

REGISTERED NURSE STANDARDIZED PROCEDURES

FOR STREET-BASED OUTREACH AND ENGAGEMENT

NOTICE

These standardized procedures were developed as a tool to guide care and assessment by registered nurses working in Street-Based Engagement Services and Outreach providing care to persons who are unsheltered. The primary goal of this work is to help us all offer high-value assessment and coordination to our neighbors who are unsheltered.

These protocols are intended to assist agencies including county healthcare systems, community clinics, or healthcare-based homeless outreach teams in establishing protocols for their outreach nursing staff and/ or volunteers. Please modify at will!

These standardized procedures for registered nurses were originally drafted in 2018 and updated recently in 2021. I would like to thank the following organizations who shared their protocols and guidance: the *Alameda County Health Care for the Homeless*; *California Board of Registered Nursing*; *Lehigh Valley Health Network Street Medicine*; *Los Angeles Housing for Health*; *San Mateo Mobile Health Clinic*; *San Francisco Sobering Center*; and the *San Francisco Street Medicine Team*.

Share, edit, and feel free to send me questions or comments anytime.

Thank you!
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Please note: *These procedures are based on nursing practice within the state of California. These protocols do not supersede local, regional, or state laws and the expectation is that – prior to adoption – your agency will assure any adopted procedures conform to legal and other related regulations. Additionally, as with any medical and nursing intervention, new information and evidence-based research since these were updated may offer alternative options to those listed here. Any discrepancy or errors are not intentional – if you do find anything or have comments, please let me know!*

**Street-Based Engagement & Outreach
Registered Nurse Standardized Procedures
Updated July 2021**

1.0	<p>Functions to be performed: The specified functions may be performed in street-based engagement and street medicine teams where services are offered by the: Registered Nurse (RN)</p>
2.0	<p>Specific circumstances: Staff will review and implement these Standardized Procedures for RNs when a patient is being examined during street-based engagement including in out-of-doors locations for acute or ongoing care.</p>
3.0	<p>Procedure and Requirements:</p> <p>3.1 Confirm patient identity/ demographics.</p> <p>3.2 Perform initial assessment, either focused based on patient complaint or a general assessment including blood pressure, pulse, oxygen saturation, temperature, blood glucose as indicated, wound assessments, and psychosocial needs as appropriate.</p> <p>3.3 Nursing staff must contact 911 immediately when assessing a patient or potential patient who presents with:</p> <ol style="list-style-type: none"> 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 < 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 < 93° F (33.9° C) tympanic

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. The registered nurse role oversees patient health and wellness, including the assessment, management and care coordination for chronic disease and acute medical complaints. Nursing care provided in street-based outreach and engagement offers a general level of assessment and care within the RN scope of practice, such as vital sign monitoring, obtaining health history, providing education, care coordination, and medication procurement and management.

For patients without regular care in a clinic-based or primary care setting, the registered nurse offers, in collaboration with medical provider guidance, a comprehensive level of care in the field in order to support health and wellness.

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. For acute health conditions or complaints, perform physical exam pertinent to presenting problem(s). See procedural guideline *Triage and Treatment of Illness by Registered Nurse* for additional support on managing acute conditions.
4. Consult regularly with assigned provider and/or medical back-up that oversees your team utilizing verbal orders or telemedicine when appropriate.
5. To ensure collaboration and communication within the healthcare system, document assessment and related notes within the electronic health record as close to the assessment day as possible, ideally same-day or within one business day.

Primary Care Connection

Connecting the patient 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 patient.

1. Provide every patient with next primary care clinic appointment and encourage appointment adherence through support as appropriate. If patient is not scheduled, team can assist in scheduling patient for clinic appointment in appropriate timeline.
2. Refer patient to medical home if not yet assigned. Consult with your team administration and/ or regional coordinators to assist with complications in this process.
3. As able and appropriate, continue to provide care to the patient until health care needs have been transitioned to a clinic.

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CALL 911/ EMERGENCY RESPONSE

Nursing staff must call 911 when assessing a patient or potential patient 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 < 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 < 93° F (33.9° C) tympanic

Street health outreach team management should be alerted immediately of all critical emergencies involving cardiopulmonary resuscitation (CPR), administration of naloxone, AED/ defibrillator use, and/or resulting in patient disability or death.

Staff may contact management at any time with questions regarding patient care, staff safety, or operations.

CONTACT MEDICAL BACK-UP

What is Medical Back-up:

During street engagement encounters, a patient or other individual may present with a clinical scenario necessitating medical assessment or evaluation. Medical back-up may include team providers (NP, PA, MD, DO), emergency department attending-on-duty, contracted medical providers (i.e., HIV consulting physician), 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 states their affiliation "I am calling from the _____ [Street-Health Outreach Team]" and be prepared to give the following information as able:

- Patient 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 patient 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?"

At times medical back-up is not available and there is concern for patient 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 patient 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 patient may verbally state they are not in need of additional medical services. This can happen with either a current or prospective patient. 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 patient is at risk of decompensation or worsening condition, and the patient is still refusing care, medical back-up should be contacted for assessment and consultation. Emergency medical staff (paramedics, EMTs, supervisors/captains) can offer additional support in negotiating a plan of care with the patient.

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 patient and this can be determined on a case-by-case basis.

- Provide information as appropriate for medical back-up call
- Inform dispatch that the patient 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 patient.
- EMS should assess patient at this time. If patient still refuses transport to further care, determine with EMS if:
 1. Additional support is needed to encourage/order participation (supervisors, law enforcement, crisis outreach team). In this case, EMS or Outreach staff should contact 911 dispatch or the appropriate agency for further support. Or,
 2. Patient has capacity to refuse transport. If it is determined the patient can refuse transport:
 - Have EMS complete an AMA form. Keep a copy.
 - Document specifically how capacity was determined.
 - Reference in the Appendix: *“Evaluating Patients’ Decision Making Capability”* by Thom Dunn.
 - As able, educate patient to signs and symptoms that indicate a more critical or worsening condition, including steps to contact emergency services. If available, include a friend or family in this education (i.e., encampment mates for which the patient verbally consents to involve in this specific conversation).
 - Plan follow-up with the patient to check-in as soon as feasible.

TRIAGE & TREATMENT OF ILLNESS BY THE REGISTERED NURSE

The Registered Nurse (RN) may complete nursing assessments and provide nursing care in accordance with the State Nurse Practice Act and the County or partner agency's specific nursing protocols. 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 patient'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 and corresponding electronic health record.

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.

PHLEBOTOMY aka VENIPUNCTURE

Purpose:

To obtain a venous specimen for testing and treatment using proper technique and equipment to prevent infection, sustain viability of the vein and produce the highest quality specimen.

