San Francisco General Hospital and Trauma Center
Urgent Care Center

URGENT CARE CENTER
Registered Nurse

Medical Screening Examination

and

Standardized Procedures
# Table of Contents

Authorization List ............................................ Page 3  
Introduction ............................................... Page 4  
Standardized Procedure: Registered Nurse in the Urgent Care Center ................................ Page 5  
Protocol #1 ................................................ Page 9  
Medical Screening Examination  
Protocol #2 ................................................ Page 11  
Radiological Studies Ordered from Medical Screening Area  
Protocol #3 ................................................ Page 14  
Chest Pain (Adult)  
Protocol #4 ................................................ Page 18  
Shortness of Breath with Wheezes  
Protocol #5 ................................................ Page 20  
Shortness of Breath without Wheezes  
Protocol #6 ................................................ Page 22  
Vaginal Bleeding  
Protocol #7 ................................................ Page 24  
Abdominal pain  
Urgent Care Center Nursing Medical Screening Examination Grid ................................ Page 26  
Medical Screening Exam Log ................................ Page 37  
Medical Screening Exam RN Skills Checklist ................................ Page 38  

## Distribution List:

Copy 1: Triage Nurses  
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Revised 11/21/12
San Francisco General Hospital and Trauma Center
Urgent Care Center
Urgent Care Center Registered Nurse
Standardized Procedures and Protocols

The following Registered Nurses have reviewed the standardized procedures and have demonstrated competency as Urgent Care Registered Nurses. They are authorized to practice in the Urgent Care Center under the Standardized Procedures and Protocols contained in this manual:

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List updated 11/21/12
San Francisco General Hospital and Trauma Center
Adult Urgent Care Center

Standardized Procedures:
Adult Urgent Care Center Registered Nurse

Introduction

The Urgent Care Center (UCC) at San Francisco General Hospital and Trauma Center is an ambulatory clinic that provides same-day care for medically stable sick and injured adults. UCC Nurses, Physicians, Nurse Practitioners and Physician Assistants possess expertise in the care of adults of all ages needing immediate care.

The following protocols are the policies and guidelines for the care provided to patients at San Francisco General Hospital and Trauma Center (SFGH) Urgent Care Center (UCC) by the Registered Nurse (RN). Since it is impossible to anticipate every clinical situation or presenting chief complaint that may arise, it is expected that consultation with the Lead Clinician (Attending Physician or other provider designee) may be warranted. The RN will consult the Lead Clinician whenever, in her/his clinical judgment, a question arises regarding the appropriate assessment, treatment, or disposition of any UCC patient. In general, the RN shall function within the scope of practice as specified in the State of California Nurse Practice Act.

The Standardized Procedures were developed with assistance from the following:

1. Implementation of Standardized Procedures. Position Statement of the California Nurse Association
2. Standardized Procedure Work Sheet, State of California Board of Registered Nursing, Department of Consumer Affairs.
STANDARDIZED PROCEDURE ~ REGISTERED NURSE

Title: Registered Nurse in the Adult Urgent Care Center

I. Policy Statement

A. It is the policy of San Francisco General Hospital and Trauma Center that all standardized procedures are developed collaboratively and approved by the Committee on Interdisciplinary Practice (CIDP) whose membership consists of Nurse Practitioners, Physician Assistants, Registered Nurses, Physicians, Administrators and other Affiliated Staff and conform to all 11 steps of the standardized procedure guidelines as specified in Title 16, CCR Section 1474.

B. A copy of the signed procedures will be kept in a policies and procedures manual in the Urgent Care Center, and on file in the credentialing liaison Medical Staff Office.

II. Functions to be performed

The Registered Nurse, as outlined in the Nurse Practice Act, Business and Professions Code Section 2725, is authorized to implement appropriate standardized procedures or changes in treatment regimen after observing signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and determining that these exhibit abnormal characteristics. The RN provides interdependent functions that overlap the practice of medicine. These overlapping functions require standardized procedures. These standardized procedures include guidelines stating specific conditions requiring the RN to seek physician consultation.
III. Circumstances Under Which RN May Perform Function

A. Setting
The Registered Nurse may perform the following standardized procedure functions in the Urgent Care Center consistent with his/her experience and training.

B. Scope of Supervision Required
1. The RN is responsible and accountable to the Urgent Care Center Nurse Manager and Medical Director or physician designee.
2. Overlapping functions are to be performed in areas, which allow for a consulting physician to be available to the RN, by phone or in person, including but not limited to the clinical area.
3. Physician consultation is to be obtained as specified in the protocols and under the following circumstances:
   a) Urgent conditions requiring prompt medical intervention
   b) Upon the request of the patient, registered nurse, or provider

4. Scope of Practice
   Protocol #1
   Medical Screening Examination
   Protocol #2
   Radiological Studies Ordered from Medical/Screening Area
   Protocol #3
   Chest Pain
   Protocol #4
   Shortness of Breath with Wheezes
   Protocol #5
   Shortness of Breath without Wheezes
   Protocol #6
   Vaginal Bleeding
   Protocol #7
   Nausea, Vomiting and Diarrhea
IV. Requirements for the Registered Nurse

A. Experience and Education
   1. Active California Registered Nurse license
   2. Current Basic Life Support certification

B. Special Training
   1. Enrollment in the SFGH EMTALA and Medical Screening Evaluation training
   2. Successful completion of the didactic (1.5 hours) and clinical training (40 hours preceptorship) requirements

C. Evaluation of the Registered Nurse competence in performance of standardized procedures
   1. Initial: at the conclusion of the standardized procedure training the Nurse Manager or designee will assess the RN’s ability to perform the procedures.
      a. Successful completion of the RN orientation program
      b. Successful completion of a review of accuracy and completeness of documentation for actual patient cases (minimum of ten).
   2. Annual: Nurse Manager or designee will evaluate the RN’s competence through an annual performance appraisal and skills competency review along with feedback from colleagues, physicians, direct observation and/or chart review. Audit tool developed will be used to evaluate along with MSE competency checklist for each RN.
   3. Follow-up: Areas requiring increased proficiency as determined by the initial or annual evaluation will be re-evaluated by the Nurse Manager, or designee at appropriate intervals until acceptable skill level is achieved. This evaluation may include chart reviews.

