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San Francisco Sobering Center
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Sobering Center Medical Protocols

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SOBERING PROTOCOLS
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SOBERING CENTER ADMISSION CRITERIA

Intoxicated clients with no acute medical condition or co-existing medical complaints may be transported to the San Francisco Sobering Center, if the client meets the following criteria:

All of the following must be present:

a. Indication of alcohol intoxication (odor of alcoholic beverages on breath, bottle)
b. Glasgow coma score 13 or greater
c. Systolic blood pressure above 80
d. Diastolic blood pressure under 110
e. Pulse rate over 60 and under 140
f. Oxygen saturation above 89%
g. Respiratory rate over 8 and under 24
h. Temperature above 93º F (33.9º C) and below 101.5 º F (38.6 º C) tympanic
i. Blood sugar level over 50 and below 250
j. No active bleeding noted
k. Not actively seizing
l. No open wounds or lacerations
m. Ability to provide basic information
n. Age 18 or older

Clients may enter via one of the following sources of entry:

a. Ambulance (EMS) transports;
b. Homeless Van Service;
c. Police Department custody;
d. Screened and cleared by Hospital ED or Clinic and sent via Van;
e. Case management/ outreach service providers;
f. Client pre-approved by Sobering management;
g. Walk-ins including case managed clients.

Exclusion Criteria:

a. Client has not consumed alcohol.
b. Client is intoxicated solely with other drugs, illicit or prescription, which does not include alcohol.
c. Client has obvious trauma which does not have corresponding documentation stating condition has been medically cleared. These clients must be refused by nursing staff upon arrival.
d. If client is found to not meet inclusion criteria, or is in need of immediate medical attention after intake, refer to appropriate protocol(s).

Managing Inappropriate Referrals:

a. If the client does not meet inclusion criteria, please assist the referring agency or individual to find a more appropriate disposition. It is the responsibility of the referring agency or individual to arrange and transport to an alternative disposition.

CALL 911/ EMERGENCY RESPONSE

Nursing staff must call 911 when assessing a 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
8. Black tarry stools or bright red bloody stools
9. Hemoptysis
10. Violent Behavior
11. Actively suicidal and/or homicidal
12. Systolic blood pressure < 80 or < 90 and unable to take POs
13. Systolic blood pressure > 180 with headache or confusion
14. Diastolic blood pressure > 110 with headache or confusion
15. Heart rate < 60 with dizziness, syncope or altered mental status
16. Heart rate > 140
17. Blood glucose < 50
18. Blood glucose < 60 and stuperous or obtunded
19. Respiration less than 8 or greater than 24 per minute
20. Audible wheezing and respiratory distress
21. Oxygen saturation less than 90%
22. Temperature < 93º F (33.9º C) tympanic

An Automatic External Defibrillator (AED) is accessible in the San Francisco Sobering Center at all times for instances of suspected cardiac arrest. In case of use with or without shock, email Deputy Director and Program Director in order to provide maintenance.

Emergency boxes and oxygen source (concentrator or tank) is available within the Sobering Center clinical station for medical emergencies.

Sobering management including the Deputy Director and Program Director **should be alerted immediately of all critical emergencies in the Sobering Center involving cardiopulmonary resuscitation (CPR), AED/ defibrillator use, and/or resulting in client death.**

Staff may contact management at any time 24/7 with questions regarding client care, staff safety, or facility operation.

CONTACT MEDICAL BACK-UP

What is Medical Back-up:

During encounters, a client may present with a clinical scenario necessitating medical assessment or evaluation. Medical back-up includes onsite nurse practitioners and physician assistants, the Medical Director, SFGH emergency department attending-on-duty, and 911. The particular clinical scenario will often dictate which medical back-up is appropriate as stated in the protocols.

How to Contact Medical Back-Up:

During business hours seven days a week 8am – 5pm, consult with the onsite provider on duty or contact the Medical Director via pager.

If unavailable, or between 5pm – 8am, call ZSFG ED at (628) 206-8111 and ask for attending on duty (AOD).

Procedure:
All nursing staff must state *"I am calling from the San Francisco Sobering Center"* and be prepared to give the following information:

- 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.

Sobering 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 Van?"*

Forms:
Referring staff should fill out the *Acute Transfer Form*. Make a photocopy of the form. Give the transporting team (EMS or Van) one copy, and place the other in the ATF Binder.

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 Sobering client or a Respite 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 Sobering 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. Make and keep a copy.
        - Document in CCMS specifically how capacity was determined.
            - Reference in the Appendix: *"Evaluating Patients' Decision Making Capability"* by Thom Dunn.

ABDOMINAL PAIN

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
- Signs of Dehydration (low blood pressure, sunken eyes, decreased skin turgor)

Assessment

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* and/or *Diarrhea* as appropriate.

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.
6. Document into Adverse Event section of Sobering Center Encounter Form.

ABUSE

Registered Nurses are among the health practitioners who must report known or observed instances of abuse to the appropriate authorities. (Abuse Reporting Requirements CA Board of Registered Nursing, CA Nursing Practice Act 2010 Edition). Medical Assistants are not mandated reporters; however, any observations by a medical assistant must be reported immediately to the RN on staff to further evaluate available information.

