Defining the Role of the Professional Nurse in the Ambulatory Setting.... Voice, Visibility and Value

The Telephone Advice Nurse

Objectives

Upon completion of this presentation, you will be able to...

- Define telephone triage: What it IS and what it ISN’T
- Identify standards that impact telephone triage nursing
- Discuss the role of protocols in management of patients over the phone
- Recognize risk management principles in telephone triage nursing
- (Bonus) Discuss several pitfalls to avoid in provision of care of over the phone

Telephone Triage

(...What it IS)
Is an integral part of ambulatory care nursing
Is practiced in all ambulatory settings
Is often undervalued and under-recognized*
However, it is the future of nursing
- Growing nursing shortage
- Aging population
  - Increased numbers
  - Growing presence of chronic illnesses
- Limited financial (and other) resources

Telephone triage is recognized & valued in your organization!
Are you aware that you are doing it?

- Description:
  - A component of telephone nursing practice that focuses on assessment, prioritization, and referral to the appropriate level of care.

- Definition:
  - An interactive process between nurse and client that occurs over the telephone and involves identifying the nature and urgency of client health care needs and determining appropriate disposition.
Appropriate means...

Desired Outcomes

- Safe patient care
  - Sound clinical judgment
  - Collaboration & continuity of care (patient follow-through and appropriate provider involvement)
- Decreased organizational liability due to patient mismanagement
- Patient satisfaction (recruitment & retention)
- Staff satisfaction and retention
- Efficient and cost effective care delivery

Essential Components of Critical Thinking

- Education
- Experience
- Standards
- Competence
- Attitude
Misconceptions about Telephone Triage

- A nurse is a nurse is a nurse
- Triage exists to keep patients out of the clinic
- It's only a phone call (so it can't be serious)
- You need to go faster
- Telephone triage isn't real nursing
- You're getting too involved
- Good nurses know if patients should be seen
- Our patients are unreasonable & demanding
- Patients don't know what's best for them

Telephone Triage vs. Education & Advice ???

1. What are the symptoms of chickenpox?
2. What's the right dose of Tylenol for my 2 year old son?

What Does This Mean to Nursing Practice?

- New specialty has emerged (with a new area of accountability)

(You can do it WRONG, but you can't NOT do it)
Why formalize phone triage?

- Study of 35 adolescent care clinics
- Simulated triage calls
  - Adolescent actress
  - R/O ectopic
- > 1/3 gave inappropriate advice
- < 1/3 of advice given by RN
- No difference in the quality of advice given by an RN and a secretary!!!

Elements of Decision Making in Telephone Triage

1. Time/Distance, etc
2. Resources
3. Pt characteristics

Process for Telephone Nursing

1. Information Gathering
   - Getting started
   - Information seeking
   - Secondary information gathering (later)
2. Processing Information
   - Identify & verify problem
   - Planning (thinking ahead)
   - Decision making (what needs to be done?)
3. Output
   - Disposition (where + nursing support)
   - Closing call
   - If uncomfortable, secondary information gathering
**Parallel Processes in Data Collection & Decision Making**

- **Explicit information**
  - Signs & symptoms
  - Verbal (concrete) information
  - High acuity calls (symptom based calls)
  - Low complexity (obvious needs)

- **Implicit information**
  - Non-verbal cues
  - Contextual factors (distance from care, available transportation, patient preferences)
  - Low acuity calls (physiologic need not readily apparent)
  - High complexity (“if they don’t need an appointment, they need something”)

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**Interpreting is Pervasive in Telephone Triage Nursing**

1. The nurse filters and converts patient data into medical information (e.g., separating relevant from irrelevant information)
2. The information is processed (nature, urgency, implications for patient management)
3. The nurse translates necessary medical information into language the caller can understand
4. Yield is INDIVIDUALIZED CARE

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**Protocols are important, but...**

- “The decision-making processes required for priority-setting and the provision of advice have been found to be complex and multifaceted. Conceptualization of this valuable patient care activity as a linear ‘triage’ function serves to make invisible the nursing care provided.”

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Wilson & Hubert (2002), abstract
Practice Standards

Standards

- BASIC NURSING
- Regulatory
- Professional
- Accreditation
- Organizational Policy

Telephone Triage...

