CALL OUTCOMES – LESSONS LEARNED

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2023 A Call Away Conference - Children's Mercy Kansas City
May 10, 2023

THE PERFECT CALL DOESN'T EXIST

CALL OUTCOMES

- Promotes patient safety
- Maintains quality
- Identifies best practices and opportunities for improvement

24 HOUR OUTCOMES

What is it?

A QI initiative in which we review calls where the RN arrived at a disposition of See in 24 hours or lower, yet the patient goes on to present to a BJC ED within 24 hours of the triage call.

Purpose:

We look at these calls to identify potential learning opportunities, guideline revision opportunities, and/or process improvement opportunities.

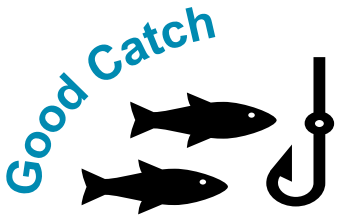
24 HOUR OUTCOMES

Process:

Unless the child is admitted, we review only the written documentation, looking for a complete assessment, most appropriate guideline, and most appropriate disposition.

If admitted, a committee member reviews the audio and the call is presented at our monthly 24-Hour Outcomes meeting. Feedback from the committee is provided to the RN.

GOOD CATCH PROGRAM



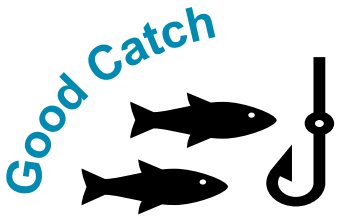
What is it?

QI initiative in which we look at patients who were referred to the ED by the triage nurse and go on to be admitted.

Purpose:

Recognize nurses for a job well done and share ED visit outcomes with our staff.

GOOD CATCH PROGRAM



Process:

We review the written documentation of the triage call, looking for a complete assessment, most appropriate guideline, and most appropriate disposition. We then access the ED notes to provide a summary of the symptoms present at time of presentation and care provided.

LESSONS LEARNED & BEST PRACTICES

CALL #1 - REVIEW

Age of Patient: 16 months

Caller's CC: Coughing fits that make her throw up, on antibiotics.

Guideline Used: Cough

MEDICAL VISITS (OFFICE/ED/Urgent Care) IN LAST 2 WEEKS: PCP 12/10-Temp. Flu-. Prescribed Amoxicllin for possible fluid sound on left lung.
ONSET/SEVERITY: Started Amox 12/10. Cough started 12/10. Coughing every 10min. Wet cough. Coughing spells. Vomited x1 from cough.
ACTIVITY LEVEL: fine when not coughing. Still playful and active.
OTHER SYMPTOMS: No temp. No wheezing. Subcostal retractions-had this when in PCP office and said was doing this due to temp but doesn't have a temp and its worse now. Belly pulling when breathing. RN listened-Breathing hard to hear, seems quite. Drinking well-good I&O.

Positive GO TO ED NOW Triage Question: Ribs are pulling in with each breath (retractions) when not coughing
R/O: pneumonia

ED SUMMARY

- Patient presented to ED a little over an hour after triage call with respiratory distress, retractions, tachypnea, nasal flaring, tracheal tugging.
- Ronchi in all fields but good air movement throughout with no wheezing.
- Started on 6 L HFNC and transferred to PICU
- CXR concerning for focal pneumonia. Patient (+) RSV.
- Continued course of Amoxicillin prescribed by PCP
- Discharged home after 4-day hospital stay

LESSONS LEARNED

RE-ASSESSMENT is key after recent evaluation

AVOID reliance on earlier diagnosis

Perform a COMPLETE respiratory assessment

Determine what's changed in patient's symptoms?
BETTER-SAME-WORSE

KEY POINTS: BRONCHIOLITIS

- Young infants with bronchiolitis can *rapidly* develop respiratory distress.
- The smaller the airway diameter the more *airway resistance* a little swelling or a little mucus creates.
- Complications of Bronchiolitis include Apneic Episodes (stop breathing for 20 seconds or longer).
- Apnea risk is always highest for infants less than 6 months of age with respiratory distress.