Subjective information

- Report or client statement of an incident that reasonably suggests physical abuse, abandonment, isolation, financial abuse, or neglect of client or other individual.
- A client (age 18 and over) has reported rape and/or sexual assault.
- Client reports known injury or abuse of another elderly person, adult dependent or child under 18, who may or may not be present in the Sobering Center

Objective information

- Visible wounds or other physical injury is present
- Paperwork or reports indicating investigation or presence of abuse
- Client is an elder or dependent adult with suspected presence of abuse

Assessment

- If client is able and willing, perform head to toe assessment to confirm there are no injuries requiring immediate medical care.
- Do not attempt to investigate the abuse or remove any evidence (such as clothing)

Plan

7. If immediate medical assistance is needed, refer client to the ED. Call medical back-up for advice on transport method and location. Contact provider during business hours for assessment of non-urgent injuries.
8. Document all statements of abuse in exact words, and document all injuries explicitly (i.e. location, nature of wound/injury, size, cause of injury, and photograph as able).
9. Staff should report reasonable suspicions of abuse to local law enforcement officials in accordance with the California law; specifically the suspicion of elder/dependent adult abuse, child abuse, assaultive and abusive conduct and rape/sexual assault.
10. Although abuse reporting is mandated by law, caution should be taken not to unnecessarily violate the patient's confidentiality expectations. The SFGHMC Risk Manager (415-206-6600) should be contacted before any psychiatric information is disclosed or if there are any questions regarding information to disclose.
11. Follow Community Oriented Primary Care (COPC) Policy 1.01 for specific reporting of Elder Abuse, Child Abuse, Assaultive and Abusive Conduct or Sexual Assault/Rape.
12. Alert Sobering Center Program Director and/or Deputy Director if a report is filed.

Refer to COPC policy 1.01 Victim of Abuse for further guidelines. *http://in-sfghweb03.in.sfdph.net/copc/policies%20and%20procedures/OTHERS/HTML%20documents/1.01%20Victim%20of%20Abuse.htm*

ALCOHOL (ETHANOL) POISONING

Subjective Information

- Amount of alcohol consumed, complaints of nausea, difficulty standing or sitting

Objective Information

- Stopped or decreased respirations with <8 breaths per minutes
- Seizure activity
- Irregular pulse or tachycardia
- Hypotension
- Pallor or turning blue
- Continued emesis
- Unresponsiveness or stupor
- Confusion or slurred speech

Assessment

Alcohol (ethanol) intoxication is a diagnosis of exclusion and should be considered only after ruling out more serious conditions such as head trauma, hypoxia, hypoglycemia, hypothermia, or other metabolic or physiologic differentials.

Alcohol poisoning can occur when an individual consumes an excessive amount of alcohol in a short time, particularly if the amount is greater than typical intake. Alcohol poisoning is different than intoxication or "being drunk" and is considered a medical emergency. Alcohol poisoning is not common, but is possible, in chronic alcoholics.

Due to ongoing metabolism after ethanol is absorbed from the gastrointestinal tract, an individual may continue to become more intoxicated even after ingestion has stopped and/or vomiting has occurred.

Plan

1. Lay client on their side in recovery position to avoid aspiration.
2. Obtain finger-stick blood glucose to assess hypo/ hyperglycemia (see protocol).
3. Assess client for injury including trauma or bleeding.
4. If client is able, attempt to re-hydrate orally with water or electrolyte solution.
5. Call 911 for emergency medical care for patients with decreased or absent respirations (see protocol), tachycardia (see protocols), altered mental status (see protocol) and seizure (see protocol).
6. Refer to medical provider during work hours.
7. Reorient and reassure clients with confusion or disorientation.
8. Document into Adverse Event section of Sobering Center Encounter Form.

ALCOHOL WITHDRAWAL

Subjective Information

- Client complains of withdrawal, strong craving for alcohol, past history of seizures, number of hours since last drink

Objective Information

- Tremors, visual hallucinations, seizures
- Vital signs (HR >120; SBP either >180 or with large fluctuations)
- Clients with D.T. (delirium tremens) - the most serious and dangerous form of alcohol withdrawal - will have agitation, disorientation, tachycardia, hypertension, and may have fever and diaphoresis.

Assessment

Alcohol withdrawal is common in chronic alcoholics and may occur even while the patient is still drinking and still has detectable blood alcohol level. Severe alcohol withdrawal (DT's) is less common and is considered a medical emergency.

Plan

1. Call 911 for emergency medical care for patients with agitation, tachycardia (see protocol), hypertension (see protocol), and seizure (see protocol).
2. Reorient and reassure clients with hallucinations, tremor and mild disorientation.
3. Refer to medical provider during work hours.
4. Document into Adverse Event section of Sobering Center Encounter Form.

ALLERGIC REACTION/ ANAPHYLAXIS

Allergic reactions range from mild, self-limited symptoms to rapid death after exposure to an antigen which has been injected, ingested or inhaled. Reactions:

1. Mild to moderate allergic reactions involve the gastrointestinal tract and skin.
2. Severe/anaphylactic reactions involve the respiratory and/or cardiovascular systems. These may initially appear minor (i.e., coughing**,** hoarseness, dizziness, mild wheeze) but any involvement of the respiratory tract or circulatory system has the potential to rapidly become severe. Death can occur within minutes.