Policy:

Applies to registered nurses in Street Health Outreach Teams and intended for field- or mobile-based phlebotomy.

Recommended Equipment:

Tape or Band-Aid

Appropriate size needle

Dry gauze pad or cotton ball

Gloves

Isopropyl alcohol pads

Disposable tourniquet

Tubes for tests ordered (including extras for required discard/ wasting or need to redraw)

Disposable vacutainer adapter

Sharps container and Biohazard container/tote

Documentation paperwork

Writing supplies

Procedure:

1. Explain procedure to patient. Confirm patient understands process and purpose of venipuncture.
2. Confirm patient's identity via two patient identifiers (e.g., having patient state full name and date of birth)
3. Gather all supplies and identify all tubes required for ordered labs
 - a. Choose needle size and type related to vein size and amount of blood needed.
 - b. Confirm the order of draw based on tube type (available through your contracted laboratory)
 - i. Typical order for drawing blood specimens is: 1) Blood cultures; 2) Non-additive tubes; 3) Coagulation tubes; 4) Other additive tubes
 - ii. When drawing all additive specimens, coagulation and CBC are drawn first
4. Perform hand hygiene and don gloves.
5. Check for restrictions on available venipuncture sites
 - a. **Venipuncture is not to be performed:** on an artery, an extremity with an active shunt or fistula, or central vascular access device or on the same side as axillary lymph node surgery
 - b. If presence of hematoma on the extremity, perform venipuncture above hematoma (proximal) to avoid hemoconcentration of the blood sample.
 - c. **Venipuncture of the legs or feet may predispose the patient to phlebitis.** Use of a lower extremity requires provider consultation (verbal or telemedicine ok) prior to venipuncture.
6. Apply tourniquet to appropriate site and assess for appropriate vein for venipuncture
 - a. The vein ideally should be visible without applying the tourniquet.
 - b. In case of no obvious appropriate sites, consult with patient to help identify particular veins or locations at which phlebotomy has been previously successful.
7. Cleanse area of skin with minimum 70% alcohol preparation swab in a circular motion and allow to dry. Use multiple alcohol swabs as needed to ensure clean site. Do not fan or blow on site to speed rate of drying.
8. Perform venipuncture to assessed vein, in order of proper collection

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- a. If there is no blood flow, gently reposition the needle in the vein and insert a new tube into the vacutainer adapter. Do not remove the needle from the skin. If another venipuncture is necessary, prepare a new site and use a clean needle.
 - b. After two unsuccessful attempts at venipuncture by a nurse, reassess and consider using another resource (e.g., another RN or staff member certified in phlebotomy, provide oral hydration and wait at least 15mins, urgent care clinic).
 - c. Consult with provider as needed.
9. Release the tourniquet while needle still in patient
- a. Note: the tourniquet is typically released as soon as blood enters the first tube. You may leave the tourniquet on during the entire procedure if needed.
 - b. Remove tourniquet before withdrawing needle.
10. Retract the needle from the patient while applying gauze or cotton ball to the area of collection for approximately 2 minutes, or until bleeding has ceased. As able, patient may apply pressure instead of the nurse.
- a. Do not bend the arm at the puncture site as this may increase chance of hematoma.
 - b. If bleeding does not cease, apply bandage and additional pressure on top of existing gauze or cotton ball. Do not remove original dressing.
 - c. Notify health care provider if bleeding continues for five minutes.
11. Discard needle/ vacutainer adapter and any discard lab tubes in the sharps container.
- a. After drawing tubes with additives, invert the tube gently ten times. Do not shake any tubes.
12. Remove gloves and perform hand hygiene.
13. Unless soaked with blood or bodily fluids, the gloves, gauze, alcohol pads, and tourniquet may be disposed of in double-bagged system within regular trash.
14. Document in patient chart including:
- a. Number of attempts
 - b. Patient's tolerance
 - c. Venipuncture site
 - d. Lab test(s) obtained
 - e. Receiving lab
 - f. Other details as appropriate
15. Apply appropriate labels to specimens and complete the specimen requisition. Documentation on each tube must include:
- a. Patient name, DOB
 - b. Collection date and time
 - c. Identification of collector (nurse initials)
 - d. Completion of the lab slip including venipuncture location
 - e. Any additional information as required by processing laboratory
16. Place collection tubes in clear biohazard bag and place in specimen delivery bag for laboratory. Ensure labs are delivered within acceptable window of time for processing (confirm with laboratory).
17. In follow-up visit, assess venipuncture site as able to ensure no signs or symptoms of infection are present.

References:

Perry, A., Potter, P. & Ostendorf, W. (2019) Nursing Interventions & Clinical Skills, 7th Edition. Mosby. Available at: <https://www.elsevier.com/books/nursing-interventions-and-clinical-skills/perry/978-0-323-54701-7>

World Health Organization Guidelines on Drawing Blood: Best Practices in Phlebotomy. Accessed July 2021 at <https://www.ncbi.nlm.nih.gov/books/NBK138665/>.

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

- Patient 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 sexual intercourse
- 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

As able for topical exposures, remove allergen from proximity of patient. For other exposures, such as respiratory or ingestion, advise patient to cease intake as able. If the allergen may be a medication, contact the prescribing provider for additional recommendations and order.

An allergic reaction with mild systems may or may not require medication management, based on the patient preference and level of discomfort.

Mild symptoms:

(Hives, Rash, Allergic Rhinitis)

- Contact medical back-up for medication orders, such as diphenhydramine (Benadryl) PO.
- Monitor Symptoms. If symptoms unresolved within 2 days, recommend patient 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.
- If patient has an existing prescription and available medication, Epinephrine 0.3 mg IM x 1 may be administered.
- Protect the airway, and 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 condition such as 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. chronic illnesses (seizures, diabetes, hypertension, liver, kidney, or cardiac disease), alcohol or drug use, 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 (Pupils Equal Round & Reactive (to) Light & Accommodation)
 - 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. **Clenched fist or fight bites** occur when skin over a joint strikes a tooth which may damage the skin and the underlying structures. They are not bites but assessed 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 or injury?
- Type and size of the animal? Possibility of rabies (animals with fur)?
- How did it happen?
- When did it happen?
- How has the patient treated the injury thus far?
- Preexisting conditions which may have weakened the immune system or altered healing

Objective Information

- Assess wound site:
 - Note the structures involved
 - Damage may include fractures, lacerated tendons, blood vessels, nerve 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 patient to a safer environment or to secure the 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)

All bite injuries should be referred to urgent care or other clinic. If unable to refer patient to clinic or other medical setting, proceed with the following care.

