o Lower extremities 8-10 days

To remove sutures:

- Clean wound with warm water or saline and gauze to remove encrusted blood and loosen scar tissue.
- Use suture removal kit: Tweezers are used to pick up the knot of each suture, and then the surgical scissors are used to cut the suture. Tweezers are then used again to remove the loosened suture and pull the thread from the skin.
- If wound is closed appropriately then continue until the sutures have all been removed.
- Cleanse wound again using warm water/mild soap, and allow wound to dry thoroughly
- Apply adhesive strips (Steri-Strips, butterfly adhesives) to allow the wound to continue strengthening.
  o Keep the adhesive strips of 5 days. Soak in warm water for removal. Do not peel off.
  o Remind the client that suture removal does not mean the wound is completely healed. Continued care is necessary for healing and reduction of scarring.
    ▪ Keep wound clean and dry, and keep out of sunlight
- If the wound dehisces during or after suture removal, apply butterfly adhesive strips or steri-Strips to approximate and support the edges. Refer to clinic and/ or medical back-up for evaluation.
- If unsure if all sutures have been removed or if unable to remove all, refer to clinic or medical back-up.
TINEA CORPORIS (RING WORM)

Dermatophytes are the prevailing cause of fungal infection of the skin, hair, and nails. Tinea Corporis is the infection of body surfaces other than feet, groin, face, scalp hair, or beard hair. It is commonly and incorrectly known as “ringworm”, as there is no worm. Rather, it represents a skin infection caused by fungus. It begins with a pruritic, circular or oval, erythematous, scaling patch or plaque that spreads from the center outwards. The center clears, and an active, advancing, raised border remains creating a ring-shaped plaque. It can be contracted by animals (kittens and puppies), who then infect humans. Tinea corporis is more prevalent in warm, humid climates and may also result from the spread of infection from other sites on the body. Extensive tinea corporis should raise concern for an underlying immune disorder.

Subjective
- Itching or burning at site
- Immunocompromised condition which may increase risk for infection or exacerbate

Objective
- Annular, erythematous, scaling plaques commonly found on neck, arms, legs, chest, abdomen, or back,
  - Active border on the outside and clear in center
  - Can develop papules, vesicles, and crusting.
- Lichenification may appear (can change the shape) from scratching.
- Plaques can cover large areas in immunocompromised or diabetic clients.

Plan:
1. Limited, localized disease should be treated topically, applied at 2cm outside border of lesions. Topical over-the-counter antifungals may be used for 1 to 6 weeks depending on clinical response.
   a. Topical corticosteroids by themselves or in combination with antifungals are contraindicated in immunosuppressed patients. In certain cases, this may lead to persistent fungal infections.
   b. Clotrimazole 1%. Gently massage into affected area and surrounding skin areas bid for 2-6 weeks.
   c. Miconazole (cream or lotion). Cover affected areas bid for 2-6 weeks.
   d. Tolnaftate powder. Apply bid for 2-3 weeks (may need 4-6 weeks).
2. Prescription products may be warranted. Contact medical back-up for further assessment.
   a. Ketoconazole 2% cream. Gently rub into affected area BID for 2-4 weeks.
   b. Econazole 1% cream. Apply sparingly over affected areas once daily or BID for 4 weeks.
3. Teach patient with chronic tinea pedis (athlete’s foot) to put sock on before their pants to not spread infection to the legs. See Athlete’s Foot protocol as appropriate.
   a. Recommend client avoid occlusive and tight clothing and if possible to wear cotton or synthetic materials. Provide clothing as able and appropriate.

   Educate client that ringworm is very contagious until lesions have been treated for a minimum of 48 hours. Do not share towels, hats, or clothing until lesions are healed.
4. Refer to medical back-up if patient does not respond to treatment or if swelling and pain occur.
WOUNDS

Wounds are disruptions of the normal structure and function for the skin and skin architecture. An acute wound is anticipated to progress through the normal stages of wound healing. A chronic wound is physiologically impaired. Due to poor hygiene, lack of access to hygiene facilities, poor nutritional status, and immune-suppression, wound infections are common.