V. Development and Approval of Standardized Procedure

A. Method of Development
   Standardized procedures are developed collaboratively by the registered nurses, nurse managers, physicians, and administrators and must conform to the eleven steps of the standardized procedure guidelines as specified in Title 16, CCR Section 1474.

B. Approval
   The CIDP, and Credentials, Medical Executive, and Joint Conference Committees must approve all standardized procedures prior to the implementation.
C. Review Schedule
The standardized procedures will be reviewed every three years by the registered nurses, nurse managers, and medical director and as practice changes.

D. Revisions
All changes or additions to the standardized procedures are to be approved by the CIDP accompanied by the dated and signed approval sheet.
Protocol #1: Medical Screening Examination

A. Definition: This protocol covers the medical screening examination (MSE) performed in the Urgent Care Center (UCC). The MSE is an examination performed by physicians, or qualified Registered Nurses, on all patients who present to the UCC seeking care. The examination, viewed as an ongoing process, may range from a brief to a detailed examination involving all the laboratory, x-ray, and consultative resources available within SFGH’s range of services. The primary purpose of the MSE is to reasonably determine whether an emergency medical condition exists or not, and to determine the MSE (medical acuity) level of the patient.

B. Data Base

1. Subjective Data
   a. Statement of chief complaint
   b. Patient history and signs and symptoms of relevant to disease process/injury and organ systems affected
   c. Pain assessment to include location and intensity (0-10 scale)
   d. Pertinent past medical history, medications and allergies
   e. Current immunization status for adults with surface trauma
   f. Any treatments used prior to arrival to the clinical area
   g. Safety Risk Factors

2. Objective Data
   a. Limited physical exam appropriate to disease process/injury
   b. Level of consciousness
   c. Vital signs
   d. Skin signs
   e. Emotional state
   f. Physical appearance, size and location if injuries, with assessment of circulation, movement and sensation as appropriate
   g. Ability to ambulate and assessment of gait, as appropriate
   h. Assessment of symptoms of pregnancy or possible labor, including gestational age
   i. Clinical signs of pain, such as distressed facial expression, diaphoresis, body posture, and vital signs changes
   j. Disease and age appropriate POCT, laboratory and radiological studies

C. Assessment
1. Consistent with subjective and objective findings
2. Assessment of status of disease process/injury (see "Urgent Care Center Nursing Medical Exam Screening Grid" for details regarding determination of MSE levels)

D. Plan
1. Treatment
   - Age appropriate screening and/or diagnostic tests for purposes of disease identification
   - Immunization update
   - Interventions to treat pain

2. Patient conditions requiring attending consultation
   - Acute decompensation of patient situation
   - Unexplained historical, physical or laboratory findings
   - Upon request of patient, RN or provider

3. Education
   - Patient education appropriate to diagnosis including treatment modalities and lifestyle counseling

4. Follow up
   - As indicated and appropriate to patient health status and diagnosis, including pain reassessment

E. Record Keeping
   All records relevant to patient care will be recorded in the medical record and EMTALA log.
Protocol #2: **Radiological Studies Ordered from Medical Screening Area**

A. **Definition:** This protocol covers the ordering of radiological studies from the Medical Screening area.

B. **Data Base**
   1. **Subjective Data**
   a. Statement of chief compliant including mechanism and date of injury
   b. Patient history and signs and symptoms relevant to disease process/injury and organ systems affected including patient's age and previous injuries to same joint
   c. Pain assessment to include location and intensity (1-10 scale)
   d. Any treatment used prior to arrival and/or provider visits, hospital visits, radiology studies

   2. **Objective Data**
      a. Limited physical exam appropriate to disease process/injury
         i. Acute ankle injury:
            a) ability to bear weight (4 steps onto affected extremity)
            b) presence or absence of tenderness over posterior distal 6 cm of tibia or fibula
         ii. Acute foot injury:
            a) ability to bear weight (4 steps onto affected extremity)
            b) presence or absence of tenderness over base of 5th metatarsal or navicular
         iii. Acute knee injury caused by blunt trauma or fall
            a) ability to bear weight (4 steps onto affected extremity)
      b. Specifics of the above exams and x-rays ordered must be noted in MSE documentation, e.g. “ttp distal left lateral malleolus. Pt to Radiology for ankle series”

C. **Assessment**
   1. Consistent with subjective and objective findings
   2. Assessment of status of disease process
   3. Positive criteria for x-rays as defined below:
      a. Acute ankle injury: one of the findings below
         i. tenderness over the posterior distal 6 cm of tibia
         ii. tenderness over the posterior distal 6 cm of fibula
         iii. inability to bear weight both immediately after the injury and at the time of the MSE
      b. Acute foot injury: one of the findings below
         i. tenderness over the base of the 5th metatarsal
ii. tenderness over the navicular
iii. inability to bear weight both immediately after the injury and at the time of the MSE

c. Acute knee injury caused by blunt trauma or fall:
i. age > 50
ii. inability to bear weight both immediately after the injury and at the time of the MSE

D. Plan

1. Treatment
   • Patients with positive criteria as defined above
     o After registering in Urgent Care, will be sent immediately to Radiology:
       ▪ Acute ankle injury: AP, lateral, and mortise views
       ▪ Acute foot injury: specify multiple views and describe area of tenderness (e.g., “R foot multiple views, TTP over base of 5th metatarsal”)
       ▪ Acute knee injury: AP, lateral, and oblique views
     • Patient will be placed in queue for provider visit upon returning from Radiology

2. Patient conditions requiring attending consultation
   • Obvious deformity
   • Patient who may need pain medication before going to Radiology
   • Patient with positive x-rays from another facility

3. Education
   • Patient education and counseling appropriate to disease process/injury
   • For patients receiving x-ray orders, explain the sequence of events including registration, travel to Radiology, return to UCC, and provider evaluation.
   • For patients not receiving x-ray orders during the MSE, explain the sequence of events including registration and provider evaluation. Explain that the patient should wait for a provider evaluation.

