Telephone Triage for the Healthcare Professional

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OBJECTIVES

- Upon completion of this lecture, the participant will be able to:
  - Discuss components of a symptom analysis
  - Discuss legal issues associated with telephone triaging
  - Discuss issues related to documentation

Telephone Triage

- Process by which telecommunication devices are used for the long-distance management of patients
  - Patient education
  - Support patient at home

Historical Perspective

- Began during WW I in France
- Designed to salvage the "walking wounded" and not "waste" valuable resources on victims with fatal injuries
- Probably performed even before WW I because it is known that one of the first phone calls made by Alexander Graham Bell was for assistance with a battery acid burn

Why Such A Demand Today?

- People living longer with chronic illnesses
- Shift from inpatient to outpatient management of many illnesses and conditions
- HMO's/Managed Care Organizations
- Reduction in number of primary care providers
  - Study showed reduction in primary care workload by 40% – 50% with the hiring of a triage nurse
- Cell phones
- Cost of healthcare

Telephone Triage

- Triage means "sorting out"
- It involves ranking patient complaints in terms of urgency, in order to book those appointments that are necessary
  - It also involves deciding when the appointment should occur
- It involves educating and advising the patient regarding a number of health related issues

Responsibilities of the Triage Nurse

- Assess a patient's health concerns without the advantage of face to face interaction
- Must be able to listen thoroughly to identify health problems
- Effectively communicate to deliver recommendations
- Identify problems through non-verbal clues

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Telephone Triage

- It is fundamental to the survival of most practices
  - Providers can not see every person calling in with a question nor can they return every call
  - With demands to see more patients being placed on health care providers, more and more practices are and will be utilizing triage nurses

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Where Is Triage Occurring?

- Primary care offices
- Specialty practices
- Emergency rooms
- Insurance companies / HMO's – many are requiring that a patient call a triage number prior to going to an emergency room

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Who Is Doing The Triage?

- In many offices…
  - Receptionists
  - Medical Assistants
  - Licensed Practical Nurses
  - Registered Nurses
  - Nurse Practitioners
  - Physician Assistants
  - Physicians

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State Law

- All states have different laws regarding who can and who can not triage
  - Many states allow LPN's, medical assistants and certified nursing assistants to triage
  - Other states only allow RN's to triage
  - What does your state say?

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National Council of State Boards of Nursing Nurse Practice Act

- Nurses must use the nursing process and must <u>not</u> make medical diagnoses

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AAACN 2007 Statement

- Telephone triage does not involve making diagnoses—nursing or medical—by phone.
- Telenurses do not diagnose but rather collect sufficient data related to the presenting problem and medical history, match the symptom pattern to the protocol, and assign acuity
- Telephone triage aids in getting the patient to the right level of care with the right provider in the right place at the right time (AAACN, 2007).

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Examples of Medical Diagnoses

- R/O Strep throat
- R/O UTI
- ? Sinusitis
- Probable appendicitis

- What should a nurse write in the chart?

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Statistics Important for Scheduling

- Phone calls occur on average once every 6 minutes
  - More frequently in family practice, internal medicine and pediatrics
- Offices report anywhere from 100-1000 calls/day
- Most studies have found that the majority of these calls occur during office hours (particularly between the hours of 10:00 am and 12:00 noon)

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Statistics Important for Scheduling

- Monday and Friday tend to be the heaviest in terms of call volume
  - In particular, Monday morning and Friday afternoon
  - Tuesday tends to be the lightest day

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What is An Ideal Triage Set-up?

- Triage person dedicated to triaging
- Rotation

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Statistics Important for Scheduling

- Of the calls received…
  - 3% are for life threatening emergencies
  - 47% appointments/referrals/prescription refills
  - 50% are for telephone advice
    - 2/3 of all calls result in advice only (no appointment needed)

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Who Calls?

- The majority of calls received are from women
  - Many calls concern the health of their children or husband
  - Elderly individuals also make a number of calls to a practice for advice

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Statistics Important for Scheduling

- Majority of the calls are about respiratory problems, fever, GI problems, skin disorders, infectious diseases and trauma.
- The average nurse has approximately 3 – 5 minutes per call and must therefore must be skilled at handling these calls efficiently and thoroughly

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Please Remember…

- Nurses are not educated regarding telephone triage in nursing school
- Most of the education comes from “trial by fire” or personal experiences with their own family members and children

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So…

How Are We Doing With Telephone Triage?