- a. Clean thoroughly with irrigated water, soap and water, or sterile saline.
- b. Utilizing clean technique, cover wound with non-adherent dry dressing, and advise patient to keep dry and clean for 24-48 hours.
- c. If there is bleeding, a clean towel or non-adherent dressing should be used to press the wound to slow or stop the bleeding.
- d. If bleeding does not stop after applying pressure for 15 minutes, **call 911**.
- e. Red, painful, swollen, and warm injury sites indicate possible infection. Contact medical back-up for further instruction.
- f. All bites to the hands must be referred to a higher level of care, either clinic or ED. Contact medical back-up for instruction.
- g. 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 care. These items may be also secondarily provided to law enforcement officers in case of human-to-human bite.
 - iii. Avoid removal of deep tissue.

3. Bites (after 24hrs)

- a. Any damage to circulation or lack of distal pulses requires immediate medical intervention. Contact 911 or an emergency department immediately.
- 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.
- 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, patient should wash feet daily and dry thoroughly. Vinegar soaks for 20-30mins (one cup vinegar to 2 quarts water) can be recommended as appropriate.
- Management with over-the-counter medications may be appropriate. Contact medical back-up for orders, including clotrimazole cream 1% or anti-fungal foot powder.
- Severe symptoms or those that are difficult to resolve may be treated with oral medications including itraconazole (Sporanox), fluconazole (Diflucan), or terbinafine (Lamisil). Refer to urgent care or contact medical back-up for additional assessment and medication orders.

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 i.e. weak, thready or bounding pulse

Plan

1. Any patient 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. Patients 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.**
- 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 patient 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 patient’s typical heartburn.
2. Place patient in a comfortable seated or lying position as able. Be prepared to initiate CPR.
3. Medications may be administered only under direct orders of a prescribing provider. If provider and medications are available, patients with active chest pain may be provided (prioritizing in order listed):
 - a. **Oxygen** via nasal cannula (*if at location with access to oxygen*)
 - b. **Aspirin** PO *except* when primary complaint is “tearing chest pain”
 - c. **Nitroglycerin**: *except* when primary complaint is “tearing chest pain”. Must have SBP >110mmHg to administer.
 - i. For patients with an **existing prescription of nitroglycerin**, the nurse may recommend self-administration as appropriate.
4. Upon EMS arrival, report medications provided and hand off further treatment when directed.
5. 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.

<p>ASSESSMENT: Note the absence or presence of the following symptoms to guide intervention options.</p> <ul style="list-style-type: none"> • Red eyes • Tearing, discharge • Runny nose • Nasal congestion • Sneezing • Throat redness, swelling • Quality of cough • Auscultate chest • Palpate sinuses for pain 	<p>EXCLUSIONARY CRITERIA: If any of these are present, consult medical back-up and/or the relevant additional protocols.</p> <ul style="list-style-type: none"> • Fever >100° F (38° C) • Elevated blood pressure • Elevated heart rate • RR >24 and/ or O2 sat. on RA <94% • Neck stiffness • Exudate in throat and/or on tongue • Abnormal breath sounds • Swollen glands • Ear Pain • Sinus pain with purulent drainage • Shortness of breath • Uncontrolled asthma • Cold symptoms for >7 days • Untreated +PPD or +QFT • Exposure to person with COVID-19
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Plan

1. If patient presents with any listed Exclusionary Criteria, contact medical back-up and/or the relevant protocols for further guidance.
 - a. As able for patients with active cough or untreated tuberculosis or COVID-19, place mask on patient and encourage staff to wear masks.
2. Assure that patients with Asthma/ COPD have access to prescribed medications and refills
3. Assess if patient may require medication management of the URI symptoms, and contact medical back-up for further assessment and consultation.

4. Over-the-counter medications often recommended for URI-related symptoms may include:
 - a. For nasal congestion/ sinus pressure:
 - i. **Pseudoephedrine hydrochloride**
 - ii. Caution may be used in patients with HTN, and contra-indicated for patients also taking MAOIs
 - b. For chest congestion/ cough:
 - i. Expectorant/ Suppressant cough syrup: Guaifenesin / Dextromethorphan syrup (Robitussin DM, Mucinex DM).
 - c. For non-hacking coughs with thick mucus:
 - i. Expectorant syrup: Plain Guaifenesin cough syrup.
 - d. For fever/ pain:
 - i. Ibuprofen or Acetaminophen (typically not recommended in patients with liver disease)
 - e. Sore throat: Cepacol throat lozenges
 - f. Depending on symptoms: Saline nasal spray; multi-vitamins; Vitamin C

CONSTIPATION

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.
- 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).

- Contact medical back-up for further assessment and orders, which may include Metamucil, docusate sodium (Colace), senna, or suppository.
 - Educate patient to not attempt all four interventions at one time.
 - Advise patient to increase water intake as appropriate.
- Monitor symptoms. If symptoms remain 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 medical back-up or patient's primary care provider if frequent symptoms (recurrence of constipation every 2-3 weeks)
- Confirm patients that are 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, COVID-19, 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 persons who are homeless and outreach staff should have screening for tuberculosis regularly.

Subjective Information

- History of tuberculosis (TB) exposure
- History of COVID-19 exposure (see *Coronavirus Disease 2019* protocol)
- 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
- Unvaccinated status (COVID-19)

Objective Information

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

Plan

1. Patients with **intermittent cough**: place a mask over patient nose and mouth and alert medical back-up for evaluation (See also *Cold/ URI* protocol). If no provider available, refer patient to primary care or urgent care.
2. Patients with **persistent cough** and/or additional signs or symptoms of infectious condition (i.e., active TB, COVID-19 – see *related protocol*) require urgent evaluation and testing. Place mask on patient. Alert medical back-up and/or transport patient to urgent care or primary care. If no provider or clinic available, consider transport to emergency department via non-emergent transportation. See “Patient Refusal of Medical Services” as appropriate, if a higher level of care is needed and refused. Additionally, if TB is suspected, follow clinic guidelines to contact the Public Health Department for further instruction.
3. If available, conduct onsite swab and test for COVID-19. In case of positive results, follow protocols to promote self-quarantine or refer patient to appropriate shelter setting.
4. Patients with **hemoptysis**, cough with **fever**, or **difficulty breathing** (see *Shortness of Breath* protocol) require urgent evaluation. Contact 911 for transportation.
5. Staff has the option of wearing a mask as appropriate. Mask use is encouraged when caring for individuals with a cough.

CORONAVIRUS DISEASE 2019 (COVID-19)

Coronaviruses are a large family of viruses that can cause illness in animals and humans. COVID-19 is caused by the virus “severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)”. This is a respiratory illness spread person-to-person primarily through respiratory droplets when someone with COVID-19 sneezes, coughs, or talks. Though apparently rare, persons can be infected with COVID-19 from touching hands, objects, or services with droplets and then touching their own eyes, nose, or mouth. Persons with mild or no symptoms are still able to transfer the virus to another individual. Though vaccination does offer a substantial amount of protection, it does not offer full immunity; persons who are vaccinated for COVID-19 may still acquire and transmit COVID-19 to other individuals.