4. Follow up
   • As indicated and appropriate to patient health status and diagnosis
   ▲ Insure that Charge Nurse is notified of patient traveling to Radiology and chart is placed in “pending” area

E. Record Keeping
All records relevant to patient care will be recorded in the medical record and EMTALA log.
Appendix: Ankle and Foot illustrations

Ottawa Ankle Exam: Check for tenderness over posterior distal lateral and medial malleolus

Ottawa Foot Exam:
Check for tenderness over navicular and at the base of the 5\textsuperscript{th} metatarsal
Protocol #3: **Assessment and Management of Chest Pain (Adult)**

A. **Definition:** This protocol covers the initial assessment and management of high-risk patients with chest pain by RNs during the MSE in Urgent Care. “High-risk” includes patients with preexisting conditions increasing their risk for acute cardiac or pulmonary problems

    **Indications**
    - Complaint of pain anywhere in the front of the chest within the last 72 hours, whether patient has pain currently or not

    **Exclusions**
    - Acute chest trauma or suspected musculoskeletal pain
    - Fever > 38 ° C (100.4 ° F)

B. **Data Base**

1. **Subjective Data**

   **A. Review history and signs and symptoms suggestive of ischemia**
   - Retrosternal chest discomfort
   - Pain spreading to shoulders, neck, arms, or jaw, or pain in back
   - Associated lightheadedness, fainting, diaphoresis, or nausea
   - Shortness of breath
   - Global feeling of distress, anxiety, or impending doom
   - Palpitations

   **B. Current medications, allergies and past medical history (“have you ever had…”), including**
   - High blood pressure
   - Angina
   - MI
   - Coronary surgery or stent
   - Congestive heart failure
   - Stimulant use (crack, cocaine, speed, meth)
     - If yes: when?
   - Abnormal heart rhythm
   - Lupus
   - HIV/AIDS
   - Elevated cholesterol
   - Stroke
   - Blood clots in lung, leg or large blood vessels
   - Hormones for birth control or menopause
• Peripheral artery disease
• Smoker
• Takes antihypertensive or nitroglycerin
• Kidney disease
• Diabetes

• Characteristics of pain; i.e., PQRST (provoking or palliating factors, quality, radiation, severity/intensity, timing/duration), location, patient self-rating of pain on 0-10 scale (0 = no pain, 10 = worst pain of one’s life)

• Any treatments or medications used prior to arrival

2. Objective Data

Perform focused physical exam relevant to chest pain/cardiac disease
• Level of consciousness
• Measure vital signs with pain scale
• Place on pulse oximetry and measure SpO₂
• Skin signs: color, temperature, moisture and capillary refill
• Laboratory and imaging evaluation:
  • 12-lead ECG, show to Lead Clinician when completed

C. Assessment
a. Consistent with subjective and objective findings
b. Assessment of status of disease process
c. Determine whether pt. at high risk for cardiac or pulmonary emergency based on responses to subjective and objective questions:
High risk: 3 or more positive answers to history questions OR
  Male > 55 yo + one positive answer OR
  Female > 65 yo + one positive answer

D. Plan
1. High Risk: Treatment
   a. Administer oxygen via nasal cannula at 2 liters/minute. Titrate to maintain SpO₂ >94%
   b. Administer Aspirin 325 mg chewed (if no contraindications)
   c. If BP > 90/60 give Nitroglycerin 0.4mg tablets sublingual q5 minutes x up to 3 doses, and check BP q5 minutes x3
   d. Call 9-911 for ALS transport to ED

2. Unclear Risk: Patient conditions requiring attending consultation and/or transport to ED
   a. Vital signs consistent with Level 1 triage criteria:
      (1) HR <50 or >120
      (2) BP <90/60 or >180/110
      (3) RR >24
(4) SpO₂ <95%
(5) T >39° C (102.2° F)
b. 12-lead ECG, show to Lead Clinician when completed
c. Transport to Emergency Department if indicated under provider direction

3. Education
   a. Patient education and counseling appropriate to disease including treatment modalities and lifestyle counseling

4. Follow-up
   a. As indicated and appropriate to patient health status and diagnosis

E. Record Keeping
   All information relevant to patient care will be recorded in the medical record and EMTALA log

Appendix: Chest pain algorithm

High Risk History Questions:

- Have you ever had
  - High blood pressure
  - Angina
  - MI (heart attack)
  - Coronary surgery or stent
  - CHF (heart failure)
  - Abnormal heart rhythm
  - Lupus
  - HIV/AIDS
  - Elevated cholesterol
  - Stroke
  - Diabetes
  - Peripheral artery disease
  - Kidney disease
  - Deep venous thrombosis (blood clot in the legs or arms)
  - Pulmonary embolism (blood clot in the lungs)

- Have you taken or do you take
  - Blood pressure medication
  - Nitroglycerin for chest pain

- Do you smoke?
- Have you used stimulants (crack, speed, meth, cocaine)? When?
Triage of Chest Pain in Urgent Care

Patient presents with complaint of chest pain within last 72 hours

Ask High Risk History Questions

Patient answers 3 or more questions with "YES"??

Yes

CALL 911
Start O2 at 6L
Give ASA 325 mg if patient not allergic

No

Patient answers 2 or more questions with "YES"??

Yes

Pt. is male > 55 yo or female > 65 yo??

Yes

High suspicion for cardiac or pulmonary emergency?

No

PQRST

Finish MSE
Protocol #4: Assessment and Management of Shortness of Breath with Wheezes (Asthma/COPD)

A. Definition: This protocol covers the initial assessment and management of patients with shortness of breath with wheezes seen by Registered Nurses (RN) in the Adult Urgent Care Center.

   Indications
   • Shortness of breath with confirmed wheezing and history of asthma/COPD

B. Data Base

1. Subjective Data
   • Review history and signs and symptoms of asthma/COPD
   • Pertinent past medical history, current medications and allergies
   • Characteristics of shortness of breath and associated symptoms (cough, fever, chills)
   • Any treatments used prior to arrival and/or provider or hospital visits

2. Objective Data
   a. Perform focused physical exam relevant to respiratory disease
      • Auscultate lung sounds bilaterally
      • Note respiratory rate, depth, and work of breathing
      • Stridor or audible wheezing
   b. Measure vital signs and repeat as necessary
   c. Measure peak flow before and after 1st nebulizer treatment
   d. Place on pulse oximetry and measure SpO2
   e. Skin signs: color, temperature, moisture, and capillary refill

C. Assessment

   a. Consistent with subjective and objective findings
   b. Assessment of status of disease process

D. Plan

1. Treatment
   a. Initiate oxygen via nasal cannula at 2 liters/minute. Titrate to maintain SpO2 >94%

2. Patient conditions requiring attending consultation or transport to ED
   a. Vital signs consistent with Level 1 triage criteria:
      (1) HR <50 or >120
(2) BP <90/60 or >180/110
(3) RR >24
(4) SpO₂ <95%
(5) T >39° C (102.2° F)

b. Transport to Emergency Department as directed by provider.