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In A Study Conducted by Verdile…

- A research assistant, posing as the daughter of a 56 year old man with bad indigestion and heartburn (and a smoker), called various offices/emergency rooms. Here’s what happened…
  - 3 out of 46 nurses refused to give any information
  - Receptionists managed 9% of the calls
  - Over half (56%) of the nurses failed to ask the caller any questions about the patient or his complaints
  - 32% of nurses instructed the woman to give the client an antacid despite being given information that pointed toward myocardial ischemia

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Study Continued…

- One nurse advised the caller to give “sublingual nitroglycerin every 5 minutes.” When the patient’s daughter asked the nurse what nitroglycerin was, the nurse stated…”Ask any cardiac patient, they all have nitroglycerin.”
- Only 4 nurses advised the caller to call 911

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There Are Serious Problems With The Telephone Triaging Being Performed In This Country!!

They Must Be Corrected!

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What Can We Do To Improve Telephone Triage At Your Facility?

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First and Foremost…

- You need to decide what kind of triage you want to go on here
- Do you want the nurses doing triage or do you want every caller to be scheduled for an appointment?

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It Begins When The Phone Rings!!!

- Introduction
  - Identify Self
    - Name, title
    - How may I help you?
  - Greeting
    - Friendly
    - Upbeat
    - Warm, yet official

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The First Two Lines Should Never Be…

- Good morning, Wright & Associates Family Healthcare, This is Wendy. Will you hold please?
  - And before they even have a chance to respond, the call is slammed on hold.

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Basic Elements of a Telephone Call

- Introduction
  - Gather Information
    - Name and phone number
    - Is this a medical emergency?
    - Never put on hold without finding out if there is an emergency

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Communication Skills

The Most Important Part of Triage

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Communication Skills

- Attitude
  - Sets the tone for the entire interaction
  - A poor attitude can prevent you from receiving the information you need to make appropriate decisions
    - It is NOT the patient's problem that you are busy, tired, frustrated, underpaid and handling the 100th call of the morning
    - Put a smile on your face and answer the phone like you are happy to be there

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Communication Skills

- Listening techniques
  - Most important part of the conversation
  - Study showed that letting a patient speak uninterrupted for 3 minutes often times (90%) resulted in the patient giving you the diagnosis or at least significant clues to the problem

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Communication Skills

- Language
  - Make sure you communicate with the patient so it can be understood
  - Nurses will often talk in language that is understandable to other health care professionals but not the patient
  - Have a translator available if you can not speak the patients language

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Communication Skills

- Interviewing techniques
  - Avoid leading questions
    - You're not having chest pain are you?
  - Use open ended questions, when needed
    - Tell me what's going on…
  - Use closed ended questions for the rambler, long-winded patient
    - Are you having pain?

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Getting To The Heart of The Matter…A Symptom Analysis is Essential

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Symptom Analysis

- Chief Complaint
- Onset
  - Date
  - Manner
  - Precipitating and/or predisposing factors

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Symptom Analysis

- Headache x 5 days (Chief Complaint)
  - Presents today with a headache that began 5 days ago (Date). Began suddenly and without obvious cause (Manner and precipitating / predisposing factors).

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Symptom Analysis

- Characteristics
  - Character
  - Location
  - Intensity or Severity
  - Timing
  - Aggravating and Alleviating Factors
  - Associated Symptoms

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Symptom Analysis

- Headache is described as a dull ache (Character) located in the temporal regions only and is non-radiating (Location). Described as a 3 on a 1 -10 scale (Intensity) and is constant (Timing).

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Symptom Analysis

- It is made worse by bending over (Aggravating) and better with 2 Extra Strength Tylenol (Alleviating). It is associated with mild nausea (Associated). Denies fever, chills, stiff neck, visual changes, photophobia, rash, vomiting, trauma (Pertinent Negatives).

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Symptom Analysis

- Course Since Onset
  - Incidence
  - Progress

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Symptom Analysis

- This is the first time a headache like this has occurred (Incidence). Since beginning, it is slightly improved (Progress).