- IS NOT
  - A barrier to care
  - Restricted to the “triage department”
- IS
  - Management of time-sensitive, symptom-based calls (in any setting)
  - The practice of nursing (and thus application of the nursing process)
Nursing Process

- Assess
- Diagnose
- Plan
- Implement
- Evaluate

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Nursing Process

- Assess
- Evaluate
- Diagnose
- Implement
- Plan

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Nursing Process

- Assess
  - Data collection (Subjective & Objective)
- Diagnose
  - Conclusion (Triage category)
- Plan
  - Collaboratively
- Intervene
  - Think continuity!
- Evaluate
  - How will you know if your patient doesn't get better?

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Standards

- Basic Nursing
- **REGULATORY**
  - Professional
  - Accreditation
  - Organizational Policy

California response to survey:

- **Recommendation of meds (RNs)**
  - OTCs without protocol: No
  - OTCs with protocol: Yes* ???
  - Refills with protocol: Yes* ???
  - Prescription drugs with protocol: No
- **Recommendation of meds (LVNs)**
  - OTCs without protocol: No
  - OTCs with protocol: No
  - Refills with protocol: No
  - Prescription drugs with protocol: No
- **LVNs and Telephone Triage:** No
AAACN TNP Standards

- Telehealth Administrative Nursing Practice
- Staffing
- Competency
- Telehealth Nursing Practice
- Continuity of Care
- Ethics & Patient Rights
- Environment
- Telehealth Nursing Knowledge Development
- Performance Improvement
- Leadership

AAACN TNP Standard II:
Staffing

Sufficient numbers of competent telehealth registered nurses are available to meet the patient care needs for the telehealth practice setting. Staffing models address the complexity of telehealth encounter care needs while maintaining a safe and caring work environment.

AAACN TNP Standard IV:
Telehealth Nursing Practice

The nursing process provides the basis and structure for the practice of professional nursing and is used consistently with all telehealth nursing encounters.

AAACN 2007
AAACN TNP Standard V: Continuity of Care

Telehealth nurses manage telehealth encounters to facilitate continuity of care by utilizing the nursing process, interdisciplinary collaboration, and coordination of all appropriate health care services, including available community resources.

Telehealth nurse executives, managers, and leaders plan for and provide essential financial and organizational resources that support continuity of care within and across health systems.

AAACN TNP Standard X: Leadership

Telehealth nurses acquire and utilize leadership behaviors in practice settings, across the profession, and in the health care community at large.

National Certification

- Telephone Nursing Practice (NCC)
  - Discontinued effective 12/31/07
  - Certification may be maintained via CE credit
- Ambulatory Care Nursing (ANCC)
  - Incorporating more telehealth
  - AAACN is encouraging telehealth nurses to take this exam
Standards

- Basic Nursing
- Regulatory
- Professional
- ACCREDITATION
- Organizational Policy

Accreditation (voluntary)

- The Joint Commission *
- AAAHC*
- NCQA*
- URAC

*Generic standards, applicable to patient care (including care delivered by phone!)

Standards

- Basic Nursing
- Regulatory
- Professional
- Accreditation
- ORGANIZATIONAL POLICY
Rules of Engagement for Successful Triage

1. Dedicated RN staff
2. Systematic Assessment
3. Decision Support Tools
4. Medical Record Template

RULE FOR SUCCESS # 3
DECISION SUPPORT TOOLS

Decision SUPPORT Tools or Decision MAKING Tools ???
Decision Support Tools

- Clinical rules for handling calls and giving advice
- Guide the nurse in decision making

- Should provide structure without being inflexible
- Should NEVER supercede nursing judgment

DSTs Avert Disaster

- Decrease likelihood of overlooking important facts
  - Function as a checklist to prevent oversights
  - Will help a busy nurse focus
  - Supplement knowledge deficits
- Are the “great equalizer”
- Provide standardization within the organization
- Decrease ambiguity in decision making
- Represent the standard of care
- DO NOT TAKE THE PLACE OF NURSING JUDGMENT!!!
Proper Use of DSTs

- Complete assessment BEFORE opening the protocol (to assure proper protocol selection)
- Review all appropriate protocols, take highest level action recommended
- Protocols don't represent artificial intelligence; Deviate (and document) when it's indicated
- Be CERTAIN to use the nursing process and THINK!
- Avoid over reliance on protocols!