Subjective information

- Client states ingestion of or contact with substance of which they are allergic.
- Complaints consistent with below-listed physical manifestations.

Objective information

- Difficulty breathing
- Glascow Coma Scale < 13 (see Appendix I)
- Signs/ Symptoms may involve:
  - Skin (Itching and hives or welts; flushing or skin edema; tingling; itching);
  - Gastrointestinal (Abdominal pain; nausea/vomiting; diarrhea);
  - Cardiac (hypotension; palpitations; chest pain; respiratory; difficulty breathing; bronchospasm, wheezing);
  - Upper airway swelling (including lips and tongue).

Assessment

Reactions involving more than one organ system or causing difficulty breathing or hypotension/shock **are by definition severe** and may progress rapidly to death. Observe the client for rapid increase in severity of signs/symptoms, as the sequence of itching, cough, dyspnea and cardiopulmonary arrest can lead quickly to death.

Plan

Mild: Cutaneous symptoms only including angioedema and hives:

a. Assess area for other possible skin conditions, including lice, lacerations, burns.
b. Medications:
    a. **Diphenhydramine** (Benadryl) PO: Adults: 25-50mg PO every 6-8 hours. Adult not to exceed 400 mg/day.
    b. **Famotidine** (Pepcid) PO: Adults: 20mg PO given simultaneously with Diphenhydramine. Maximum 2 doses total.

Severe/ Anaphylaxis:

a. Call EMS/911 and/or the provider on duty. Do not leave client unattended.
b. Administer **epinephrine IM**: 0.3mg IM via EpiPen.
c. Apply **oxygen** at 8 L/min by simple mask or 4 L/min via nasal cannula.
d. Assure airway; begin CPR if indicated. Place client in supine position, legs elevated, if tolerated. Monitor vital signs q5mins.
e. Any client who has received epinephrine must be transported by EMS to the emergency department.

ALTERED MENTAL STATUS

Subjective information

- Knowledge of client baseline mental status and how current mental status compares
- Client unable to give accurate information

Objective information

- Confusion and disorientation
- Glascow Coma Scale < 13 (see Appendix I)
- Focused exam including:
  - Pupils [equality, size, and responsiveness]
  - Oxygen saturation by pulse oximeter, blood pressure and pulse
  - Presence of asterixes (flap)
  - Finger stick glucose (See hypo/hyperglycemia protocol)

Assessment

Changes in mental status can be a result of various situations/conditions including but not limited to: stroke, metabolic syndromes, medications, infections or head injury. Any of these conditions may coexist with intoxication of alcohol or any other substances. Intoxication can impair ability to answer questions and ambulate independently. If the client is not able to give simple yes or no answers about him or herself, he may have dangerously altered mental status and must be referred to the ED for further evaluation. Abnormalities of focused neurological exam can point to serious problems.

Plan

1. Obtain finger stick blood glucose. If blood glucose < 50, call 911 and see related protocol.
2. Call 911 if client is totally unresponsive, unable to follow simple commands, or severely disoriented.
3. Ask client about recent head injury. Examine for contusions and abrasions.
    a. Follow head injury protocol as applicable.
4. Perform neurological assessment on admission and every 30 minutes thereafter if client presents with anything atypical from expected alcohol intoxication.
    a. Check both pupils for reactivity and equal size, check for ability to respond to simple commands, and check movements of 4 extremities.
5. Refer to ED if client's condition deteriorates or does not recover as expected. Contact medical backup for transportation method and location.
6. Monitor level of consciousness and progress in improvement every 1-2 hours. If after 2-4 hours client level of consciousness is not improved, transport to ED by non-emergent ambulance.
7. Confusion/Dementia: If you have a client that remains altered and a safe discharge is not obvious (aka continued confusion, dementia, elderly with stroke), sending them to the ED for advanced assistance could be warranted. Contact medical backup and/or the program director or deputy director for support.
8. Document into Adverse Event section of Sobering Center Encounter Form.

BRADYCARDIA

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
- Abnormal characteristics ie. weak, thready or bounding pulse

Assessment

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

Plan

1. Any client with a pulse <60 must be referred to the ED. Call 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.
4. Document into Adverse Event section of Sobering Center Encounter Form.

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 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.

"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
- 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. A client complaining of chest pain should not be admitted to the San Francisco Sobering Center.
2. Medications: Clients with active chest pain should be provided (prioritizing administration in order listed):
    a. **Oxygen**: 4 L/min via nasal cannula
    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 into Adverse Event section of Sobering Center Encounter Form, and within CCMS database.

COUGH

Subjective Information

- History of tuberculosis (TB) exposure
- Complaints of cough, weight loss, night sweats
- History of +PPD (TB skin test) or +QFT (QuantiFeron)

Objective Information

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

Assessment

Homeless individuals are at risk of contracting tuberculosis and exposing others if they have active pulmonary tuberculosis. Alcoholics and persons with poor nutrition and immuno-suppression (e.g. HIV infection) are susceptible to reactivation of latent TB. All homeless persons and staff who work with the homeless population should have screening for tuberculosis at least once every 6 months.