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Health History

- Medications
- Allergies: NKDA, NKFA, NKEA
- LMP
- PMH
- PSH
- Immunizations
- Family History, if applicable

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A Symptom Analysis

- Takes 3 – 5 minutes
- Gives you a diagnosis 80 - 90% of the time if conducted thoroughly and accurately
- Should be done on all phone calls unless the patient says…I am having pain in the center of my chest, am nauseated and feel like I am going to die (or something similar)
  - Feel free to cut the call short in order to call 911

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Based on the Symptom Analysis…

- The nurse must make a decision…
  - 911
  - ER or urgent care
  - Appointment now
  - Appointment today
  - Appointment - first available
  - Advice only

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Concluding A Telephone Call

- Conclusion
  - Give very clear instructions
  - Speak slowly and restate what you have heard, if needed
  - Always end call with-call me should…
  - Pt advised to return or call for PCWAS

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PCWAS

- Nationally accepted abbreviation utilized in telephone triaging
- P ersistent
- C hanging
- W orsening
- A nxiety provoking
- S ymptom specific

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Documentation

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Documentation

- Documentation is crucial to practice and is essential at a malpractice trial
- It provides a record of the quality of care you provided and tells a story so that other's after you will know what has been done
- Lack of documentation can make you vulnerable to a malpractice claim

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Principles of Documentation

- NOT DOCUMENTED…….

NOT DONE!!!!!

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Document, Document, Document

- Always document telephone calls and conversations no matter how trivial they may seem
  - It might be crucial later

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What Else Can You Do?

- Always Document
  - Clearly
  - Legibly
  - Correct Spelling
  - Neatly
  - Accurately

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Forms

- It is very helpful to have a form, specific for triaging
- Saves a lot of time
- Has been shown to be much more thorough than just SOAP notes written into a chart

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What to do if you forget to document?

- Late entry
  - Must be explained why you are late
  - Date and time
- Changed records
  - Include date, reason for change, signature and title of the person making a change

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Documentation

- Use accepted abbreviations only
- Document all nursing care
- Document all teaching
  - Document what patient said in response

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Document All

- No shows
- Cancelled appointments
- Telephone calls made to a patient to check on him/her
- Letters sent and calls made to remind patient of a particular test needing to be done

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Never Record Your Feelings In The Chart

- Always record objective information in the chart NOT subjective information
  - Example: Patient calls to schedule an appointment. He is offered 3 appointments; none of which is convenient. He is unable to make any of them due to work, children. He yells into the phone…No one in that office cares.
    - How could you document this?

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Never….

- Alter records
- Use white out in a chart
- Leave blank flow sheets (implies care not performed)
  - Flow sheets should not be in a chart if they are not used
- Be very careful what you enter into a chart

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Examples of Information Seen During Chart Audits

- COM (Crotchety old man)
- FLK (Funny looking kid)
- FLK from FLP (Funny looking kid from funny looking parents)
- Two hands stamped on the chart (Treat with kid gloves)
- FFC (Fit for coffin)
- DIIK
- 29 year old well-endowed beautiful young woman
- T/T = 2/3

Additional Examples

- DFO – “done fell out” or “passed out”
- PPBABS – “Place pine box at bedside”
- TOBASITH – “Take out back and shoot in the head”
- Positive “O” sign – Unconscious with tongue visible in open mouth
- Positive “Q” sign – Unconscious with tongue hanging out of open mouth

Courtesy – Wesley Myers, NP; North Carolina

What Else Is Important To Improve The Triaging That Is Being Conducted At Your Facility?

Charts

- Whenever possible, have the chart available when providing any advice
  - In my office, the policy is…No Chart, No Triage
  - This is not always possible depending upon your worksite etc…

The Phone Calls Should Be Private

- The phone conversations should not be overheard by other patients, such as those in the waiting room and other exam rooms

Additional Techniques

- Avoid creating guilt
  - Why didn’t you call sooner?
  - Why haven’t you checked her temperature?
- Create realistic expectations
  - Don’t say….Everything will be fine, I’m sure

Empathy

- Convey empathy
  - Try to convey to the patient that you are truly sorry for the problems they are having
  - Remember…you can't possibly understand their grief or pain but you can surely act concerned for their issue

Additional Techniques

- Be aware of wellness bias
  - Studies have shown that health care professionals often think people are better than they actually are
- Trust instincts
  - If it doesn't feel right, respond
- Be accommodating
  - Don't argue with the patient

Breach of Confidentiality

- It is essential to understand those things that can cause a breach in confidentiality
- Examples
  - Discussing a patient where others can hear
  - Releasing information without permission
  - Leaving a message on an answering machine
  - Discussing a patient's condition with family members
  - Leaving record in view of others
  - Not shredding documents

Hobbs vs. Lopez, Ohio, 1994

- College student had pregnancy test performed by MD. Told MD she wanted a 1st trimester abortion if positive. Test was positive. Physician instructed RN to call and give information to patient. RN called and reached Mrs Hobb's (patient's mother). Gave mom the results and information on locations of abortion sites. Patient sued for medical malpractice, breach of privilege, and negligent infliction of emotional distress.