Symptoms may present both as a respiratory condition and more broadly. As of June 2021, these include: fever or chills, cough, shortness of breath, fatigue, headache, nasal congestion, muscle or body aches, sore throat, new loss of smell or taste, nausea or vomiting, and/ or diarrhea. Estimated incubation period is 2 to 14 days. Updated information may be found at the Centers for Disease Control and Prevention at <http://www.cdc.gov/coronavirus/>.

Priorities for assessment of COVID-19 is to rapidly identify suspect cases early to reduce transmission within the public and initiate monitoring or treatment to reduce negative health complications including death.

Subjective Information

- History of COVID-19 exposure
- Symptoms consistent with those listed above, including new emerging symptoms
- Vaccination status for COVID-19
- Vaccination status for flu, pneumonia

Objective Information

- Persistent coughing, congestion, shortness of breath
- Fever
- Clinical alert indicating exposure to COVID-19 case
- Cases of COVID-19 in neighboring persons within same or nearby encampments

Plan

1. Due to the emerging process of SARS-CoV-2, specific methods of testing and treatment are not being included here in these procedures. Refer to latest CDC and county guidelines for testing, medical back-up, transport, and treatment of patients with positive or suspected COVID-19.
2. General guidelines:
 - a. Mask use is encouraged when working with any patient with a cough. Staff should don a medical or cloth face mask prior to performing additional assessment. Additional PPE may be warranted depending on staff preference and clinical scenario, including eye protection (goggles or face shield) or gloves.
 - b. Place a mask over patient nose and mouth.
 - c. As available, perform onsite rapid COVID-19 test.
 - d. Refer to medical back-up for suspected and positive cases. If no provider available, refer patient to primary care or urgent care.
 - e. Report suspected or positive cases of COVID-19 to team management or public health department as specified by local or state guidelines.

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:
 - Refer patient to dentist or dental clinic
 - Contact medical back-up for pain medication (such as acetaminophen or oil of clove) as appropriate while awaiting dental examination.
2. ANY facial swelling and/or moderate pain:
 - Consult with medical back-up
 - Assist patient 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 patient 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 no 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 patient 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).
 - a. **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
 - b. **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
 - c. **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
 - d. **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. Bathing (arrange access to bathing, if possible)
 - i. Lukewarm baths can hydrate, cool the skin, and relieve itching
 - ii. Use unscented mild soap

- b. Wound care may alleviate symptoms and help to restore the skin barrier. Contact medical back-up for further assessment and prescription ointment orders.
 - i. Advanced practice registered nurses with an active, accredited Wound Certification may practice to the scope of their credentialing in wound care management.
 - 1. Accreditation should be from either Accreditation Board for Specialty Nursing Certification (ABSNC) or National Commission for Certifying Agencies (NCCA).

- c. Contact medical back-up to obtain over-the-counter or prescription medication orders.
 - i. Mild:
 - 1. Medications typically recommended include emollients (thick creams) such as Eucerin or Cetaphil or ointments such as petroleum jelly, Aquaphor, and Vaseline.
 - 2. If a low potency topical corticosteroid cream or ointment (hydrocortisone) is prescribed, advise the patient it should be applied after bath or cleansing.
 - ii. Moderate
 - 1. A medium to high potency corticosteroid creams (fluocinolone, triamcinolone, betamethasone) may be appropriate.
 - iii. Severe
 - 1. May require referral for phototherapy or systemic immunosuppressant. Consult with medical back-up or primary care for a referral.

2. Skin Irritation

- a. Topical or Oral steroids may be prescribed to prevent thinning and/or irritation of the skin. Contact medical back-up, urgent care, or primary care for assessment and orders.

3. Control Itching

- a. Topical or Oral antihistamines may be prescribed to alleviate itching. Contact medical back-up or primary care for assessment and orders.

- b. Wet dressing may be applied 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. It can be worn overnight and changed twice daily
 - ii. Wet dressing may be applied utilizing the clean technique at minimum. If a clean technique is not achievable in the field, patient should be transferred to a location where a clean technique may be achieved.

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 skins response to the irritant.

Subjective

1. Review patient’s contact with chemicals, 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? What has helped resolve the issue?
 - 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 borders
 - 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 reduce or eliminate contact with irritants or allergies**
2. **Goal is restoration of skin barrier and hydration**
 - a. Mild
 - i. Over-the-counter emollients (thick creams such as Eucerin or Cetaphil) or ointments (such as petroleum jelly, Aquaphor, or Vaseline) may be recommended. Contact medical back-up for additional assessments and orders.
 - ii. Low potency topical corticosteroid cream or ointment (i.e. hydrocortisone) may be indicated, and should be applied after bath or cleansing. Contact medical back-up for additional assessments and orders.

- b.** Moderate or Severe symptoms with skin inflammation
 - i.** Medium to high potency corticosteroid creams (fluocinolone, triamcinolone, betamethasone) or other prescription medications may be indicated. Contact medical back-up for orders.
 - ii.** If there is a lot of swelling or a rash covering much of the body, consult with medical back-up or refer patient to urgent care/ ED.

3. Control Itching

- a.** Over the counter oral antihistamines such as Zyrtec or Claritin (non-drowsy) or Benadryl or Atarax (may cause drowsiness) may address itching not controlled by topical medications. Contact medical back-up for orders.
 - i.** Recommend patients follow dispensing guidelines as indicated on the package or as prescribed by a provider.

- b.** Wet dressing may be applied 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 and changed BID.
 - iii.** Wet dressing may be applied utilizing the clean technique at minimum. If a clean technique is not achievable in the field, patient should be transferred to a location where a clean technique may be achieved.
 - iv.** Registered nurses with an active, accredited Wound Certification may practice to the scope of their credentialing in wound care management.
 - 1.** Accreditation should be from either Accreditation Board for Specialty Nursing Certification (ABSNC) or National Commission for Certifying Agencies (NCCA).