3. Education
   a. Patient education and counseling appropriate to disease including treatment modalities and lifestyle counseling

4. Follow-up
   a. As indicated and appropriate to patient health status and diagnosis

E. Record Keeping
   All information relevant to patient care will be recorded in the medical record and EMTALA log
Protocol #5: **Assessment and Management of Shortness of Breath Without Wheezes**

A. Definition: This protocol covers the initial assessment and management of patients with shortness of breath without wheezes seen by Registered Nurses (RN) in the Adult Urgent Care Center.

   **Indications**
   - Chief complaint of shortness of breath
   - Absence of wheezes, and
   - RR >24, or
   - RA SpO₂ <94%  

B. Data Base

1. Subjective Data
   - Review history and signs and symptoms of shortness of breath
   - Pertinent past medical history, hospitalizations for respiratory disease, current medications and allergies
   - Characteristics of shortness of breath and associated symptoms (cough, fever, chills, chest pain, ankle edema)
   - Any treatments used prior to arrival, and/or provider or hospital visits

2. Objective Data
   - Perform focused physical exam relevant to respiratory disease
     - Auscultate lung sounds bilaterally
     - Note respiratory rate, depth, and work of breathing
   - Measure vital signs on triage with pain scale
   - Measure vital signs and repeat as necessary
   - Place on pulse oximetry and measure SpO₂
   - Skin signs: color, temperature, moisture, and capillary refill
   - Laboratory and imaging evaluation:

C. Assessment

   a. Consistent with subjective and objective findings
   b. Assessment of status of disease process

D. Plan

1. Treatment
   - Initiate oxygen via nasal cannula at 2 liters/minute. Titrate to maintain SpO₂ >94%
2. Patient conditions requiring attending consultation and/or transport to ED
   a. Vital signs consistent with Level 1 triage criteria:
      (1) HR <50 or >120
      (2) BP <90/60 or >180/110
      (3) RR >24
      (4) \( \text{SpO}_2 <95\% \)
      (5) \( T >39 \^\circ \text{C} (102.2 \^\circ \text{F}) \)
   b. Transport to Emergency Department as directed by provider.

3. Education
   • Patient education and counseling appropriate to disease including treatment modalities and lifestyle counseling

4. Follow-up
   • As indicated and appropriate to patient health status and diagnosis

E Record Keeping
All information relevant to patient care will be recorded in the medical record and EMTALA log
Protocol #6: **Assessment and Management of Vaginal Bleeding**

A. Definition: This protocol covers the initial assessment and management of patients with vaginal bleeding seen by Registered Nurses (RN) in the Adult Urgent Care Center

**Indications**
- Vaginal bleeding, and
- Known or suspected pregnancy, and
- Age < 50 years

B. Data Base

1. **Subjective Data**
   - Review history and signs and symptoms related to gynecological emergency
     - Gravida, para, abortions
     - Date of last menstrual period; duration and amount of flow, length of time for pad/tampon saturation, presence of clots or tissue
     - Pregnancy suspected or confirmed. If confirmed, expected date of confinement (EDC)
     - If patient is postpartum: date of delivery, complications
   - Pertinent past medical history, current medications and allergies
   - Characteristics of any pain (PQRST): location, quality, and intensity (0-10) and associated symptoms (abdominal cramping, fever, chills)
   - Any treatments used prior to arrival, and/or provider or hospital visits

2. **Objective Data**
   - Vital signs with pain scale. Include orthostatic vitals signs if HR >100 or SBP <90
   - Laboratory:
     - Stat urine B-HCG
     - Urine dip

C. **Assessment**

   a. Consistent with subjective and objective findings
   b. Assessment of status of disease process
D. Plan

1. Treatment
   • Age appropriate screening and/or diagnostic purposes of disease identification

2. Patient condition requiring attending consultation and/or transport to ED or 6C
   a. Vital signs consistent with Level 1 triage criteria:
      (1) HR <50 or >120
      (2) BP <90/60 or >180/110
      (3) RR >24
      (4) SpO₂ <95%
      (5) T >39° C (102.2° F)
   b. Negative stat urine beta-hCG
   c. Pregnancy-related problem listed under Level 1 triage criteria as noted in Urgent Care Nursing Medical Screening Evaluation Grid (transfer to 6C Birth Center if ≥14 weeks of gestation or if <14 weeks send to the ED as directed by provider if symptoms present.

3. Education
   Patient education and counseling appropriate to disease process, including treatment modalities and lifestyle counseling

4. Follow-up
   • As indicated and appropriate to patient health status and diagnosis

E. Record Keeping
All information relevant to patient care will be recorded in the medical record and EMTALA log
Protocol #7: **Assessment and Management of Nausea, Vomiting and Diarrhea**

A. **Definition:** This protocol covers the initial assessment and management of patients with vomiting and diarrhea seen by Registered Nurses (RN) in the Adult Urgent Care Center

**Indications**
- Vomiting more than two times today, blood or coffee ground emesis
- Diarrhea/loose stool more than four times today, and
- Vital signs suggesting hemodynamic instability (HR >100 or SBP <110), or
- Orthostatic vital signs or dizzy when standing

B. **Data Base**

1. **Subjective Data**
   - Review history and signs and symptoms suggestive of volume loss
     - Frequency, amount, and color of emesis, hemoptysis
     - Frequency, amount, and color of stool, melena
   - Pertinent past medical history, CHF or renal failure; current medications and allergies
   - Characteristics of any pain (PQRST); location, quality, and intensity (1-10) and associated symptoms (abdominal pain, fever, chills)
   - Any treatments or medications used prior to arrival

2. **Objective Data**
   - Measure vital signs with pain scale. Include orthostatic vital signs.
   - Place on pulse oximetry and measure SpO₂
   - Skin signs: color, temperature, moisture, and capillary refill

C. **Assessment**

a. Consistent with subjective and objective findings
b. Assessment of status of disease process