Always Assume the Worst

- When triaging, nurses should always consider the most worrisome diagnoses first…
  - In particular, consider myocardial infarction, ectopic pregnancy, testicular torsion, breast cancer, appendicitis, aneurysm

Starkey vs. St Rita's Medical Center, 1997

- 36 year old male began experiencing chest pain and pressure, fatigue, diaphoresis at work. Came home and went to bed. Wife gave him antacid with no improvement. He went to bed and wife called a general triage number at the local hospital. Nurse advised her that it sounded like he may be having a heart attack but not to wake him. Let him rest and see how he was when he awoke. When he awoke, symptoms continued. Suffered an MI and is now unable to work.

Document a Patient's Refusal of Care

- Document that you have explained the risks, benefits and alternatives of treatment
- Also discuss and document the risks of refusing treatment

Cardinal Rules of Triage

- Always err on the side of caution.
- When in doubt, send 'em out!
- Beware the middle-of-the-night call.
- Be alert to possible atypical, silent, or novel presentation.
- Serious symptoms may present as a single symptom or a complex of symptoms.
- Always speak directly with the client when possible.
- Assume the worst until proven differently.

Clawson ,1998

Cardinal Rules of Triage

- Make corrections for your own fallibility.
- The more vague the symptoms the greater the need for good data collection.
- Speed does not equal competence; avoid premature closure.
- Never abandon the caller in crisis.
- Temperature extremes often trigger medical problems (Clawson, 1998).
- All severe pain should be seen urgently.
- Several calls in a short period of time may be an indicator of acuity.
- Beware the developing disease.

Clawson ,1998

Common Triaging Errors

- Using leading questions
- Using medical language
- Inadequate data collection
- Inadequate talk time
- Stereotyping clients or problems
- Failure to talk directly with the client
- Believing the client's self-diagnosis
- Not believing a client

Developing a Good Relationship with the Patient

- Encourage them to call in 24 hours with an update
- Call them back in 4 hours to check on them
- A study published in the Journal of Emergency Nursing showed that parents were satisfied with the interaction they had with an office if the nurse who triaged them seemed to care and listen to their problems.

Little Things Mean More Than You Know

- Pleasant receptionists and nurses
- Do not create guilt
- Receptionists and nurses should not argue with patients regarding referrals, prescriptions, appointments
- Avoid long waits for phone calls to be returned
  - Calls coming in during the morning hours should ideally be returned in the morning
  - Give the patient a realistic time frame as to when the call will be returned

Greenberg, ME in Nurs Economics

- Published May-June 2000
- Over 80% of the callers surveyed (120 calls) reported that if they hadn't been able to speak to a nurse, they would have sought medical attention elsewhere

Happy Patients Do **NOT** Sue

Angry Ones Do!!!!

Unfortunately….

- The number of malpractice cases involving telephone triage nurses is increasing
- The nurse is not the only one who will be held liable
  - The clinician(s) under whom he/she is triaging will also be named in the case

Telephone Triage Protocol Books

- Telephone triage protocol books are currently recommended for all practices that employ nurses for triage
- Protocol books protect the nurse as well as the health care provider
- All providers (MD's, NP's, PA's) within the practice should review the protocol books and sign them
  - This provides documentation that they have read them and that they are in agreement with them

Telephone Triage Protocol Books

- In addition, all nurses should read them and sign them
  - This provides documentation that the nurses have read them and agree to practice under these guidelines
  - If the nurse sways from an established protocol, she/he needs to document this deviation

Telephone Triaging Protocols

- Pediatric Telephone Protocols: Schmidt
- Telephone Triage: Briggs
- Pediatric Telephone Medicine - Brown; $30.00
- Telephone Triage - Wheeler; $41.95
- Telephone Health Assessment - Simonson; $33.95
- AAFP-1-800-944-0000; $26.00 - $222.00
- Centra Max $8000.00 -$9000.00 per seat

Study (2001)

- Goal: Assess patient satisfaction and return on investment of telephone triage services
- Results:
  - Average nurse response time: 50 seconds
  - 90%+ of patients were satisfied
  - Significant reduction in hospital emergency room usage
  - Reduced health plan expenditures
  - For every $1.00 spent - $1.70 saved

Telephone Triage Can Work

- In an article published in the Wall Street Journal (1991), a telephone triage center received 10,000 calls in 1 year.
  - Saved 2,951 emergency room visits
  - Saved $48,000
  - Physicians agreed with decisions made by the nurses 99% of the time
  - Patients were satisfied with the care 92% of the time

Thank You!!!