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 symptoms, 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

- Patient 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 sexual intercourse
- Patient report of recent diagnosis of shigella, c-diff (clostridium difficile)
- Rectal pain
- Stimulant use

Objective

- Vital Signs (obtain 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.
- Assess for diarrhea related to recent antibiotic treatment (within last 4 weeks)

Plan

1. Mild Symptoms: (*diarrhea lasting < 2 days, no observed blood in stool, normal vital signs, no vomiting*)
 - a. Encourage increased PO fluid intake.
 - b. Over-the-counter oral medications may alleviate mild symptoms, such as bismuth subsalicylate (Pepto Bismol) or loperamide (Immodium). Contact medical back-up for further assessment and orders.
 - i. Note: Pepto Bismol can darken stool
 - ii. If possible cause of diarrhea is recent antibiotic treatment, consider clostridium difficile (C-Diff). Alert medical back-up to antibiotic history, as treatment with loperamide may worsen condition.
 - c. Monitor Symptoms x 2 days. If symptoms unresolved, notify medical back-up for additional assessment.
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 and/or 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 often present without a fever, will 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:

- Over-the-counter antihistamines, such as diphenhydramine, loratadine, or cetirizine, may help alleviate symptoms. Contact medical back-up for further assessment and orders.
 - Advise patient to avoid alcohol while taking diphenhydramine

Moderate/ Severe symptoms:

- May indicate a worsening condition or more systemic allergic reaction. Symptoms may include presence of a fever, significant exudate, significantly low blood pressure, congestion, or chest tightness.
- If any cardiac or advanced respiratory symptoms are present (hypotension; palpitations; chest pain; difficulty breathing; bronchospasm, wheezing), contact medical back-up.
- If airway is compromised (rapid respiratory rate, low oxygen saturation, tripod positioning), contact EMS via 911.

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, including mild (dehydration, mild alcohol or drug withdrawal, bruxism) 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, watery, red
 - c. Pupils: PERRLA
 - d. Facial symmetry and weakness
3. Neck, head, and shoulder exam: Trauma? Tenderness? Stiffness?
 - a. Posture, range of motion
 - b. Hand grips: equal in strength?
4. Gait, balance, coordination: Normal, weak, uncoordinated

Plan:

1. Mild symptoms

- a. Many over-the-counter pain relievers are available and may be recommended including aspirin, acetaminophen, NSAIDS. Contact medical back-up for further assessment and orders.
 - i. Do not provide these medications for patients with gastritis, active or chronic alcohol consumption, ulcers, liver disease, kidney disease, and bleeding conditions. Consult with medical back-up regarding options.
 - ii. Avoid alcohol while taking acetaminophen or ibuprofen
- b. Provide oral fluids in cases of dehydration

- 2. Patients 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 typically 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 un-noticed and patient collapses)
 - Loss of 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 (stiff with legs out straight, fists clenched, arms bent to hold hands on chest)
- 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.**

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 – Assessing Acute Hypertension

- If patient 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 patient's SBP is 160-189 or DBP is 90-109 and is asymptomatic, discuss patient history of elevated blood pressure including typical range. Offer rehydration with 1 liter of water.
- Confirm if patient has medication prescribed for hypertension and available on person. If patient has not yet taken their medication, evaluate prescription and encourage patient to take as directed. Consult medical back-up for follow-up evaluation.
- Encourage patient to visit urgent care or primary care provider for follow-up and bring in all medications for review, as appropriate.

Plan - Repeat Measures of Hypertension

- For ongoing assessment and care of elevated blood pressure, repeat assessments with provider follow-up is recommended. Blood pressure is defined by blood pressure reading classifications (American Heart Association guidelines, 2012):
 - **Normal** BP reading—systolic blood pressure (SBP) is <120 mm Hg; diastolic blood pressure (DPB) is < 80 mm Hg
 - **Pre-hypertensive** BP reading: SBP is ≥120 and ≤ 139 mm Hg; DBP is ≥80 and ≤89 mm Hg
 - **Hypertensive** BP reading: SBP is ≥140 mm Hg or DBP is ≥90 mm Hg
- Assess blood pressure on two repeat engagements with the patient at least one day apart. Recheck elevated blood pressures on both arms.
- If BP is elevated in the pre-hypertensive or hypertensive range for each repeat assessment, schedule a face-to-face appointment with a street- or clinic-based medical provider for further evaluation.

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 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 prone to hypoglycemia.

Subjective (as able)

- **Medical history:** individual or family history of diabetes
- Previous occurrences of hypo- or hyperglycemia: primary cause if known and resolution
- Any medications for diabetes prescribed including insulin or oral medications
- Last time patient checked their FSBG or took insulin
- Confirm when and what the patient 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. If available as existing patient prescription, use glucagon pen while waiting. If glucagon is available in emergency kit, obtain verbal orders and administer as indicated.
 - ii. Additionally, a small amount of glucose gel, if available and with orders, may be administered orally. Administer directly or put on gloved finger and rub inside cheeks and on gums.
 - b. FSBG 50-69 and oriented with ability to swallow, give nutritional or high sugar snack.
 - i. Recheck at 20 minutes and 60 minutes.
 - ii. **If FSBG does not elevate above 69, contact medical back-up** for orders
 - c. **All persons stuporous/obtunded or unable to comply with consuming snack shall be referred to the ED via 911 for evaluation** (also see *Altered mental status* protocol).
 - i. Administer **glucagon pen** per orders indicated above while awaiting 911.
2. **Hyperglycemia (FSBG >250).**
 - a. Encourage fluids and use of medications and insulin as directed. Assist patient to self-administer medications as appropriate. As able, confirm with patient 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 typical and not abnormal. 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 orthostatic blood pressure.

Plan

- Manually recheck blood pressure immediately if SBP less than 100 or DBP less than 60. Confirm with patient their typical blood pressure.
- Interventions depend on systolic blood pressure:
 - SBP < 80 without alteration to mental status, contact medical back-up
 - SBP < 90, and patient is unresponsive or unable to take PO fluids, call 911.
 - If SBP is 80-99 and patient 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 patients on medications should be encouraged to comply with their prescription medication regimen, a patient with symptomatic 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 without adequate shelter is most often as a result of exposure. Though rare, it may also be a sign of other conditions such as sepsis or hypothyroidism. Consider these alternate conditions if patient presentation is not consistent with environment.