D. **Plan**

1. **Treatment**
   - Consult with Lead Clinician re: any of the following treatments or tests:
- anti-emetic medication
- If HR >100 or SBP <100 or orthostatic, start saline IV heplock—draw full tubes CBC.
- Save stool sample if diarrhea

2. Patient conditions requiring provider consultation and/or transport to ED
   a. Evaluation criteria consistent with Level 1 triage criteria
      (1) HR <50 or >120
      (2) BP <90/60 or >180/110
      (3) RR >24
      (4) SpO2 <95%
      (5) T >39°C (102.2°F)
   b. Altered mental status
   c. History of CHF or renal failure
   d. Vomiting more than two times prior to being seen by provider
   e. Transport to Emergency Department as directed by provider

3. Education
   • Patient education and counseling appropriate to disease process

4. Follow-up
   • As indicated and appropriate to patient health status and diagnosis

E. Record Keeping
   All information relevant to patient care will be recorded in the medical record and EMTALA log
Urgent Care Center Nursing Medical Screening Evaluation Grid

This acuity system is to be used by Urgent Care Center RNs to both:
1) Determine the level of acuity of a patient after a medical screening exam
2) Triage patients to the appropriate level, location, and provider of care

There are 5 Triage Levels:

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td><strong>Emergency Medical Condition. Transport to ED or 6C Birth Center.</strong> Emergent medical problem with a medical emergency condition, for immediate monitored transport.</td>
</tr>
<tr>
<td>Level 2</td>
<td><strong>Expedited visit.</strong> Urgent medical problem, including possible serious illness or injury, certain dermatologic or respiratory symptoms suggestive of communicable disease, etc., to be assessed immediately by Urgent Care provider.</td>
</tr>
<tr>
<td>Level 3</td>
<td><strong>Urgent medical problem.</strong> Should be seen same day. Patient has a condition where delaying care to a later scheduled appointment date carries risk of worsening of the medical condition or unnecessary suffering.</td>
</tr>
<tr>
<td>Level 4</td>
<td><strong>Nonurgent medical problem, does not need to be seen same day in UCC.</strong> Patient does not have a condition where delaying care to a later scheduled appointment date carries risk of worsening of the medical condition or unnecessary suffering.</td>
</tr>
<tr>
<td>Level 5</td>
<td><strong>Nonurgent medical problem, does not need same-day provider visit in UCC.</strong> Includes nurse visits, referral to primary care or specialty care.</td>
</tr>
</tbody>
</table>

**GENERAL EXCLUSIONS TO URGENT CARE**

- Altered mental status associated with: fever, trauma, alcohol or drug withdrawal
- Overt suicidal or homicidal ideation
- Psychotic and disruptive
- Threatening or violent behavior
- Impending delirium tremens (DTs)
- Unstable vital signs
- Hemoptysis, hematochezia, hematemesis, active hemorrhage
- Likely cardiac chest pain
- Likely stroke
- Standing orders for IV medications
- Physical examinations for pre-operative patients, pre-employment physicals, or for the sole purpose of completing forms for disability or general assistance (GA)
- Routine adult immunizations, except for Tdap, influenza and pneumococcal vaccination
- Patients under the age of 18 years (patients undergo medical screening and then are sent to primary care, 6M Pediatric Urgent Care, or ED as appropriate)
The following tables are not comprehensive lists of all complaints that fall under each MSE level; the RN performing the MSE will use her/his clinical judgment in determining the patient’s MSE level.

### Level I: EMERGENCY MEDICAL CONDITION
Transport to ED or 6C Birth Center
- Does the patient have an emergency medical condition?
- Does the patient need a higher level of care than can be safely provided in the UCC?