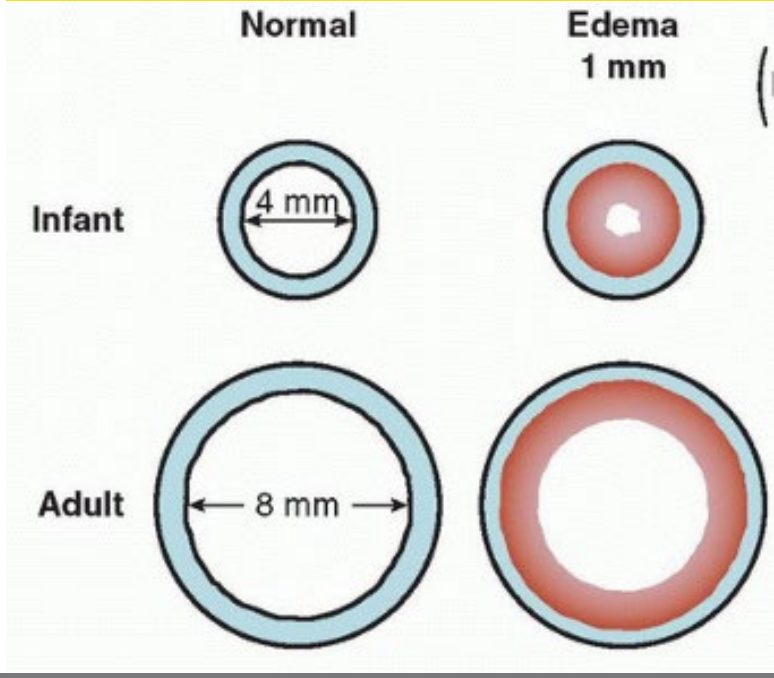
KEY POINTS: BRONCHIOLITIS

- Consider need for EMS 911 option whenever you send child with respiratory distress to the ED. Ask yourself: "Could this child stop breathing enroute?"

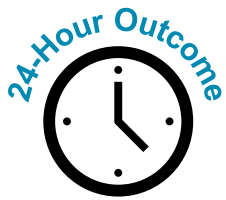
- Some infants need re-evaluation *within hours* of initial evaluation and release from the ED or office

- RSV causes up to 80% of cases of bronchiolitis. Other respiratory viruses such as parainfluenza or human metapneumovirus can cause bronchiolitis.

Impact of 1 mm edema infant vs adult airway



CALL #2 - REVIEW



Age of Patient: 20 days of age

Caller's CC: The umbilical cord fell off stump seems to be infected

Guideline Used: Umbilical Cord – Discharge or Infected

MEDICAL VISITS (OFFICE/ED/Urgent Care) IN LAST 2 WEEKS: first wellness visit on 2/24 with Dr. Plax

ONSET/SEVERITY: umbilical cord fell off about 1 week ago and yesterday 3/12 mom noticed the area is really red and skin is peeling, skin looks raw, redness and peeling is only in the belly button, current temp is 97.5

ACTIVITY LEVEL: fussy related to cold symptoms per mom, appetite is normal, UOP - normal, BMs - normal

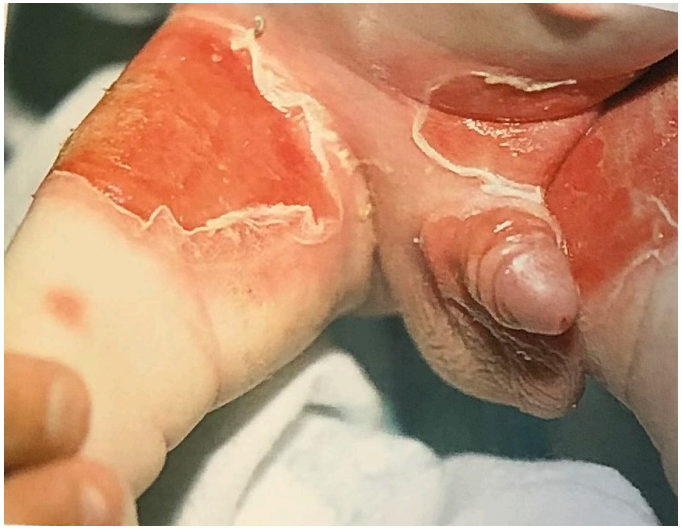
OTHER SYMPTOMS: congestion and mild cough