Rule for Success #4
DOCUMENTATION TEMPLATE

IF IT’S NOT WRITTEN, IT DIDN’T HAPPEN!

- Document ALL calls
  - When appt given (even if today)
  - Advice only calls (you assessed the patient!)
  - Not patients of your practice and anonymous callers
- Document to paint a picture
  - What they told you
  - What you told them
  - Plan for follow-up
- Document all pertinent findings
  - Both positives & negatives
- Signatures per policy and file promptly
Documentation Essentials

- General information for all patients
- Patient assessment
- Conclusion
- Plan / Patient instructions
- Follow-up / Evaluation plan
- Closing statements

Common Pitfalls

(Bonus Round)

Pitfalls to avoid

- Jumping to conclusion
  - She had surgery earlier today; her vomiting must be due to anesthesia
  - He's taking Indocin; that's why he's vomiting
  - He has chronic sinusitis...
  - She's too young to be having a stroke
  - female to be having an MI

Carol Rutenberg, RNC-BC, MNSc
Telephone Triage Consulting, Inc ©2009
Pitfalls to avoid

- Accepting patient self-diagnosis
  - I have a sinus headache
  - I have a cold
  - I have pinkeye

Pitfalls to avoid

- Depending on clerks to determine urgency
  - 12% of the time (35/292), discrepancies were observed in chief complaints identified by clerks and RNs
  - 32% of those (11) were considered to be significant
  - 82% (3% [9] of the total calls) were underestimated by clerks and thought to be a potential problem
  - 7 of those (2.4% of total calls) were triaged by the RN to “seek immediate care”, ultimately representing a delay in care
  - Generalizing these numbers to your population, you have at least _____ patients at risk per _____ (N x 2.4%) year*

Klasner et al. (2006)

Pitfalls to avoid

- Failure to speak to the patient
  - Obscure or unknown symptoms
  - Suicidal ideation
### Pitfalls to avoid

- Functioning outside scope of practice
  - Recommendation of medications

### Pitfalls to avoid

- Fatigue and haste

### Pitfalls to avoid

- Failure to insure continuity of care
  - New onset seizures
Pitfalls to avoid
- Failure to LISTEN and THINK
  - My baby’s having an immunization reaction

Pitfalls to avoid
- Being multitasked and/or distracted
  - “Night from hell in the unit”

Pitfalls to avoid
- Failure to anticipate worst possible
- Failure to err on the side of caution
- Failure to adequately assess
- Knowledge deficit
Pitfalls to avoid

- Knowing the patient TOO well!
- "In a study to investigate the decision-making strategies of 'knowing the patient', Radwin (1995) also found that the decision-making process of nurses was largely influenced by how well they knew their patients.
- Marriner (1983) pointed out that prejudicial perceptions such as stereotyping, labeling and preoccupation often decreased nurses' perceptiveness which, in turn, weakened the accuracy of cue interpretation and diagnosis formulation."  

Three Types of “Nurse” Calls

- TRIAGE
  - Time sensitive
  - Episodic
  - Determines nature, urgency, and access to care
- CARE MANAGEMENT
  - Usually not time sensitive
  - Focuses on continuity & is based on care plan
- OTHER NURSING CALLS
  - Disease management
  - Behavioral modification
  - Basic two way communication with patient

Telephone Triage Nurses: Zebra Hunters Extrordinaire!