<table>
<thead>
<tr>
<th>Complaint</th>
<th>Indications for Transport to ED or 6C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest Pain, Cardiac Complaints</td>
<td>Pain &gt;8/10 in severity</td>
</tr>
<tr>
<td></td>
<td>Shortness of breath</td>
</tr>
<tr>
<td></td>
<td>Radiation of pain to arms, jaws, back</td>
</tr>
<tr>
<td></td>
<td>Signs of typical cardiac chest pain</td>
</tr>
<tr>
<td></td>
<td>EKG (+) for arrhythmia on EKG</td>
</tr>
<tr>
<td></td>
<td>Pulse &lt;50 or &gt;120 with symptoms</td>
</tr>
<tr>
<td></td>
<td>Blood pressure &lt;90/60</td>
</tr>
<tr>
<td>Fractures</td>
<td>Acute complicated fractures (open fractures)</td>
</tr>
<tr>
<td></td>
<td>Fractures with neurovascular compromise</td>
</tr>
<tr>
<td>Injury from domestic violence</td>
<td>Referral to ED or Social Worker depending on level of injury</td>
</tr>
<tr>
<td>Eye pain</td>
<td>Eye pain with change in vision</td>
</tr>
<tr>
<td>Dental pain</td>
<td>Facial swelling</td>
</tr>
<tr>
<td></td>
<td>Trismus</td>
</tr>
<tr>
<td>Hypotension</td>
<td>Blood pressure &lt;90/60 with tachycardia and/or orthostasis, or otherwise symptomatic</td>
</tr>
<tr>
<td>Dyspnea, tachypnea</td>
<td>Severe dyspnea</td>
</tr>
<tr>
<td></td>
<td>O2 sat &lt; 95% (unless at baseline)</td>
</tr>
<tr>
<td></td>
<td>Respiratory rate &gt;24 with symptoms</td>
</tr>
<tr>
<td>Seizure</td>
<td>In UCC (stabilize first, then transport to ED)</td>
</tr>
<tr>
<td></td>
<td>Not in UCC, first seizure ever</td>
</tr>
<tr>
<td></td>
<td>Not in UCC, on antiseizure medications but still having seizures</td>
</tr>
<tr>
<td>Sexual Assault</td>
<td>Referral to ED, exam done by Rape Treatment Center Nurse Practitioner on call</td>
</tr>
<tr>
<td>Uncontrolled symptomatic hypertension</td>
<td>SBP &gt;180 OR DBP &gt;110, with</td>
</tr>
<tr>
<td></td>
<td>• Persistent/severe headache</td>
</tr>
<tr>
<td></td>
<td>• Changes in vision</td>
</tr>
<tr>
<td></td>
<td>• Chest pain</td>
</tr>
<tr>
<td>Symptomatic hyperglycemia</td>
<td>Signs/symptoms of ketoacidosis or hyperosmolar coma</td>
</tr>
<tr>
<td>ENT</td>
<td>Severe ear pain, bloody ear discharge, ear trauma</td>
</tr>
<tr>
<td>Category</td>
<td>Description</td>
</tr>
<tr>
<td>---------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Severe or uncontrolled active epistaxis</td>
<td>Inability to swallow, drooling, facial swelling Possible foreign body threatening airway obstruction Acute anaphylaxis, wheezing, dyspnea</td>
</tr>
<tr>
<td>Fever</td>
<td>T &gt; 39º C</td>
</tr>
<tr>
<td>GI</td>
<td>Vomiting with signs/symptoms of severe dehydration, or hematemesis Severe pain, vomiting, difficulty walking, mass, hernia, melena, hematochezia, coffee ground emesis Severe pain, Temp &gt;39º C with rectal pain, suspicion of perirectal abscess, hematochezia Frail, abdominal pain, nausea, vomiting</td>
</tr>
<tr>
<td>GU</td>
<td>Dysuria, frequency, urgency Symptoms of urosepsis (tachycardia, hypotension, severe dehydration, Temp &gt; 39º C, nausea, vomiting, abdominal or flank pain)</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>Extremity trauma: Unable to use limbs, swelling, deep/complex lacerations (within window for primary closure) Back pain: Non-ambulatory, new onset of incontinence</td>
</tr>
<tr>
<td>Neurological</td>
<td>Headache: accompanied by acute neurological changes, “worst headache of one’s life” Signs/symptoms of stroke (acute changes in motor function or speech) Head trauma with loss of consciousness within past 48 hours</td>
</tr>
<tr>
<td>Pregnancy, with potential pregnancy-related problem (call 6C at x6-8725 if unsure):</td>
<td>Nausea Vomiting UTI – flank pain Vaginitis Constipation Headache, elevated BP, visual changes Rhythmic abdominal or back pain Severe abdominal or pelvic pain Change in fetal movement Leaking of fluid from &lt;14 week gestation or unknown gestational age with abdominal or pelvic pain, vaginal bleeding, or rupture of membranes → send patient to ED ≥14 weeks → send to 6C Birth Center</td>
</tr>
</tbody>
</table>
| vagina/rupture of membranes | Vaginal Bleeding  
Breast pain/infection  
Perineal pain/discomfort  
Fever |
<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>Skin</strong></td>
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</tr>
<tr>
<td>• Burns</td>
<td>Second or third degree burns &gt;5% BSA, OR on perineum, face or hands</td>
</tr>
</tbody>
</table>
| • Lacerations               | >10 cm on body or >6 cm on face or genital areas  
Deep or complex lacerations  
Lacerations involving joints, tendons, eyelids, lips, cartilage |
| • Abscesses                 | Large abscesses >10 cm  
Signs or symptoms of systemic infection  
(Temp >39, tachycardia)  
Severe pain |
| **Psychiatric**             |                  |
| • Altered mental status  
associated with: fever, trauma, alcohol or drug withdrawal, impending delirium tremens (DTs)  
Overt suicidal or homicidal ideation  
Psychotic and disruptive | See Suicidality Screening Tool |
Level II: EXPEDITED VISIT

Send patient to registration and room patient immediately to see provider.

- Does the patient have a possible serious medical condition?
- Does the patient have severe pain?
- Does the patient have a possible communicable disease that puts other patients in the waiting room at risk?
- Does the patient need to be seen by a provider immediately?

<table>
<thead>
<tr>
<th>Condition/system</th>
<th>Indications/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dehydration</td>
<td>Glucose &gt; 400 2+ or greater urine ketones If no resolution of hyperglycemia with IV hydration and SQ insulin, consider transfer to ED.</td>
</tr>
<tr>
<td>Diabetes, uncontrolled</td>
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</tr>
<tr>
<td>Eye</td>
<td>Red eye  eye pain  Decreased vision</td>
</tr>
<tr>
<td>Hypertension, uncontrolled asymptomatic</td>
<td>SBP &gt; 180, DBP &gt; 110</td>
</tr>
<tr>
<td>GI</td>
<td>Nausea/vomiting/diarrhea with signs of dehydration Acute abdominal pain Rectal bleeding</td>
</tr>
<tr>
<td>GU</td>
<td>Signs/symptoms of pyelonephritis (dysuria, frequency, urgency, flank pain, fever, nausea, vomiting) Acute pelvic pain</td>
</tr>
<tr>
<td>Pain, Severe</td>
<td>Patient self-rating of pain as “7” or above (out of 10) and with clinical signs consistent with severe pain, such as distressed facial expression, diaphoresis, splinting or other abnormal body posture, and vital sign changes</td>
</tr>
<tr>
<td>Respiratory illness, serious</td>
<td>Signs of pneumonia (tachypnea, dyspnea, hypoxia, cough, fever) Signs of possible active tuberculosis (recent positive contact, cough, hemoptysis, night sweats, unintended weight loss, immunocompromised</td>
</tr>
<tr>
<td>Skin</td>
<td>Simple lacerations &lt;10 cm (see exclusions under Level I above) Communicable rashes (measles, scabies, lice, varicella, etc.)</td>
</tr>
<tr>
<td>Condition likely to require radiologic imaging as part of the workup</td>
<td>e.g., possible fracture, pneumonia</td>
</tr>
<tr>
<td>Vital signs, abnormal</td>
<td>O2 Sat &lt; 95% (unless baseline &lt; 95%)</td>
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<td>Temp 38.0º C to 38.9º C, or &lt; 36º C</td>
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<td>RR &gt; 20</td>
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<td>BP:</td>
</tr>
<tr>
<td></td>
<td>• SBP &lt; 90 or &gt;180</td>
</tr>
<tr>
<td></td>
<td>• DBP &lt;60 or &gt; 110</td>
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<tr>
<td></td>
<td>HR &lt;60 or &gt;110</td>
</tr>
</tbody>
</table>
### Level III: URGENT MEDICAL PROBLEM

(Encourage patient to remain in clinic until seen by provider.)

- Does the patient have a complaint for which s/he should be seen today?
- Does the patient have a condition where delaying care to a later scheduled appointment carries risk of worsening of the medical condition or unnecessary suffering?
- Should the patient be seen today to prevent deterioration of a condition, potentially resulting in serious illness or injury?