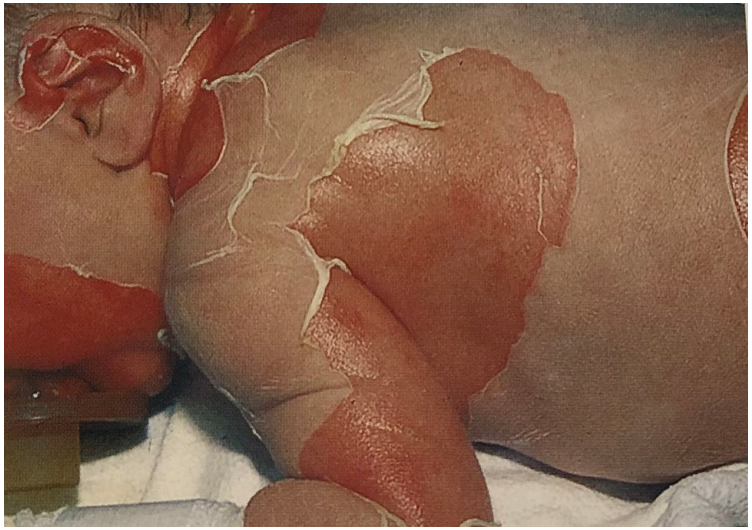
ADDITIONAL INFORMATION: at PCP office yesterday for older brother's cold symptoms - discussed [redacted] and was told to use bulb suction to help with secretions, being seen at PCP office tomorrow 3/13

Positive SEE WITHIN 3 DAYS Triage Question: Nubbin of pink tissue inside the navel

ED SUMMARY

- Patient presented for scheduled well-check the next day and was immediately sent to SLCH ED 19 hours after triage call.
- Concern for **Staph Scalded Skin Syndrome (SSSS)**. Peeling of hands, feet, groin, majority of abdomen, face with several areas with an erythematous rash extending beyond the border of desquamation.
- Admitted to NICU. Periumbilical cellulitis could have been the original site of staph aureus infection that triggered the development of SSSS.
- Treated with IV Ancef, transitioned to Keflex for home treatment.





LESSONS LEARNED

Review assessment for COMPLETENESS and ACCURACY

Utilize PATTERN RECOGNITIONS

- What is normal v. abnormal behavior for newborn?
- What is different (or abnormal) about this newborn?

AVOID accepting parent's self-diagnosis

Failure to error on the side of caution

Failure to anticipate the worst possible

KEY POINTS: NEWBORNS

- Newborns are the HIGHEST RISK age group for rapid deterioration with *subtle* symptoms.

- If a triage nurse is worried for any reason about a newborn, refer them in to be evaluated now or put the call back to the PCP.

- Paradoxical response to being held or moved indicates a serious condition.

CALL #3 - REVIEW

Age of Patient: 20 months

Caller's CC: stomach cramping, child keeps grabbing it and screaming, vomiting, struggling with pooping

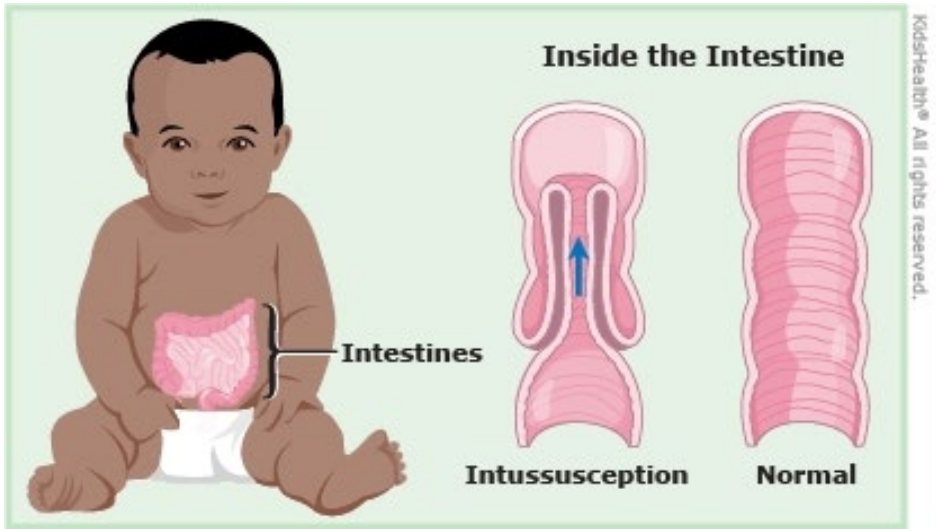
Guideline Used: Vomiting without Diarrhea