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° (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 patient indoors. Provide radiant heat, dry clothes, blankets, warm liquids (note: never force fluids on a patient 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 patient 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 patient has a diminished level of consciousness.
5. If temperature < 93° F (33.9 ° C) and patient is fully alert and oriented however you are unable to place patient 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 quintana, 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 patients with possible symptoms of Trench fever or other infection, refer to medical back-up.
- Intervention removing bugs depends upon the ability of the patient to find or be placed in a clean environment. A treated patient, who then returns to an infected area, will likely be immediately re-infected with lice. Thus, treatment should be reserved primarily for patients once able to transition to a clean environment.
 - If patient warrants treatment, use best judgment regarding safety of fellow staff and risk for infection.
- Lice treatment:
 - Remove all clothing and belongings from patient.
 - Wash all clothes with hot water and dry at least 30 minutes in high heat dryer.
 - Do not dry in dryer prior to washing.
- Body lice: Have patient 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 patients with head lice with **1% permethrin** shampoo.
 - Note: Do **not** treat with permethrin unless a staff member will complete the combing process. Shampoo alone is not effective and has resulted in large-scale permethrin resistance.
 - Leave lotion on for minimum 10 minutes. After ten minutes, comb through all hair with comb provided in permethrin packet.
 - After combing, wash hair and body thoroughly with soap and water.
 - Inform patient that treatment should be repeated in 7-10 days. Patient should follow-up with primary care or urgent care.
- Permethrin may exacerbate pruritus, edema, and erythema. Consider medical assessment if possible infection is present.
 - Patient should be returned to clean bedding. Any bedding used by patient 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 patient
- 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 patients without recent pregnancy or abortion, without fever or signs of excessive bleeding:

- Contact medical back-up for further assessment and orders for analgesic medication, such as ibuprofen.
- Advise patient 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 patients **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 patients **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
 - Over-the-counter analgesics may be effective, such as acetaminophen, ibuprofen, or NSAIDs. Contact medical back-up for further assessment and orders.
2. Severe Symptoms (Sudden onset, co-occurring nausea/ vomiting, tachycardia, HTN, fever, debilitating pain, recent trauma resulting in possible fracture/ head injury)
 - Refer to Medical back-up and/or 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 patient to urgent care or primary care
 - Encourage patient 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:

- Patient 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 patient take slow sips of water; reassess in 30 minutes. If it persists, contact medical back-up or recommend patient be evaluated in urgent care or primary care clinic.
4. Emesis: If patient vomits, assess for nausea and have patient 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 conceal 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 incarceration or with a long period of sobriety are often at higher risk of opioid overdose because of lost tolerance related to cessation.

Subjective

- Patient states they taken oral, inhaled, or injected opiates

Report by witnesses or other persons familiar with patient who indicate prior or current history of drug use

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 used syringes, opiate medication, empty medication bottles

Plan

1. Attempt to arouse patient 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 patient remains unarousable, call 911 for a possible overdose.
3. 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.
 - iii. **If team does not have naloxone on site, team members may ask other parties in the area if they have naloxone. New, unused naloxone may be administered to patient.**
 - b. **Oxygenation:**
 - i. For nonresponsive patients or patients with respirations < 4 bpm, provide rescue breathing every 4-5 seconds. Utilize an ambu bag as available.
 - ii. If oxygen is available, obtain orders from a prescribing provider and apply nasal cannula at 4 L/min.
4. Patients receiving naloxone **should** be encouraged to continue to the ED via EMS, due to the risk of overdose after the naloxone effect diminishes (30-45 minutes).

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- a. If patient unable or unwilling to continue to ED, provide education to risk of overdose in next 1 to 3 hours even in absence of additional drug use.
 - b. Team members who can provide training, may provide a training in real-time to patient and other interested parties in naloxone use and administration. Provide naloxone kits to patient and interested parties for emergency use.
5. Contact medical backup after calling 911 for additional verbal orders.

SCABIES

An infestation of the skin by mites that burrow into the skin. It often presents 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. These lesions are often not visible because of excoriation or secondary infection. Scabies 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 (Norwegian) Scabies is characterized by hyperkeratosis and may occur in people who are immunocompromised, with HIV/AIDS, older adults, and patients with Down syndrome. They are poorly-defined, crusty red patches or bumps on the skin. If untreated, scales become warty, crusts and fissures appear, and lesions become odorous, nails are thickened and discolored. Norwegian scabies are easily spread.

Subjective

- Medical History:
 - 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 2-15 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. In addition to suspected scabies infection, alert medical back-up when there is:**
 - a. Suspicion of crusted scabies, signs of further infection, or if patient is pregnant.
- 2. Treat mites:** Obtain orders from medical back-up for 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.
 - a. A second full-body treatment should be repeated in 8-10 days.
 - b. Note: Confirm if patient has been recently treated for scabies. Itching and rash are often present up to 4 weeks after successful treatment; medication does not need to be repeated.
- 3. Treat family members/ living mates:** Close contacts of a person with symptoms also need to be treated for scabies. Confer with 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. Contact medical back-up for orders as indicated.
 - 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 patient against injury. Place patient in side-lying position.
 - a. Note: do not place anything in the patient's mouth. This is dangerous and does not protect patient.
2. Obtain vital signs and blood glucose when safe. Refer to appropriate protocols as needed.
 - a. Monitor ABCs. If any decompensation, initiate CPR as appropriate and contact 911.
3. Continue to monitor the patient 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 patient against injury and call 911. A staff member must be present with patient 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
 - 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)
- Gaspings 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 patient is responsive and able to engage, confirm if they have any previously prescribed inhalers, particularly albuterol. If able, secure inhaler and have patient 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 patient 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.
2. If no provider on site or patient 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. Patient 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 patient is alert and oriented with an oxygen saturation between 90-93% and/or respirations between 8-12 per minute, consult with medical back-up.

SORE 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 (i.e., 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 signs or symptoms of upper respiratory or influenza infection)
 - a. Over-the-counter medications may be indicated with low-risk symptoms, such as benzocaine/ menthol throat lozenges or acetaminophen.
 - Be sure to alert medical provider if patient has liver disease or a substance use disorder, particularly avoiding alcohol while taking acetaminophen
 - b. Monitor Symptoms. If symptoms unresolved within 2 days, notify medical back-up or primary care provider.

2. **Moderate to Severe symptoms:** (Difficulty/ inability swallowing, respiratory distress, secretions, drooling, dysphonia (muffled voice), neck swelling, tonsillar exudate)
 1. Contact medical back-up and/ or refer to urgent care, primary care, or EMS as appropriate
 - As available, perform a Rapid Antigen Detection Test and/ or throat culture indicated to rule in/out Group A Strep when 2 or more of following symptoms present:
 - Tonsillar exudate
 - Tender anterior cervical adenopathy
 - Fever
 - Absence of cough

SUICIDAL CLIENT

Suicidal behavior is associated with many different types of events, illnesses, and life circumstances. Patients who are currently homeless may have one or more risk factors for suicide, including prior suicide attempt, 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 has 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, signs of ingestion
- Presence of weapon or

Plan

1. If patient is attempting suicide or unable to contract for safety, call 911 for 5150 (danger to self) evaluation. Observe patient at all times and obtain additional staff support as needed. If safe for staff and other nearby persons, intervene to keep patient from self-harm.
2. If patient is able to verbally contract to not harm self, engage with patient 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 patient attempting suicide or attempting to leave the location while actively suicidal. A staff member should keep visual contact on patient 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 patient.
4. You may refer patient to crisis intervention services at any time before or instead of 911.