<table>
<thead>
<tr>
<th>Condition/system</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abscesses (uncomplicated)</td>
<td>May refer to ISIS during business hours (before 2 p.m. Monday, Tuesday, Thursday, Friday; before 11 a.m. Saturday; ISIS closed on Wednesdays and holidays). Consider treatment (I&amp;D) at UCC if needed before next available time at ISIS.</td>
</tr>
<tr>
<td>Bites (insect, animal)</td>
<td></td>
</tr>
<tr>
<td>Cancer, new diagnosis</td>
<td>Prioritize referral to primary care</td>
</tr>
<tr>
<td>Chronic medical problem (e.g., diabetes, hypertension), uncontrolled, before referral to primary care</td>
<td>Level II if symptomatic, random blood glucose &gt; 400, SBP &gt; 180, DBP &lt;110</td>
</tr>
<tr>
<td>Dental problems</td>
<td></td>
</tr>
<tr>
<td>- Recurrent bleeding gums</td>
<td></td>
</tr>
<tr>
<td>- Pain in jaw or tooth</td>
<td></td>
</tr>
</tbody>
</table>
| ENT | Ear pain
Probable foreign body |
| Eye: | |
| - Conjunctivitis without danger signs or trauma | |
| - Non-painful irritation or redness with normal vision | |
| - Small hemorrhage on sclera | |
| Follow-up: UCC provider-initiated follow-up of patients seen previously in UCC | See in Urgent Care once if follow-up of urgent problem, then refer to primary care. No return visit to UCC unless follow-up of urgent problem |
| Follow-up: ED patients | See in Urgent Care once, then refer to primary care |
| Follow-up: Post-operative patients | See in Urgent Care once, then refer to primary care or specialty clinic |
| GI | Mild or chronic abdominal pain
Dyspepsia
GERD |
<table>
<thead>
<tr>
<th>Condition</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constipation</td>
<td>Rectal pain/irritation</td>
</tr>
<tr>
<td></td>
<td>Hemorrhoids</td>
</tr>
<tr>
<td></td>
<td>Anal/rectal warts</td>
</tr>
<tr>
<td>HIV Post-exposure prophylaxis (PEP)</td>
<td>Consider referral to City Clinic during business hours vs. treatment at UCC with PEP line consultation. After hours and on weekends, see in Urgent Care once, then refer to primary care or San Francisco City Clinic</td>
</tr>
<tr>
<td>Medication refills, urgent (diabetes, HTN, cardiac, etc.)—patient ran out or running out of medications</td>
<td>See once in Urgent Care, then refer to primary care</td>
</tr>
<tr>
<td>Migraine or other headache</td>
<td>Joint or limb pain, including gout</td>
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<td></td>
<td>Tendinitis</td>
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<tr>
<td></td>
<td>Minor trauma or sports injuries</td>
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<tr>
<td></td>
<td>Back pain</td>
</tr>
<tr>
<td></td>
<td>Sciatica</td>
</tr>
<tr>
<td></td>
<td>Carpal Tunnel Syndrome</td>
</tr>
<tr>
<td>Musculoskeletal (not requiring X-rays)</td>
<td>May order from Medical Screening with provider consultation; provider should write short note if consulted by Medical Screening nurse; order repeat films if initial studies done outside SFGH</td>
</tr>
<tr>
<td>Musculoskeletal injuries requiring X-Rays</td>
<td>Nails, ingrown</td>
</tr>
<tr>
<td></td>
<td>Symptoms unrelated to pregnancy (See Level I criteria for patients with potentially pregnancy-related symptoms)</td>
</tr>
<tr>
<td></td>
<td>Mastitis</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>Depression without suicidality (See Level I criteria and Suicidality Screening Tool for management of suicidal patients in UCC Medical Screening)</td>
</tr>
<tr>
<td></td>
<td>Insomnia</td>
</tr>
<tr>
<td></td>
<td>Anxiety</td>
</tr>
<tr>
<td></td>
<td>Panic attacks</td>
</tr>
<tr>
<td>Respiratory:</td>
<td>Consider Level I or II for Temp ≥ 38.0, hemoptysis, tachypnea, dyspnea, hypoxia (O2 sat &lt; 95% unless baseline &lt; 95)</td>
</tr>
<tr>
<td></td>
<td>URI or bronchitis without fever or tachypnea</td>
</tr>
<tr>
<td></td>
<td>Sore throat</td>
</tr>
<tr>
<td></td>
<td>Allergic rhinitis</td>
</tr>
<tr>
<td>Sexually transmitted infections</td>
<td>Symptomatic patients or high risk (suspected contact, MSM, other factors affecting ability to comply with treatment or follow up)</td>
</tr>
<tr>
<td>Condition</td>
<td>Description</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Consider referral to San Francisco City Clinic for selected patients (asymptomatic, low risk, can reliably follow instructions)</td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td>Blisters, itching, warts, moles (especially if suspicious for cancer)</td>
</tr>
<tr>
<td></td>
<td>Simple abrasions</td>
</tr>
<tr>
<td></td>
<td>Rashes</td>
</tr>
<tr>
<td></td>
<td>1st and/or 2nd degree burns &lt;5% BSA</td>
</tr>
<tr>
<td>Subungual hematoma with pain</td>
<td>Level IV if no significant pain</td>
</tr>
<tr>
<td>Suture removal, if wound complication (infection, dehiscence)</td>
<td>Uncomplicated suture removal is Level V (nurse visit)</td>
</tr>
<tr>
<td>Tetanus booster (Tdap)</td>
<td>If needed due to an injury; otherwise Level V</td>
</tr>
<tr>
<td>Wound checks</td>
<td>Uncomplicated dressing changes may be done as nurse visit (Level V)</td>
</tr>
<tr>
<td>UTI, uncomplicated</td>
<td>Level I or II for symptoms of pyelonephritis, including: fever, nausea/vomiting, back pain, abdominal pain, abnormal vital signs</td>
</tr>
</tbody>
</table>
**Level IV: NONURGENT MEDICAL PROBLEM**