Plan

1. Clients with intermittent cough: place a mask on client and alert provider for evaluation. If no provider available, refer client to urgent care after sobering.

2. Clients who refuse to wear a mask should be discharged and referred to urgent care or an emergency room. See "Client Refusal of Medical Services" as appropriate, if a higher level of care is needed and refused.

3. Clients with persistent cough require urgent evaluation. Place mask on client. Alert provider during business hours. If no provider available, contact medical backup and transport client to emergency department via non-emergent transportation.

4. Clients with hemoptysis, cough with fever or difficulty breathing (see shortness of breath protocol) require urgent evaluation. Call 911 for transportation.

5. Staff has the option of wearing a mask as appropriate.

6. Document into Adverse Event section of Sobering Center Encounter Form.

DEHYDRATION

Subjective Information

- Client complains of being thirsty
- Client has not consumed any non-alcoholic fluids for greater than 4 hours
- Exposure to hot conditions or dressed inappropriately

Objective Information

- Dry mucus membrane, decreased skin turgor, sunken eyes
- Low blood pressure (see hypotension protocol)
- Tachycardia (see tachycardia protocol)

Assessment

Alcohol in any form may cause dehydration due to a diuretic effect. Chronic alcoholics may not drink other fluids and become dehydrated.

Plan

1. All clients are offered and re-offered oral rehydration
2. All clients who are alert enough should be encouraged to drink as much oral rehydration as possible.
3. If patient unable to hydrate due to inability to tolerate fluids, vomiting and/or diarrhea, call medical back-up for transport to ED. This may indicate an underlying condition requiring a higher level of care.
4. Document into Adverse Event section of Sobering Center Encounter Form.

DIARRHEA/ LOOSE STOOLS

Subjective information

- Client complains of abdominal pain, nausea, vomiting, diarrhea, blood in emesis or stool, constipation
- History of constipation, gallbladder problems, pancreatitis, HIV/AIDS, GI bleeding
- Menstruating or pregnant, abnormal vaginal discharge, unprotected sex
- Poor intake over past few days
- Client report of recent diagnosis of shigella, c-diff (clostridium difficile)
- Rectal pain

Objective information

- Vital Signs
- Signs of Dehydration (low blood pressure, sunken eyes, decreased skin turgor)
- Bloody stool or melena

Assessment

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.

Plan

1. Evaluate vitals signs. Assess for shock related to internal bleeding, including hypotension (BP <100/60) or tachycardia (HR >110).

2. Encourage oral rehydration with electrolyte solution.

3. 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.

4. Call 911 if vomiting frank blood or coffee grounds, passing black tarry stools (melena), or bright red bloody stools (hematochezia)

5. If bloody, accompanied by fever, or more frequent than once/hour, patient should be transported via non-emergent transport to ED.

6. Document into Adverse Event section of Sobering Center Encounter Form.

FALLS

Subjective information

- Client states s/he has just fallen
- Client has a fall witnessed by other clients or staff

Objective information

- Witnessed fall
- Physical signs of trauma consistent with a fall (swelling, lacerations, deformities)
- Client found on floor

Assessment

Due to the effects of intoxication, clients are at risk of falling. A fall can originate from a standing position or from a sitting or lying position, such as rolling out of bed or out of a wheelchair. A fall may result in physical trauma including head trauma, loss of consciousness, internal hemorrhaging, fractures and soft tissue damage. A thorough examination is critical to evaluate for possible injury resulting from a fall.

Plan

1. Upon notification a client is on the floor and/ or has fallen, either by report or witnessing a fall, immediately assess the ABCs (airway, breathing, circulation) and the level of consciousness of the client.
2. If client is unresponsive, has a new sign of head injury, or a change in mental status, call 911. Provide life-sustaining interventions as appropriate until assistance arrives.
3. For any signs of head or neck injury, encourage client not to move and implement cervical-spine precautions as able until assistance arrives to evaluate client.
4. Check vital signs, including blood pressure, pulse, respirations, and temperature. Check blood glucose level. For abnormal results, refer to respective protocols.
5. Perform neurological assessment. Check both pupils for reactivity and equal size, check for ability to respond to simple commands, check movement of 4 extremities. For any change in neurological status, call 911.
6. For any change in client status from intake or most recent nursing assessment, refer to appropriate protocol.
7. Notify staff provider during business hours.
8. If there are no obvious signs of injury, assist client back to bed.
9. Client should be monitored closely for change in level of consciousness and orientation throughout remainder of sobering stay. Perform neurological assessment every 1 hour for two hours; then continue to perform neurological assessment every 2 hours thereafter with vital signs. Refer to Head Injury protocol for assessment and plan.
10. Document into Adverse Event section of Sobering Center Encounter Form.