Mobile Crisis Team(s)

(Insert appropriate mobile crisis team numbers here including behavioral health, community paramedicine, etc)

5. Please note: Safety is the priority. If the person has a weapon or item that may cause harm to self or others, all team members should be safely out of range (i.e., well distanced from knife or razor; out of sight or behind available barrier in case of gun). 911 may be the best option if there is a weapon present. Notify dispatch of 911 or mobile crisis for the presence of a weapon.
 - If the patient is engageable and you can communicate from a safe distance, you may recommend they place the weapon down and out of reach. Ideally, they are willing to move themselves away from the item or weapon.
 - Do not at any time attempt to remove a weapon from a person.

SUTURE REMOVAL

Sutures are often 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 the injury happen? When were the sutures 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, patient 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:
 - Eyelids: 3 days
 - Neck: 3–4 days
 - Face: 5 days
 - Scalp: 7-14 days
 - Trunk and upper extremities: 7 days
 - 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.
 - Keep the adhesive strips on 5 days. Soak in warm water for removal. Do not peel off.
 - Remind the patient 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 patients who are immunocompromised or have diabetes.

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. Contact medical back-up for further assessment and orders. Over-the-counter topical medications typically indicated for tinea corporis include:
 - i. Clotrimazole 1%
 - ii. Miconazole cream or lotion (cover after treatment)
 - iii. Tolnaftate powder
 - b. Note: Topical corticosteroids by themselves or in combination with antifungals are contraindicated in immunosuppressed patients. In certain cases, this may lead to persistent fungal infections.
2. Prescription products may be warranted. Contact medical back-up for further assessment and orders.
 - a. Prescribed medications typically include Ketoconazole 2% cream or Econazole 1% cream.
3. Teach patient with chronic tinea pedis (athlete’s foot) to put socks on before their pants to not spread infection to the legs. See *Athlete’s Foot* protocol as appropriate.
 - a. Recommend patient avoid occlusive and tight clothing and if possible to wear cotton or synthetic materials. Provide clothing as able and appropriate.
4. Educate patient 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.
5. 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 and often requires intervention to heal appropriately. 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
 - Change in size or drainage over time
 - Previously recommended treatment(s), what has been done, and response
 - 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 tobacco?
 - Nutritional intake

Objective

1. Age of injury:
 - a. Less than 24 hrs may be primarily closed in treatment 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 medical back-up..
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.

Wound 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.
 - a. If wound has not stopped active bleeding after applying pressure for 15 min, **refer to medical back-up immediately and/ or urgent care or 911 as appropriate.**
 - b. In cases of active bleeding with co-occurring altered mental status, refer to the *Altered Mental Status* protocol.

2. Wounds which have not been previously assessed or treated:
 - a. Any stab wound, refer to medical back-up and/ or urgent care, ED as appropriate.
 - b. All lacerations <6 hours old, refer to medical back-up as the separation 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 patient shower with soap and water. Do not remove intact, clean, secure dressings.
 - 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 utilizing clean technique.
 - a. Dressings should extend 1-2 cm beyond margin of laceration.
 - b. Be attentive to the possibility of foreign bodies
 - c. A primary goal of wound care is to provide a moist but not wet wound bed, while not allowing the wound to become dry.
 - d. Dressing is influenced by type and location of wound, amount of exudate, skin condition, condition of wound and available dressing.
 - i. If medications are not indicated, apply a moist saline, wet-to-dry dressing.
 - ii. Medicated dressings require provider orders. Contact medical back-up for further assessment and orders as appropriate.
 - e. Prescribed, medicated dressings specific to particular wounds may include:
 - i. Wounds neither dry or exudative: utilize a polyvinyl dressing (i.e. tegaderm)
 - ii. Dry wounds utilize hydrocolloid dressing (i.e. DuoDerm)
 - iii. Exudative wounds: an absorbent dressing, such as calcium alginate or hydrofiber (ie. Aquacel)
 - iv. Infected wounds: ideally silver sulfadiazine (Silvadene) or bacitracin-zinc ointment (if patient is allergic to sulfa drugs)
 - v. Long term, chronic wounds: products with Manuka honey may improve wound closure
 - vi. Fragile skin: hydrogel sheets to secure dressing

5. The following conditions indicate a need for in-person 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 wound accompanied by fever

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

Glasgow Coma Scale

The Glasgow Coma Scale provides a score in the range 3-15; patients with scores of 3-8 are usually said to be in a coma. The total score is the sum of the scores in three categories. For adults, the scores follow:

Activity Score

Eye opening

None	1 = Even to supraorbital pressure
To pain	2 = Pain from sternum/limb/supraorbital pressure
To speech	3 = Nonspecific response, not necessarily to command
Spontaneous	4 = Eyes open, not necessarily aware

Motor response

None	1 = To any pain; limbs remain flaccid
Extension	2 = Shoulder adducted, and shoulder and forearm rotated internally
Flexor response	3 = Withdrawal response or assumption of hemiplegic posture
Withdrawal	4 = Arm withdraws to pain, shoulder abducts
Localizes pain	5 = Arm attempts to remove supraorbital/chest pressure
Obeys commands	6 = Follows simple commands

Verbal response

None	1 = No verbalization of any type
Incomprehensible	2 = Moans/groans, no speech
Inappropriate	3 = Intelligible, no sustained sentences
Confused	4 = Converses but confused, disoriented
Oriented	5 = Converses and oriented

TOTAL (3–15): _____

Reference

Teasdale G, Jennett B. Assessment of coma and impaired consciousness. A practical scale. *Lancet* 1974;2(7872):81-4.

Evaluating Patients' Decision-Making Capacity

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EMS is called to a local drinking establishment for a report of a bar fight with injuries. After arriving on scene and checking in with the police, the crew is directed to a 22-year-old male standing outside, holding a bloody bar towel to the upper left quadrant of his abdomen. "I've been stabbed in the gut!" he shouts. The attending paramedic finds a strong radial pulse of 124 and directs the man to start walking toward the ambulance. "I'm not going to the hospital, and you can't kidnap me!" he shouts even louder. The paramedic calls medical direction, which asks, "Is he sober and competent?"

EMS providers are regularly challenged with ethical issues during the course of their work. Ethical dilemmas are situations that present with no clear right answer and where more than one course of action can be defended. In the case above, there is a patient with penetrating trauma to the abdomen. In any EMS system, this is a priority patient. But wait: He is objecting to treatment and transport. The ethical dilemma is created due to our value of patient autonomy and shared decision-making between provider and patient. However, many would argue this patient is at high risk for a bad outcome if he doesn't seek medical care.