MEDICAL VISITS (OFFICE/ED/Urgent Care) IN LAST 2 WEEKS: None
ONSET/SEVERITY: Began yesterday, grandmother thought she was feverish. Last evening will be fine for a minute will be fine and then crying and grabbing her stomach. Occurring about every 15 minutes, overnight would wake every couple of hours, today having cramping, screaming crying every 15 minutes. Vomited started last night, emesis today x 2, NB, NB. Passed a large stool within the past 20 minutes, no blood noted. Still grabbing her stomach. Does not feel warm to touch.
ACTIVITY LEVEL: right now she is calm, she is lying on grandmother, seems alert. Seems fatigues.
OTHER SYMPTOMS: Denies breathing concerns. Had ice chips this morning, did drink a little milk. Ate a few bites of sausage
but vomited. Last wet diaper @ 30 minutes ago.

Positive GO TO ED NOW Triage Question: Intussusception suspected (brief attacks of severe abdominal pain/crying suddenly switching to 2–10 minute periods of quiet) (age usually < 3 years)

ED SUMMARY

- Patient presented to ED a little over an hour after triage call.
- Ultrasound notable for intussusception in the right upper quadrant.
- Pediatric surgery consulted.
- Patient went to radiology for air enema and was successfully reduced on first try.
- Admitted overnight for observation and fluids.



LESSONS LEARNED

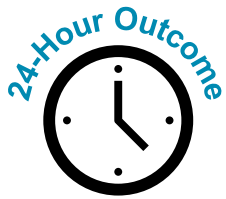
Address ALL symptoms in chief complaint

Perform a COMPLETE assessment including a clear and accurate description of pain

Select and adhere to most appropriate guideline – follow SMAGs

LISTEN and THINK to make strong clinical judgements

CALL #4 - REVIEW



Caller is great aunt who is foster parent for child

Time of Call: 0753

Age of Patient: 19 months

Caller's CC: Cold symptoms

Medical History:

- History of prematurity
- Diagnosis of asthma
- Medications: Albuterol PRN; Flovent BID

SLCH Customized Guideline Used: Asthma – After Hours

SLCH AFTER HOURS CALL REPORT

MEDICAL VISITS (OFFICE/ED/Urgent Care) IN LAST 2 WEEKS:none

1. RESPIRATORY STATUS: Says he is coming down with a cold last night 09/06/2021 runny nose cough congestion. Sleeping now. Lips pink. Denies retractions. No known covid exposures. Doesn't go to daycare. No family illnesses right now.
2. ZONE: green
3. ONSET: as noted.
4. NAME/TYPE OF RESCUE MEDICATION:albuterol neb and inhaler at home.
5: RESCUE MEDICATIONS:albuterol nebulizer, gave inhaler. Has had 3-4 txs since yesterday, just 1 puff albuterol given with tx's
6. TRIGGER:Doesnt know.
7. CHILD'S APPEARANCE:Breathing "heavy" Put phone up to child, no wheezing, stridor or grunting heard. Breathing sounds nonlabored.
8. PO STEROID IN HOME:none
9. CONTRAINDICATIONS TO ORAL STEROID: none
10. HIGH RISK FACTORS IF DIAGNOSED WITH ASTHMA: none

PREDNISONE STANDING ORDER SIGNED: NO

ADDITIONAL INFORMATION: **Mild Exacerbation:** Give rescue treatments every 4 hours as needed for cough, wheezing or shortness of breath. Call PCP within 3 days. Caregiver will call pcp office today 09/07/2021 for an appointment to be seen.