FEVER

Subjective information

- Chills and sweats
- Any infected wound, cough, sore throat, abdominal pain, vomiting or diarrhea, dysuria
- Taking antibiotics
- HIV/ AIDS diagnosis

Objective information

- Temperature greater than 100.9 ºF (38.3 ºC) (tympanic)
- Elevated pulse
- Signs of infection or abscess

Assessment

The most common cause of fever in this setting is acute infection. It may also be a result of a variety of other conditions, including drug reactions, tumors, dehydration, and alcohol withdrawal. A fever is never considered a normal finding. Per accepted clinical practice standards, **acetaminophen (Tylenol)** is not typically indicated for fevers less than 102.0 ºF.

Plan

1. Refer to ED any client with a temperature greater than 101.5 ºF (38.6 ºC) (tympanic). Call medical back up for mode of transportation.
    a. For clients able to tolerate orals, offer cold water until transport arrives.

2. Clients with a temperature greater than **100.9 ºF (38.3 ºC) accompanied by any of the following** must be referred to the ED as this combination of vital sign abnormality is worrisome for sepsis:
    a. Blood pressure < 90/60; Pulse > 100; Respiratory rate > 20
    b. Refer also to appropriate protocols for vital sign abnormalities as needed.
    c. Call medical back up for mode of transportation.

3. For temperature between 100-101.4 ºF, recheck temperature and blood pressure every 1-2 hours. Refer to medical provider during business hours. If no provider on duty, ask client to follow-up with Urgent Care after sobering stay.
    a. Rehydrate client as per dehydration protocol.

4. Acetaminophen should not be provided to clients appropriate for ED transfer due to fever conditions as indicated above. This may mask the fever and alter the diagnostic workup.

5. Document into Adverse Event section of Sobering Center Encounter Form, and within CCMS.

HEAD INJURY

Subjective information

- History of head injury: including when and how it occurred
- Any loss of consciousness at or after time of head injury
- Headaches, nausea, vomiting, lethargy, visual disturbance, weakness of an extremity, problems with coordination

Objective information

- Glasgow coma scale <13 (see Appendix I)
- Head contusions or laceration
- Level of consciousness
- Orientation to person, place, time, and situation
- Pupils; equality, size and reactivity
- Abnormal gait
- Ability to move all four extremities

Assessment

Persons with recent head injury, especially with loss of consciousness, are at risk for neurological complications. Signs of impending neurological disaster are easily confused with signs of acute intoxication. These clients must be observed carefully.

Signs of initial intracranial event are tachycardia and normal or low blood pressure.
Late signs are widening pulse pressure (when the SBP rises while the DBP falls or stays the same) and bradycardia.

Plan

1. If client is unresponsive, presents with signs of recent head trauma (red or purple bruises anywhere above the clavicles, lacerations, dried blood) or with abnormal neurological signs (unequal pupils, paralyzed limbs, not sobering as expected), call 911.

2. If client reports recent head injury but shows no obvious signs, client should be monitored closely for change in level of consciousness and orientation.
    - Monitor level of consciousness and orientation every 1 hour.
    - Perform neurological assessment on admission and every 1 hour thereafter. Check both pupils for reactivity and equal size, check for ability to respond to simple commands, check movement of 4 extremities.
    - If client does not improve as expected or becomes increasingly more confused, client should be sent to ED via 911.
    - Document into Adverse Event section of Sobering Center Encounter Form.

HYPERTENSION

Subjective information

- Headache, chest pain, confusion, dizziness, irritability, past history of elevated blood pressure, current antihypertensive medications

Objective information

- Systolic blood pressure greater than 160
- Diastolic blood pressure greater than 90

Assessment

Elevated blood pressure may be due to essential hypertension, stress, agitation, effect of drugs, chronic alcoholism, alcohol withdrawal, 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.

Clients may present with elevated blood pressures related to the stress and activity during transportation and admission to the Sobering Center.

Plan

1. Upon arrival to the Sobering Center, assist client to remove clothing from the upper body in order to obtain the most accurate blood pressure. Offer fluids and allow client to rest for 5-10 minutes.
2. After the short rest period, take initial blood pressure. If elevated with SBP>180 or DBP>110, re-check blood pressure on opposite arm.

    - If client presents with elevated blood pressure without other symptoms (headache, chest pain, confusion), provide the client rest and water.
    - Re-check in 30 minutes. If after 30 minutes, the blood pressure remains elevated above SBP>180 or DBP>110, contact medical backup and refer to ED via non-emergent transport.

    - If client has SBP>180 or DBP>110, with symptoms of headache, chest pain or confusion, refer client to emergency department via 911.

    - If SBP is 160-179 or DBP is 90-109, rehydrate with 1 liter of oral fluids and recheck blood pressure in 1 hour.

3. Refer to medical provider for evaluation during working hours.
4. Once blood pressure is within parameters, recheck blood pressure every 2 hours.
5. Assess for other signs of alcohol withdrawal (see Alcohol Withdrawal protocol).
6. Provide appropriate client teaching if able.
7. Document into Adverse Event section of Sobering Center Encounter Form.

HYPOGLYCEMIA/ HYPERGLYCEMIA

Subjective information

- Any past history of diabetes
- Past history of hyper- or hypoglycemic episodes
- Current medications
- Compliance with blood glucose checks and insulin

Objective information

- Blood glucose level
- Signs/ symptoms of hypoglycemia ex: weakness, sweating, rapid pulse, tremor, hunger, anxiety, confusion, disorientation, and deterioration of level of consciousness.
- Signs/ symptoms of hyperglycemia or DKA: confusion, lethargy, abdominal pain, nausea.

