

Triage Nurse Roles and Responsibilities

Overview: The Triage Nurse within the Oakland County Health Centers (NOHC and SOHC) will assess every client registering for STD services to determine the appropriate type of visit for each client. Specifically, the Triage Nurse will focus on Full Testing visits versus Fast Track visits, but the Triage Nurse will also monitor clinic flow and capacity.

- **Qualifications:** The Triage Nurse role will only be assigned to PHN IIs that have proven themselves to be adept at Team Leading. The Triage Nurse role involves complex critical thinking in both clinical and logistical matters. The Triage Nurse will be supported heavily by the Nursing Supervisors.
- **Physical Location:**
 - The Triage Nurse will be stationed in an area that is conducive to active, open communication with both clerical and nursing staff.
 - The Triage Nurse will have an office or other private space in which to speak to clients and review their Client Assessments.
 - In SOHC the interview room next to the X-Ray room will be utilized for this purpose.
 - In NOHC an immunization room will serve this purpose.
- **Client Assessment:** The Triage Nurse will review the Client Assessment that the client has already completed and make a clinical decision regarding the recommended visit type for the client. **Important to note: Clients may always opt-in to full testing.* It is up to the Triage Nurse to also make decisions regarding clients in pain, window periods for testing based on previous testing or antibiotic use, etc.
- **Clinic Flow:**
 - Monitoring the kiosk for client arrivals and nurse availability will be a crucial part of the Triage Nurse role.
 - Once a client completes their Client Assessment, wait time to speak with the Triage Nurse should be less than five minutes. If this is not possible, the Triage Nurse must communicate with a Nursing Supervisor to assist in triaging.
- **End of the Day:**
 - The Triage Nurse will utilize a “capacity equation” to determine how many clients can be seen in the last two hours of the clinic day. For example: To determine how many full STD testing visits (estimated at 1 hour each) can be accommodated the Triage Nurse would calculate:

(# of nurses x time remaining)/ length of visit = # of clients that can be seen

If there are 5 nurses doing full STD visits (estimated at 1 hour each), then the equation would be:
(5 nurses x 2 hours)/1 hour = 10 Full STD visits

Then there may be 2 additional nurses doing Fast Track visits (estimated at 30 minutes each), so the additional equation would be:

(2 nurses x 2 hours)/0.5 hours = 8 Fast Track STD visits

*The complexity of the end of the day management requires that the Triage Nurse have Nursing Supervisor approval once the calculation is complete. The Nursing Supervisor may use their discretion to build “wobble room” into the equation so that there is built-in capacity to see additional treatments, DIS referrals, etc. that may walk in at the last moment.

- Once the clinic has reached capacity, the Triage Nurse will assess clients for any high-risk category such as: DIS referrals, contacts to known cases, pregnant women and treatments. These clients will be seen on the same day. The clients not meeting these criteria will be offered an appointment to return at their convenience.
 - Clients will be given a Direct Connect pass with their appointment time and date written on the pass. The Triage Nurse should sign the pass and indicate an expiration date of one week after the appointment date.
 - The Triage Nurse will use an appointment book to note the appointment with the client’s name and Insight number. Thirty-minute slots will be used for Fast Track visits and sixty minutes for Full Testing visits.
 - No more than one appointment per hour will be scheduled.

Referring for further medical evaluation

- Per OCHD Standing orders, “Clients will be assessed and referred out for further medical evaluation if the following diseases are suspected:”
 - Chancroid
 - Epididymitis
 - Granuloma Inguinale
 - Hepatitis C Virus Infection
 - Suspected Herpes Simplex Virus Infection
 - Suspected Human Papillomavirus Infection
 - Suspected Molluscum Contagiosum
 - Pelvic Inflammatory Disease

Triaging Clients specific to positive “pain” response on assessment

Pelvic Inflammatory Disease

- Pain in the lower abdomen, **fever**, vaginal discharge (may have foul odor), painful sex, and pain when urinating.
- Must see a physician or mid-level practitioner for a physical exam. Laboratory work is needed for diagnosis and possible ultrasound or laparoscopy.

Ectopic Pregnancy

- Acute abdominal pain (sharp, low, lateral). Vaginal bleeding.
- Ask about LMP, history of previous ectopic pregnancy.
- Refer client immediately to ER for ultrasound.

Epididymitis

- Pain, swelling and inflammation of the epididymis.
- Unilateral discomfort/pain in the scrotum, testicle or epididymis.
 - Testicular torsion should be considered when onset of pain is sudden and severe. Refer client immediately to ER for ultrasound.
- Must see a physician or mid-level practitioner. Laboratory work and ultrasound needed.

Pain Assessment Tool:

Pain assessment using PQRST.	
P	Provoking Factors. What factors precipitated the discomfort? What were they doing at the time of onset?
Q	Quality. Ask the pt to describe the pain/discomfort and its characteristics.
R	Region Radiation. Where is the pain? Does it radiate? Is there pain anywhere else?
S	Severity. Ask the pt to rate their pain/discomfort on a pain scale.
T	Time. How long has the pt had the pain. Does anything make it worse or better?