Does not need to be seen same day in UCC

- Does the patient have a condition where delaying care to a later scheduled appointment carries little or no risk of worsening of the medical condition or unnecessary suffering?
- Does the patient have a condition that poses little or no risk of deteriorating into a serious illness or injury?
- Does the patient have a complaint for which it is not medically necessary to see the patient today?
- If we lacked the capacity to see the patient today, would it be safe for the patient to be seen tomorrow for this complaint?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Exclusions/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic eye complaints:</td>
<td>Higher level if:</td>
</tr>
<tr>
<td>• Pterygium or pingueculum</td>
<td>Decreased visual acuity</td>
</tr>
<tr>
<td></td>
<td>Trauma or pain</td>
</tr>
<tr>
<td></td>
<td>Probable foreign body in eye</td>
</tr>
<tr>
<td>Dental problems:</td>
<td>Higher level if:</td>
</tr>
<tr>
<td>• Chipped or cracked tooth without pain</td>
<td>Severe facial swelling</td>
</tr>
<tr>
<td>• Tooth that is sensitive to change of</td>
<td>Fever</td>
</tr>
<tr>
<td>temperature</td>
<td>Cannot open mouth</td>
</tr>
<tr>
<td>• Painless tooth that changed color to</td>
<td>Pain</td>
</tr>
<tr>
<td>gray, pink, or black</td>
<td></td>
</tr>
<tr>
<td>• Grinding teeth</td>
<td></td>
</tr>
<tr>
<td>• Jaw click</td>
<td></td>
</tr>
<tr>
<td>Chronic Constipation (medication</td>
<td>Higher level if:</td>
</tr>
<tr>
<td>management)</td>
<td>Abnormal vital signs</td>
</tr>
<tr>
<td></td>
<td>Signs of dehydration</td>
</tr>
<tr>
<td></td>
<td>Vomiting and diarrhea</td>
</tr>
<tr>
<td>Pregnancy tests (as sole chief complaint)</td>
<td></td>
</tr>
<tr>
<td>Nonurgent procedures</td>
<td>Refer to Procedure Clinic at the Family Health Center</td>
</tr>
<tr>
<td>• wart, skin tag, or mole removal, etc.</td>
<td>(complete Outpatient Consultation Form [Red form] and call Blue Team Clerk at x6-6554 for appointment)</td>
</tr>
<tr>
<td>“Return to Work Release” Exams</td>
<td>Open Workers’ Comp cases not seen at UCC</td>
</tr>
<tr>
<td>Subungual hematoma without pain</td>
<td>Level III if with pain</td>
</tr>
</tbody>
</table>
Level V: NONURGENT MEDICAL PROBLEM, does not need same-day provider visit in UCC

- Does the patient need a referral outside the Urgent Care Center to a facility providing a similar or lower level of care (primary care or specialty clinic)?
- Can the patient’s need(s) be served by a nurse visit?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>UCC provider-initiated UCC follow-up visit to check vital signs, wound checks, etc.</td>
<td>Nurse visit; convert to provider visit and triage to appropriate level as needed</td>
</tr>
<tr>
<td>Emergency Contraception (i.e., Plan B)</td>
<td>Nurse visit; refer to outside pharmacy</td>
</tr>
<tr>
<td>Linkage to primary care clinics for long-term continuity care, no acute complaint on presentation</td>
<td>Refer to primary care</td>
</tr>
<tr>
<td>Patients who have recently lost health insurance coverage, no urgent medical problems</td>
<td>Refer to primary care</td>
</tr>
<tr>
<td>Nonurgent medication refills</td>
<td>Refer to primary care</td>
</tr>
<tr>
<td>Routine immunizations, PPD as only reason for visit</td>
<td>May give Tdap, influenza, or pneumococcal vaccine. Otherwise, refer to primary care or Immunization Clinic at San Francisco City Clinic</td>
</tr>
<tr>
<td>STD screening, asymptomatic patient</td>
<td>Refer to San Francisco City Clinic</td>
</tr>
<tr>
<td>PPD reading</td>
<td>Nurse visit</td>
</tr>
<tr>
<td>Labs (venipuncture, urinalysis) only</td>
<td>Nurse visit</td>
</tr>
<tr>
<td>- 5M Women’s Clinic patients needing repeat beta-hCG drawn when 5M is closed</td>
<td>Perform venipuncture and notify GYN resident on call to follow up result</td>
</tr>
<tr>
<td>Ticket #</td>
<td>Intake Time</td>
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MEDICAL SCREENING EXAM (MSE) NURSE
Skills Checklist

Name of Employee____________________Date________ Rater __________________

Once the Medical Screening Exam class has been taken by the candidate, the supervising staff will complete the checklist. Completed form should be kept in the manager’s file.

<table>
<thead>
<tr>
<th>Performance Criteria</th>
<th>Level of Skill: 1-4</th>
<th>Comments</th>
</tr>
</thead>
</table>
| 1. Etiquette—greets patient appropriately, prioritizes patient appropriately and indicates reason for delays, speaks clearly and slowly. | 1-Unacceptable  
2=Development Needed  
3=Competent and Effective  
4=Exceeds Standards |          |
| 2. Interview—Consistently obtains data in a logical, complete manner; utilizes interpreter appropriately |                        |          |
| 3. MSE Protocol Usage—applies appropriate section of unit specific nursing guidelines/standardized procedure for MSE to specific patient situation |                        |          |
| 4. Urgency Level Identification—Identifies whether or not patient has a potential emergent or urgent complaint (requiring same day visit) according to Unit-specific guidelines and standardized procedures |                        |          |
| 5. Log—Utilizes Unit-specific log system with each emergent or urgent patient, filling in all required information—electronic or book. Logs to Medical Records per protocol. |                        |          |
| Performance Criteria                                                                 | Level of Skill: 1-4  
1=Unacceptable  
2=Development Needed  
3=Competent and Effective  
4=Exceeds Standards | Comments |
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>6. Other Documentation--Fills out Triage forms—for patients being referred to ED, Urgent care and other clinics.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Communication with other departments—Assures that phone calls and consultative calls are made to referring/receiving Departments as appropriate.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Assures those patients with Urgent/Emergent conditions are stabilized and monitored until medical responsibility is taken over by the next higher level provider (ED.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Assures appropriate referral/appointment is made for all patients presenting to Unit with health care complaints.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Assures appropriate transportation/supervision for patients being referred away from the Unit.</td>
<td></td>
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</tbody>
</table>