Assessment

Hypoglycemia and hyperglycemia may be difficult to distinguish from intoxication and withdrawal syndromes. 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. Alcoholics tend to deplete their sugar stores and are more prone to hypoglycemia than non-alcoholics. Diabetics are also prone to dehydration due to excessive diuresis. Perform fingerstick glucose on any client whose status is uncertain.

Plan

Blood glucose should be obtained at least once during sobering stay for all known diabetics. Observe all clients for signs and symptoms of hypoglycemia and dehydration.

Hyperglycemia (FSBG >250).

1. If FS blood glucose is greater then 250 clients need to be referred to the ED. Call medical back-up for advice on transport method and location.
2. Encourage diabetics to use their medications and insulin as directed.
3. Encourage fluids.

Hypoglycemia (FSBG <70)

4. For FSBG 60-69, give nutritional snack and recheck in 1 hour.
5. For FSBG 50-59, give **glucose tab** and nutritional snack. Recheck at 20 minutes and 60 minutes. If FSBG does not elevate above 69, refer to ED via nonemergent transportation.
6. For FSBG <50, refer to ED via 911. Administer **glucose tabs or gel** if client able to tolerate POs while awaiting 911.
7. For clients with FSBG <60 and stuporous/ obtunded, call 911 and use glucagon pen while awaiting 911. If no glucagon, a small amount of **glucose gel** may be administered orally. Put on gloved finger and rub inside cheeks and on gums.
8. All persons stuporous/obtunded or unable to comply with oral glucose shall be referred to the ED via 911 for evaluation (see Altered mental status protocol).
    a. Administer **glucagon pen** while awaiting 911.
9. Document into Adverse Event section of Sobering Center Encounter Form.

HYPOTENSION

Subjective information

- Dizziness, especially when standing or getting up quickly
- Use of any antihypertensive medication
- Use of diuretics

Objective information

- Systolic blood pressure less than 100
- Diastolic blood pressure less than 60
- Evidence of blood or fluid loss

Assessment

A systolic blood pressure less than 90 is not a normal finding per medical standards; 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, heart problems, or hypothermia.

Plan

1. Recheck blood pressure immediately if SBP less than 100 or DBP less than 60.
2. Interventions depend on intake systolic blood pressure:
    a. SBP < 80, call 911.
    b. SBP < 90, and client is unresponsive or unable to take PO fluids, call 911.
    c. If SBP is 80-99 and client is arousable 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, call medical backup.
3. Continue to monitor blood pressure every 2 hours for SBP between 90-100 or DBP less than 60.
4. Though clients on medications should be encouraged to comply with their medication regimen, a client with hypotension on anti-hypertensive medications should not take these medications until provider evaluation.
5. Document into Adverse Event section of Sobering Center Encounter Form.

HYPOTHERMIA

Subjective information

- Complains of feeling cold
- Exposure to cold, especially wet, weather
- Inadequate clothing

Objective information

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

Assessment

A subnormal temperature in this setting is most often as a result of exposure. Rarely will it be a sign of other disorders such as sepsis or hypothyroidism.

Plan

1. Provide radiant heat, dry clothes, blankets, warm liquids (note: never force fluids on a client with diminished level of consciousness).
2. Call 911 if temperature is less than 93º F (33.9 º C) and client has a diminished level of consciousness.
3. Call medical back-up or non-emergent ambulance transport if temperature < 93º F (33.9 º C) and client is fully alert and oriented.
4. Recheck temperature every 1 hour until 97º F (36.1 º C) oral or greater.
5. If temperature does not improve over 3 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.
6. Document into Adverse Event section of Sobering Center Encounter Form.

LICE AND SCABIES

Subjective information

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

Objective information

- Live lice on body or in seams of clothing
- Nits and lice in hair
- Excoriations
- Can not stop scratching
- Diagnosis from medical provider indicating active scabies or lice

Assessment

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.

Scabies is an infestation caused by mites that burrow into the skin, usually into the fingerwebs, waist, axilla and groin. Providers look for evidence of burrows. These organisms are too small to be observed by routine visual assessment.

Plan

1. Assess clients for lice and scabies at intake. Use best judgment regarding safety and risk for infestation in obtaining vital signs.
2. If client warrants treatment, treat clients after intake and prior to assignment of bed.
3. 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.
    - Treat all clients with lice in hair with **1% permethrin** (Nix) shampoo.
    - Leave lotion on for 10 minutes. After ten minutes, comb through all hair with comb provided in Nix 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.
    - Client should be returned to clean bedding. Any bedding used by client before shower should be washed immediately.
4. For clients with suspected scabies, refer to onsite provider for further evaluation. If no onsite provider available, refer client to Tom Waddell Urban Health Clinic or SFGH Urgent Care for treatment.
5. Document treatment on Sobering Center Encounter Form.

NAUSEA and VOMITING

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
- Poor intake over past few days
- Medications (particularly ASA, NSAIDS)

Objective information

- Vital Signs
- 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

Assessment

Abdominal pain can be caused by something simple 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.