Subjective

- History of wound:
  - When/ how did wound occur
  - Changed in size or drainage over time
  - Previously recommended treatment and what has been done
  - Reports of pain, does pain radiate
  - Other wounds and history of healing

- Related medical/ personal history:
  - Any medical conditions that may prevent wound from healing (obesity, diabetes, CHF, peripheral artery disease, chronic kidney disease)
  - Does the patient smoke or have a history of smoking
  - Nutritional intake

Objective

1. Age of injury:
   - a. Less than 24 hrs may be primarily closed unless other conditions exist.
   - b. Greater than 24 hrs should not be closed

2. Location of wound:
   - a. Facial wounds can be closed up to 24 hrs after injury. For all facial wounds, refer to medical back-up or a clinic for evaluation.
   - b. Hands and feet: can close within 6hrs. All hand wounds should be evaluated by a provider. Refer to medical back-up or clinic.
   - c. Scalp: can close up to 24 hrs.

3. Characteristics of wound
   - a. Length, width and depth of wound in cm. and color
     - i. Has the wound penetrated other layers of the skin or structures?
   - b. The presence and position of undermining
   - c. Dried necrotic wound surface
   - d. Drainage- amount, type, color, odor
   - e. Active bleeding

4. Signs of infection may include:
   - a. Fever (refer to protocol), wound odor, increasing redness and tenderness and swelling around the surrounding skin, striations, large amount of drainage, refer to MED SUPPORT.

5. Vascular Assessment – presence of the following may indicate a poorer prognosis for healing:
   - a. Slow capillary refill in distal areas to the wound, thread or light pulse, or a lack of hair on feet and lower leg, and hypertrophic deformed nails.

PLAN:

1. If there is active bleeding a clean towel or a non-adherent dressing should be used to press on the wound to slow or stop the bleeding.
2. Wounds which have not been previously assessed or treated:
   a. Any stab wound, refer to medical back-up.
   b. All lacerations <6 hours old, refer to medical back-up as the separation of skin may need suturing.

3. Wounds previously treated and/or with existing dressing:
   a. Remove existing dressings if dirty, and clean wound area. If able, have client shower with soap and water. Intact, clean, secure dressings should not be removed unless by client request.
      i. Cleaning superficial wounds can be done with saline or tap water.
      ii. To irrigate wounds, remove visible debris, excess slough, and irrigate with tap water or saline under pressure (utilizing a syringe)
      iii. Pat surface dry with soft moist gauze (Do not disrupt visible granulation tissue)

4. Clean and dress wounds according to standard nursing procedure.
   a. Dressing is influenced by type and location of wound, amount of exudate, skin condition, condition of wound and available dressing.
   b. Dressings should extend 1-2 cm beyond margin of laceration.
   c. Be attentive to the possibility of foreign bodies
   d. A primary goal of wound care is to provide a moist but not wet wound bed, while not allowing the wound to become dry.
      i. Apply a moist saline dressing. Dressings specific to particular wounds include:
      ii. Wounds neither dry or exudative: utilize a polyvinyl dressing (i.e. tegaderm)
      iii. Dry wounds utilize hydrocolloid dressing (i.e. DuoDerm)
      iv. Exudative wounds: an absorbive dressing, such as calcium alginate or hydrofiber (i.e. Aquacel)
      v. Infected wounds: ideally silver sulfadiazine (Silvadene) or bacitracin-zinc ointment (if client is allergic to sulfa drugs)
      vi. Long term, chronic wounds: products with Manuka honey may improve wound closure
      vii. Fragile skin: hydrogel sheets to secure dressing

5. The following conditions indicate a need for assessment by medical back-up, clinic, or ED:
   a. Wounds that appear infected (red, swollen, hot to touch, purulent)
   b. Any hand and foot wound that is red, hot, swollen, and purulent must be seen in a clinic or ED
   c. Any deep laceration or puncture wound that is red, hot, swollen, and purulent and any wound accompanied by fever

6. Evaluate nutrition status and provide support as needed:
   a. Increase protein intake (consult medical back-up for clients with kidney disease)
   b. Vitamins which may improve wound healing: Vitamin A, Vitamin E, Vitamin C, Zinc