I started thinking about these issues long after I started working in EMS in the 1980s. I'm an active paramedic field instructor for an urban EMS system, but I'm also a clinical psychologist in an academic medical center. As a psychologist, I am regularly called upon to assess the decision-making capacity of patients who refuse lifesaving care. After several years of this, I was invited to sit on the hospital's ethics committee, where many issues are similar to the case above: Someone refuses care or cannot voice their wishes, and others make decisions for them. What struck me most was how many EMS providers face the same ethical dilemmas as physicians, but without the support often found in hospitals (such as on-call specialists like psychologists, an ethics committee, risk managers, legal department, etc.). This article is intended to help guide EMS providers through an ethical dilemma they encounter often: the patient who needs treatment but declines help.

The Shared Decision-Making Model

EMS providers and physicians share many parallels. Both meet their patients and ascertain a chief complaint, then form a clinical impression after taking a history and performing a physical exam and using other diagnostics. Options are discussed, and a treatment plan is decided upon. This model, "shared decision-making" (SDM), came about in the early 1990s and honors the patient's right to autonomy over their own body. This is the bedrock of informed consent. The patient is given options, risks and benefits are explained, and the patient makes an informed choice. Conflict arises when the provider and patient are unable to reach a decision together about the best course of action, typically when the patient decides differently than what the clinician believes to be the best.

EMS providers regularly meet patients who decline ambulance transport. For example, there are individuals who are injured in motor vehicle collisions, but not sufficiently that they believe they need prehospital care and transport. Similarly, diabetics who have become hypoglycemic and recovered after the administration of glucose often decline transport. In most EMS systems, the patient and provider complete paperwork documenting the patient's decision not to be transported by ambulance. Often this paperwork documents the risks to declining care and that the patient has been informed of such risks in deciding against transport.

Less common but far more risky are the patients who would likely benefit from transport and treatment who decide against it. In some instances these patient may be making decisions that will lead to death or disability. It's a fine line for the paramedic or EMT to walk: Respect the patient's right to autonomy to refuse care, while knowing such a decision may lead to that patient's death. In these instances, most EMS systems require the EMT or paramedic to assess the patient's capacity to decline transport and make contact with medical control. The case at the beginning is an extreme one, but exploring it can help frame how to approach such situations.

Evaluating Capacity

While the word competent is often used when discussing decision-making ability, such a term is typically reserved for use only by judges making legal decisions. Our discussion concerns medical decision-making ability (as opposed to the capacity to make other decisions, such as financial ones). The physician's question, "Is he sober and competent?" speaks directly to this. It means, "Are there features about this patient that impair his ability to make decisions?" including intoxication. It's important that EMS providers are able to evaluate medical decision-making capacity.

There are several different approaches to assessing decision-making capacity. I am partial to this one and use a modified version of it when working as a paramedic and or assessing patients as a psychologist.

1. Is the patient an adult without a guardian? In the prehospital arena, children may not refuse transport. Some adults also have guardians who make their decisions. In these instances the EMS providers deal with the patient's parent or guardian.
2. Can the patient communicate a choice about his or her care? For obvious reasons, if the patient cannot communicate their wishes, decisions have to be made by someone else. I also believe patients who refuse to cooperate with an evaluation regarding their decision-making capacity fall into this category. By refusing to communicate with me, these patients are deemed as lacking decision-making capacity.

Steps 3 and 4 are incumbent on the patient being able to process information. Inherent in these steps is whether the patient is free from an altered mental status and not under the influence of an intoxicating substance. I also worry about patients with possible head injuries or other disease processes known to impair cognition (such as hypoglycemia, seizure/postictal phase, dementia, CVA, etc.). Be very careful about leaving patients behind who have central nervous system impairment and who you believe would otherwise benefit from ambulance transport. EMS providers need to be able to perform a thorough mental status exam (beyond "alert and oriented") and be aware of different signs of intoxication.

3. Does the patient have a factual understanding of their medical condition? It need only be a layperson's level of understanding, as evidenced by statements like, "You're worried a blood vessel in my heart is blocked," or "This pain in my stomach might mean I have internal bleeding after my car accident," or "Since I'm taking a blood thinner, there might be bleeding in my brain after I fell." Can the patient understand the risks and benefits of ambulance transport? Can they describe the risks of not being transported? Have the patient articulate them. Common risks are a condition that worsens and there's no provider to intervene or that without intervention they are likely to die. There are no risks to ambulance transport. (Getting into a crash is not a risk; medical risks are things like bleeding during an operation, not that the hospital might catch fire.)
4. Can the patient reason and come to a decision with a certain degree of logic? Perhaps the patient can talk about a medical condition and its possible consequences, but is still making an illogical decision—e.g., "I know you're worried I'm going to bleed to death, but bad things don't happen to me, so I don't need to go." This is an illogical conclusion. Finally, does the patient's decision present as rational and stable across time? This may be the hardest for a field provider to assess, but when it comes to whether the decision is rational, I ask, "What makes you decide this way?" When the rationale for the

decision is odd—like “I’m not going to the doctor because the mind control beams tell me not to!”—question whether it’s a rational decision.

In a hospital setting, the more serious the decision being made, the more scrutiny is placed on the process that leads to that decision. For example, a patient making a decision that might lead to their death has to demonstrate an extraordinary capacity for making such decisions. In the field, there may not be time to perform a thorough decision-making capacity evaluation that rises to this level. Further, many EMS providers may not feel comfortable documenting that they let a person die instead of transporting because they documented the patient had sufficient capacity to make such a decision.

EMS systems do not typically have ethics committees or attorneys on speed dial because in an emergency, there is considerable leeway given to simply doing what seems to be in the patient’s best interest. If the EMS provider believes the patient has impaired decision-making capacity and a bad outcome will happen if that patient is not transported, most EMS systems will permit an intervention over the patient’s objections. That is, the patient’s autonomy takes second place to intervening in a life- or limb-threatening emergency. A patient with impaired decision-making capacity and a serious medical condition needs a capable person to start making decisions on their behalf. That may be the EMS provider or a family member in conjunction with the EMT or paramedic. This should never be seen as “kidnapping.” While some patients are transported over their objections, this is a medical intervention to go the hospital. Ransom demands aren’t made, and there is no ill intent. In the case of the person stabbed in the abdomen, it is unlikely he has enough decision-making capacity to let him decline care.

Conclusion

In summary, I believe patients have a right to make informed decisions I don’t necessarily agree with. As EMS providers, we have to be careful about thoroughly assessing decision-making capacity and mental status, following protocols for patients who refuse transport, and documenting every encounter. Many systems also mandate discussing such cases with online medical control. Savvy EMTs and paramedics develop methods for resolving patients’ concerns about being transported. Sometimes it’s as easy as making sure a pet will be cared for or a loved one is contacted.