Plan

7. Evaluate vitals signs. Assess for shock related to internal bleeding, including hypotension (BP <100/60) or tachycardia (HR >110).
8. Call 911 if vomiting frank blood or coffee grounds, passing black tarry stools (melena), or bright red bloody stools (hematochezia)
9. Nausea: If nausea persists have client take slow sips of water; reassess in 30 minutes.
10. 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 unable to hold down any fluids, send to ED via non-emergent transport.
11. Document into Adverse Event section of Sobering Center Encounter Form.

OPIATE OVERDOSE/ DEPRESSED RESPIRATIONS

Subjective information

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

Objective information

- Pinpoint pupils
- Respirations < 8 bpm
- Difficult or unable to arouse to pain
- Possession of needles, opiate medication, empty medication bottles

Assessment

Suspect opioid overdose. Client may present with symptoms at intake or during stay as a sobering client.

Plan

1. Attempt to arouse client. Check ABCs and provide CPR as warranted. Utilize support staff to obtain medications and/or provide CPR.
2. Contact provider during business hours for immediate assessment.
3. If no provider is immediately available and client remains unarousable, call 911 for a possible overdose. Be prepared to provide details on client condition and presentation.

4. Medications:
    a. **Oxygen**:
        i. For unconscious clients, apply **oxygen** at 8 L/min via simple mask.
        ii. For clients with respirations < 4 bpm, utilize an ambu bag and provide rescue breathing every 4-5 seconds.
        iii. If mask is not available, apply nasal cannula at 4 L/min.

    b. **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.

7. Provide life sustaining interventions as necessary including rescue breathing.

8. Document into Adverse Event section of Sobering Center Encounter Form.

PREGNANCY

Subjective information

- Client states that she is or may be pregnant
- Client states that her period is late
- Client appears to be pregnant

Objective information

- Client has a positive pregnancy test
- Client has documentation of pregnancy
- Date of last menstrual period

Assessment

The pregnant client using drugs and alcohol has a significant risk for adverse birth outcomes. Substance using women often avoid prenatal care because they feel ashamed of their use or are too involved in using to make care a priority.

Plan

1. Start by performing a pregnancy test.
2. Make sure client gets plenty of fluids and food.
3. If she is pregnant, given the risks to mother and fetus associated with pregnancy and substance use:
    a. During business hours 8a-5p: client should be encouraged to be assessed by provider.
    b. After hours 5p-8a: contact medical backup and refer client as recommended to an appropriate level of care (ED, urgent care) via recommended transportation.
4. If client presents or develops any abnormal vital signs, contact medical backup for transportation to emergency department. Refer to respective protocols as applicable.
5. If client does not wish to remain at Sobering Center, client should be referred to an urgent care clinic.
6. Offer referral to the Homeless Prenatal Program in San Francisco:
    Homeless Prenatal Program
    2500 18th St, San Francisco 94110
    415-546-6756
7. Document into Adverse Event section of Sobering Center Encounter Form.

SEIZURE

Subjective Information

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

Objective Information

- Witnessed seizure

Assessment

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

Plan

1. In the event of a seizure, protect the client against injury. Place client in side-lying position.
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 refer to Head Injury protocol and call 911.
6. Document into Adverse Event section of Sobering Center Encounter Form.

SHORTNESS OF BREATH

Subjective information

- Complains of shortness of breath
- History of Asthma, COPD
- Current medications
- Presence of chest pain or pressure (also refer to Chest Pain protocol)

Objective information

- 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

Assessment

Respiratory rate outside acceptable parameters may be due to intoxication or pre-existing pulmonary disease.

Plan

1. During daytime hours, contact provider onsite to assess for asthma or COPD exacerbation. Treatment should be initiated via provider orders, and may include albuterol nebulizer and prednisone. These medications can be obtained by the provider via Respite onsite stores. Transcribe orders onto CCMS Encounter Form.

2. If no providers on site, call 911 if:
    a. Respirations are less than 8 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.

3. After calling 911, apply **oxygen** via simple mask at 8 LPM.
    a. If mask is not tolerated or available, assist client to hold mask directly in front of mouth/nose or apply nasal cannula at 4 LPM.

4. If oxygen saturation is between 90-93%, or respirations are between 8-12 per minute, monitor respirations and level of consciousness every 30 minutes. If breathing does not improve after 2 hours, call medical backup for transport to ED.
    a. If 911 is contacted, follow oxygen recommendations above.

5. Document into Adverse Event section of Sobering Center Encounter Form, and within CCMS database.

SUICIDAL CLIENT

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,

Assessment

Clients who come to the Sobering center are at high risk for suicidal ideations, particularly after they sober and realize their current situation. We must be alert and always assess for potential suicidality, especially if any history of mental illness or previous attempts is known.

