Telephone Triage for the DDA Nurse

Tiffany Goins BSN, RN
Elfleta Lawton-Nixon, DNP, RN
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Learning Objectives:
Upon completion of this presentation, you will be able to:

- Define telephone triage.
- Describe how the DDA residential agencies utilize telephone triage.
- Summarize the qualifications and expert nursing functions of telephone triage.
- Describe two mnemonic tools (learning strategy used to enhance memory) used in telephone triage for assessing patients or signs and symptoms.
Definition of Triage Nursing (Who, What, When, How)

Telephone triage is defined as an “interactive process between the nurse and client (staff) that occurs over the telephone and involves identifying the nature and urgency of client healthcare needs and determining the appropriate disposition” (Rutenberg & Greenberg, 2012).

What is the Goal of Telephone Triage?

To direct the caller to the appropriate level of care or service in a safe and timely manner by providing healthcare advice and directions (Blank, et al., 2012).
Telephone Triage

- Does not involve making a diagnoses nursing or medical
- Nurse collects sufficient data related to the presenting problem and medical history, match the symptom pattern to the protocol, and assign acuity.
- Aids in getting the person to the right level of care,
  - with the right provider,
  - in the right place
  - at the right time
Communication Skills

**Attitude**

- Sets the tone for the entire interaction
- Poor attitude can prevent you from receiving the information you need to make an appropriate decision.
- It is not the person served or staff’s problem that you are tired, busy, or underpaid.

**Listening Techniques**

- Most important part of the conversation
- Language
- Nurses often talk in language that is understandable to other health care professionals but not lay person’s.
Learning Strategies to enhance memory for direct care staff communications to the nurse

SBAR
- Situation
- Background
- Assessment
- Recommendations

STOP and Watch
- Seems different
- Talks or communicates less
- Overall needs more help
- Pain new or worsening
- Participates less in activities

Karen S Kesten
Georgetown University School of Nursing and Health Studies, Washington DC 20057, USA.
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Source: PubMed
Role Play

Time: 7:48 am

You receive a phone call from your DSP who has stated the following:

“Hello, the individual was coughing while she was eating breakfast.”

What would you ask?
Choking & Aspiration Protocol Example

**Key Questions:** Name, Onset, Cause, Prior History, Pain Scale

**Assessment:**
- **A.** Is the following present?
  - The person is conscious and unable to speak, cough, or breathe
- **B.** Is the following present?
  - The person is unconscious and not breathing
- **C.** Are any of the following present?
  - Difficulty breathing
  - Blue lips or face
- **D.** Are any of the following present?
  - Foreign body aspirated into lungs
  - Coughing up blood or severe pain after dislodging foreign body from throat
  - Unable to remove foreign object from throat and no other symptoms

**Action:**
- Yes - Start First Aid!
- No - Go to B
- Yes - Call 911 and begin CPR!
- No - Go to C
- Yes - Call 911!
- No - Go to D
- Yes - Call 911!
- No - Go to E
Choking & Aspiration Protocol Example Cont.

Assessment:

- Are any of the following present?
  - Able to speak and cough
  - No difficulty breathing
  - Frequent episodes of choking on saliva, foods, or fluids

Action:

- Yes - Call back or notify the PCP if there is no improvement. Follow home care instructions.
- No - Follow home care instructions or agency protocol.

Home Care Instructions/Recommendations:

- For frequent choking, eat slowly, taking smaller bites.
- Allow time for swallowing between bites of food and fluid consumption.
- Ensure that the person is in the proper eating position and that the mealtime protocol is being used.
- Ensure that the proper Adaptive Equipment is being used.
Constipation Protocol Example

**Key Questions:** Name, Onset, Last BM, Medications, Prior History, Pain scale

- **Assessment:**
  - A. Is the following present?
    - Severe abdominal pain, swelling, or vomiting
  - B. Is the following present?
    - Persistent vomiting and progressive abdominal swelling.
    - Severe pain or cramping
    - Vomiting brown, yellow, or green bitter-tasting emesis?
    - Severe Rectal bleeding
  - C. Are any of the following present?
    - No bowel movement in ____ days and interventions are unsuccessful.
    - Recent surgery or injury.
    - H/O Diverticulitis and fever
    - Fever lasting for 24 to 48 hours
  - D. Are any of the following present?
    - Dry hard stools
    - Pain with BM
    - Recent change in stools or bowel habits
    - Chronic constipation

- **Action:**
  - Yes- Call 911!
    - No-Go to B
  - Yes- Seek medical care within 2 to 4 hours.
    - No-Go to C
  - Yes- Seek medical care within 24 hours.
    - No- Go to D
  - Yes- Call back or notify PCP if there is no improvement and follow home care instructions.
Severe Bleeding Protocol Example

Key Questions: Name, Onset, Cause, Location, Medications, Pain Scale, Prior History

Assessment:

A. Is the following present?
   - Penetrating wound or difficulty controlling bleeding
   - Signs of shock
     - Lightheadedness
     - Skin is pale, cold, or moist
     - Thirst
     - Rapid pulse
   - Penetrating wound to abdomen, chest, or neck

B. Is the following present?
   - Persistent bleeding >10 minutes after application of direct pressure
   - Gaping wound
   - History of bleeding disorder
   - Taking a blood thinning medication
   - Unable to move limb or digit beyond injury site

Action:

Yes- Call 911 and follow home care instructions! Do not move the penetrating object!

No-Go to B

Home Care Instructions:
- Lay the person down and elevate the injured part.
- Apply pressure directly to the area until bleeding stops or help arrives.
- If spurting persists with direct pressure, apply pressure to the artery between the hear and the injury site.
Symptom Analysis

Chief compliant

Onset
  Date
  Manner
  Precipitating and /or predisposing factors
Symptom Analysis Takes 3-5 minutes Do not complete analysis if Individual reports i.e. S/S of myocardia Infarct call 911

- 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).

- 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).

- Health History
Summary

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

Concluding a Telephone Call
- Give very clear instructions
  - Speak slowly and restate what you have heard if needed.
  - Always end call with “call me if condition gets worse or better”
Why is documentation important?

- Is critical for practice and is essential for malpractice trial.
- It provides a record of the quality of care you provided and tells a story so that others after you will know what has been done.
- Always document telephone calls and conversations no matter how trivial they may seem.

What else can you do?

- Always document
- Clearly legibly
- Correct spelling
- Neatly
- Accurately
Cardinal rules of Triage

- Always err on the side of caution
- When in doubt send them out
- Beware the middle of the night call
- Serious symptoms may present as a single symptom or a complex of symptoms
- Assume the worst until proven differently
- Vague symptoms call for more data collection by the nurse
- Speed does not equal competence-avoid premature closure
- All severe pain should be evaluated (seen) urgently
- Several calls in a short span of time indicates acuity
What does the BON/DOH have to say?

Good Afternoon,

The Board of Nursing has not drafted an opinion related to Telehealth nursing. However, your agency may adopt policy that specifies that only an RN can telephone triage.

Bonita

Bonita Jenkins EdD, RN, CNE
Nurse Consultant - Education
Board of Nursing/DOH
Ph. 202 724-8846
Fax. 202 724-8677

Health Regulation and Licensing Administration
899 North Capitol Street NE Suite 200
References