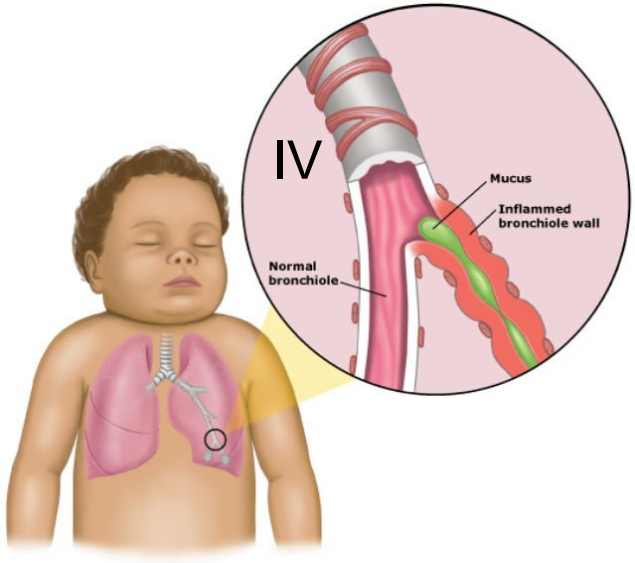
Positive SEE WITHIN 3 DAYS Triage Question: MILD- Green Zone

PCP OFFICE SUMMARY

- Mother called office at opening.
- Re-triaged by office nurse. Instructed to take child to ED.
- Mother declined. Given 1st AVAILABLE office appt at 10:45 AM.
- Presented to office a little less than 3 hours after RN triage.
- Child in respiratory distress:
    - RR 90s, O_2 sat 88%
    - Wheezing bilaterally with head bobbing and retractions
    - EMS called
    - Oxygen and albuterol started in the office pending EMS arrival
    - Transported by ambulance to SLCH

SLCH ED SUMMARY

- Arrived by EMS transport from PCP office
- Child in respiratory distress:
  - RR 78
  - O_2 sat 93% on O_2
  - Wheezing
  - Subcostal, Intercostal, Supraclavicular retractions
  - Nasal flaring
  - Tracheal tugging
  - Head bobbing
- Admitted to PICU on continuous albuterol, methylprednisolone and 10L HFNC.
- Tested (+) Rhinovirus/Enterovirus
- CXR – consistent with bronchiolitis
- 5-day hospital admission



LESSONS LEARNED

Perform a COMPLETE respiratory assessment

Use of open-ended questions

Failure to err on side of caution

Time of triage does not matter

CALL #5 - REVIEW

Age of Patient: 16 years

Caller's CC: Sore throat, can't swallow or talk

Guideline Used: Sore Throat

Status: Signed

MEDICAL VISITS (OFFICE/ED/Urgent Care) IN LAST 2 WEEKS: office visit yesterday (-) strep, (-) at home COVID test 7/30

ONSET/SEVERITY: severe sore throat. Temp 100.2 per TM. 2nd day of spitting into bottle because can't swallow. Tx with IB. Last given last evening. Winces when tries to swallow pills. No head tilt. Giving Robitussin OTC with no improvement. No SOB. No rapid or labored breathing. Holding mouth closed. Not talking. Sounds like "marbles in his mouth".

ACTIVITY LEVEL: crying intrmt due to sore throat pain. Barley holds his head up for COVID test. Minimal po intake in last 24 hours. Unsure of last void.

OTHER SYMPTOMS: No rash. no ill household contacts.

ADDITIONAL INFORMATION: Sent to SLCH ED.

ON-CALL PROVIDER: Dr. O'grady

Reason for Disposition

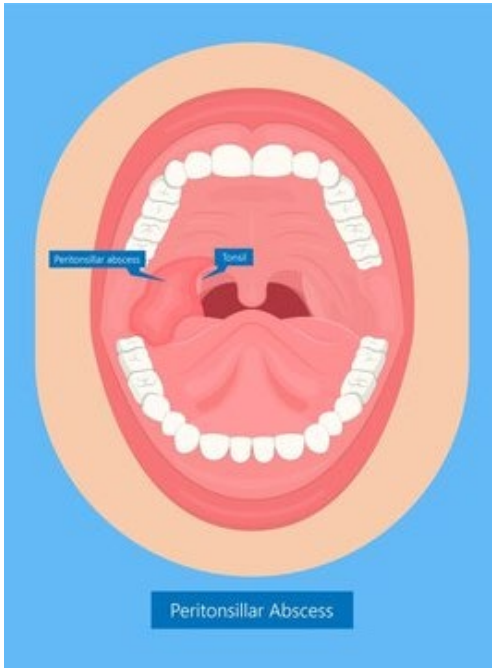
• [1] Drooling or spitting out saliva (because can't swallow) AND [2] normal breathing