- Primary Nurses/Care Management Nurses deal with continuity of care, considering the patient’s existing plan of care, focusing on what’s "inside the box"
- Triage nurses deal with episodic care (often the unexpected), anticipating worst possible, looking for the zebras that live “outside the box”
**Common Office Mistakes**

- Front office personnel doing initial triage
- Nurses multitasked including
  - Other non telephone triage duties
  - "Junk calls" (test results, Rx refills, etc)
- Walk-in triage
- Returning calls instead of taking them live
- Recommendation of meds outside of scope
- Failure to use protocols
- Inadequate documentation

**Common Call Center Mistakes**

- Clerical personnel doing initial triage
- Inadequate assessment prior to protocol selection
- Over-focusing on protocols (not listening)
- Failure to exercise critical judgment
- Failure to document pertinent negatives
- Policies prohibiting downgrading
- Emphasis on metrics (call length, disposition)
- Discouraging follow-up calls

**RISK MANAGEMENT**

- Front office personnel doing initial triage
- Nurses multitasked including
  - Other non telephone triage duties
  - "Junk calls" (test results, Rx refills, etc)
- Walk-in triage
- Returning calls instead of taking them live
- Recommendation of meds outside of scope
- Failure to use protocols
- Inadequate documentation
In Order to Minimize Risk...

- Rules of Thumb
- High Risk Callers
- Red Flags
- Organizational Safe-Guards
- Nursing Behaviors
- The Patient’s Role

Rules of Thumb

- Consider every call life-threatening until proven otherwise
- If in doubt, err on the side of caution
- Patients who call repeatedly (e.g., 2 times in 24 hours) should probably be seen.
- Avoid patient self-diagnosis

High Risk Patients/Callers

- Extremes of age
- Comorbidities such as diabetes, post-op, or immunosuppression
- Repeat callers (repeat calls for same problem)
- Frequent flyers
- Patients with multiple complaints or poor historians
Red Flags

- Lethargic; “worst headache of life”; “just not himself today”, “elephant sitting on chest”, etc.
- Worse (or different) than usual
- New symptoms or symptoms inconsistent with presumed diagnosis; unexpected course; getting better then worse
- Extremely sick (toxic)
- Concerned callers
- When you are concerned

Nursing Behaviors to Decrease Risk

- Use the nursing process on every call
  - Do a thorough assessment every time
  - Give attention to continuity of care
  - How will you know if the patient doesn’t get better?
- Use clinical judgment!
  - Use protocols to guide your decision making
  - If no protocol exists, use nursing judgment
  - Avoid over-reliance on protocols

- Remember, they're paying us to THINK
  - Are symptoms consistent with diagnosis?
  - Think about the context of the symptoms
- Remember that triage exists to facilitate care
- Follow policy/protocol unless it doesn’t fit
  - Then deviate and document why
- Document extensively
- Verify caller understanding, intent to comply and comfort with plan
**Nursing Behaviors to Decrease Risk**

- Know & function within your scope of practice
- Communicate with your team and collaborate when indicated but...
- Remember you maintain accountability for your clinical decisions and (often) patient outcomes
- Recognize when you’re “set up to fail” and do something about it!
- Use extreme caution when multitasked or rushed

**Nursing Behaviors to Decrease Risk**

- Avoid jumping to conclusions & be wary of patient self-diagnosis
- If the caller’s concerned (or if you are concerned), the patient should be seen at once
- Think continuity: What next? Is follow up needed?
- Take time to close the call properly!

**Closing the Call**

- “So this is what you told me...”
  - Read note to caller
  - Collaboratively develop plan
    - Have patient take notes!
  - “Now, tell me what you plan to do”
    - Confirms understanding, intent to comply and plan
  - “Are you comfortable with this plan?”
    - Give caller option to “override” disposition
  - Other questions or concerns?
    - May reveal their “real” reason for calling
  - What to expect & call back instructions
    - They are your eyes & ears “on the scene”
The Patient’s Role

- Confirm comfort with plan
- Patient needs to know what to do if he doesn’t get better
- Assure caller knows what “worse” looks like
- Caller gets 51% of the “vote” on whether to be seen or not
- Is the patient able to carry out the plan? (What do you need to do to assure compliance?)
  - Does he have transportation and necessary resources?
  - Do you need to “grease the skids” for the patient?
  - Does he understand the consequences of his actions?

Remember...

You are a nurse.

Every time you provide care to a patient, you are practicing nursing...

...even over the telephone!
References


- Rutenberg, C. (2000). Telephone triage: When the only thing connecting you to your patient is the telephone. American Journal of Nursing, 100(3), 77-78, 80-81.