Plan

1. If client is attempting suicide or unable to contract for safety, call 911 or Sheriff's for 5150 evaluation. Observe client at all times and obtain additional staff support as needed. If safe for staff and other clients, intervene to keep client from self harm.
2. If client is able to verbally contract to not harm self, and staffing is adequate to provide ongoing visual monitoring, continue to monitor closely throughout stay.
    - Place client in a bed visible to nursing station.
    - Engage with client to remove any potentially harmful belongings from bedside; place items in clinical station.
    - Alert front desk staff that this client should not leave the building unattended. If client does attempt to leave, they should encourage client to stay and call for help.
    - 911 should be called for any client attempting suicide or departing the building while actively suicidal. A staff member should keep visual contact on client at all times, including if client is outdoors and 911 has been contacted but not yet arrived.
3. Notify provider and/or social work staff of any suicidal patient during business hours.
4. Document into Adverse Event section of Sobering Center Encounter Form. Document client status and activity every 30 minutes on the Continued Assessment Form.
5. You may refer client to crisis intervention services before or during discharge.

Progress Foundation's Dore Urgent Care Center (DUCC) 52 Dore St., San Francisco 415-553-3100 Phone	Westside Crisis 245 11th Street, San Francisco 94103 415-355-0311 Phone Mon-Sat, 9am-7pm

TACHYCARDIA

Subjective information

- Current cardiac or antihypertensive medications
- Complaints of palpitations, anxiety, fatigue, chest pain, dizziness
- Past history of cardiac conditions

Objective information

- Pulse >110
- Regular or irregular pulse
- Syncope

Assessment

Elevated pulse or tachycardia may be due to stress, drug effect, exertion, dehydration, heart conditions, alcohol withdrawal, or a host of other conditions. A pulse above 100 is almost never normal except as a temporary reaction to stress or exercise. A client with a history of tachycardia may have an abnormally high pulse rate at baseline.

A corresponding abnormal blood pressure may indicate additional complications. Hypotension (see Blood Pressure protocol) in the presence of tachycardia can be indicative of hypovolemia or cardiogenic shock.

Plan

1. Any client with a pulse >140 must be referred to the ED via 911.

2. For clients with a pulse of 110-139, initiate fluids, including water with rehydration salts. Recheck pulse every 30 minutes until pulse <110.

3. If pulse remains persistently above 110, after two hours of fluid and electrolyte replacement, contact medical backup for plan. Document plan on Sobering Center Encounter Form in nursing notes.

4. Evaluate for other signs of alcohol withdrawal (see Alcohol Withdrawal protocol).

5. If client is prescribed medication, encourage adherence to ordered regimen.

6. Client with abnormal pulse rate greater than 110 should be referred to the provider for evaluation during working hours.

7. Document into Adverse Event section of Sobering Center Encounter Form.

VIOLENT BEHAVIOR

Subjective and Objective information

- Physical threats, verbal abusiveness, disruptive behavior, extreme agitation, combative behavior

Assessment

Assaultive or disruptive behavior is not tolerated in the Sobering center. It does not matter if this is a result of substance induced behavior or mental health disorder. Combative clients may harm themselves and others.

Plan

1. Call 911, the San Francisco Police Department dispatch, or the Sheriff's department for assistance.

2. Safely protect yourself, co-workers, and other clients from potential injury. Seek help from available staff and do not attempt to prevent client from leaving the Sobering center.

3. Do not attempt to physically restrain client or intervene in a physical altercation.

4. Give the police officers any history you may have about the client's medical history.

5. Bring to attention of program director and deputy director during working hours.

6. Document into Adverse Event section of Sobering Center Encounter Form.

7. Document in written incident report. This should be in addition to the Adverse Event documentation.

8. For any staff injuries, report immediately to the program director and/or deputy director. Seek medical attention as appropriate.

WOUNDS

Subjective information

- Place and duration of wound/injury
- Pain
- History of tetanus immunization (per client or check LCR)

Objective information

- Fever (refer to Fever protocol)
- Redness, warmth, tenderness, swelling
- Purulent discharge, color and amount
- Active bleeding

Assessment

Clients present with wounds in many stages of healing and treatment. Lacerations <6 hours old with separation of skin edges may need suturing. Lacerations >6 hours cannot be closed. Deep lacerations, especially on the hand may involve deeper structures, i.e. nerves or tendons.

Because of the poor hygiene and immuno-suppression associated with chronic substance abuse, wound infections are more common and may need antibiotic treatment, as well as local care. All of these situations require assessment by provider, ED, or urgent care staff.

Plan

1. Wounds which have not been previously assessed or treated:
    a. Any stab wound refer client to the ED.
    b. All lacerations <6 hours old, refer client to the ED or urgent care. Call medical back up for advice on transport method and location.
    c. Wounds >6hours old may or may not need transport out of the facility. Contact medical backup or onsite provider for advice.

2. 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.
    b. During daytime hours, contact onsite provider for assessment and wound care orders.
    c. Clean and dress wounds according to standard nursing procedure.
    d. For any wounds that appear infected (red, swollen, hot to touch, purulent), refer to medical backup for transport to ED or urgent care.
3. Any hand wound that is red, hot, swollen, and purulent should be seen in urgent care or the ED. Non-emergent ambulance transportation should be used.
4. Any deep laceration or puncture wound that is red, hot, swollen, and purulent and any wound accompanied by fever should be seen in urgent care or the ED. Non-emergent ambulance transportation should be used.
5. Document into Adverse Event section of Sobering Center Encounter Form.