Protocols used: SORE THROAT-PEDIATRIC-AH (SLCH)

Positive GO TO ED NOW Triage Question: Drooling or spitting our saliva (because can't swallow) AND normal breathing

ED SUMMARY

- Patient presented to ED.
- Exam with cervical lymphadenopathy R>L and asymmetric tonsils R>L
- CT was consistent with tonsillar abscess with 2b necrotic lymph node on the right
- Mono positive



- ENT consulted and attempted needle aspiration revealing no purulence.
- Given IV Toradol, one-time dose of Decadron, fluid bolus and started on IV Clindamycin.
- Admitted overnight for pain management & fluids.
- Discharged home the next day to complete 10-day course of oral Clindamycin with ibuprofen or Tylenol for pain.

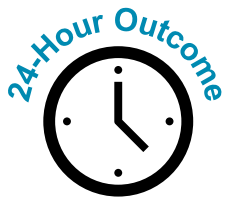
BEST PRACTICES

Don’t be reassured by recent medical visit- instead be on HIGH ALERT

RE-ASSESSMENT is key after recent evaluation- SAME-BETTER- WORSE

Documentation supports triage statement selection and disposition

CALL #6 - REVIEW



Age of Patient: 4 years

Caller's CC: History of febrile seizures, questions about medications to control fever

Guideline Used: Strep Throat Infection Follow-up Call

MEDICAL VISITS (OFFICE/ED/Urgent Care) IN LAST 2 WEEKS: PCp yesterday-Strep+. Prescribed Amoxicillin.

ONSET/SEVERITY: Started Amoxicillin at 1700. Temp this morning 100.0ax. Gave Tylenol @0800. Questions on fever reducers. History of febrile seizures.

ACTIVITY LEVEL: A little more "lethargic". Less energetic. Up and moving around. Alert and responsive. Didn't sleep overnight. Sat up with mom most of the night.

OTHER SYMPTOMS: no rashes. Drinking. Urine WNL.

ADDITIONAL INFORMATION: Gave home care and symptoms to call back for.

Positive HOME CARE Triage Statement: Taking antibiotic < 3 days for strep throat AND [2] other strep symptoms not improved

ED SUMMARY

- Patient's baseline is RA during day, with sats between 90-100%. At home, mom noticed sats in mid-80s prompting ED visit.
- Patient presented to ED about 12 hours after triage call with hypoxia and cough.
- In ED - mottled skin, sats 88%, no respiratory distress, lungs clear on CXR.
- Tested (+) metapneumovirus.
- Admitted to floor per cardiology for further management.
- Next day – patient had breakthrough seizure and became unresponsive.
- Transferred to PICU and intubated for 5 days.
- Discharged home after 6-day hospitalization.

LESSONS LEARNED

Accurate medical history is critical

Use caution for chronic or complex history

RE-ASSESSMENT is key after recent evaluation

KEY TAKEAWAYS

- Don’t be reassured by recent visit/hospitalization
  - Always do a RE-ASSESSMENT after recent evaluation
- ALWAYS perform a complete assessment
- High Risk Groups
  - Newborns
  - Medically complex patients- involve PCP
- Consider call back or contacting on on-call PCP
- Don’t make assumptions- Base clinical decision making on facts
- Give good call back if statements

SUMMARY

Call	Age	QI Initiative
#1 Cough	16 months	Good Catch
#2 Staph Scalded Skin Syndrome	20 days	24 Hour Outcome
#3 Intussusception	20 months	Good Catch
#4 Asthma	19 months	24 Hour Outcome
#5 Peritonsillar Abscess	16 years	Good Catch
#6 Chronic History	4 years	24 Hour Outcome

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RESOURCES AND TOOLS




CHARACTERISTICS OF DOCUMENTATION

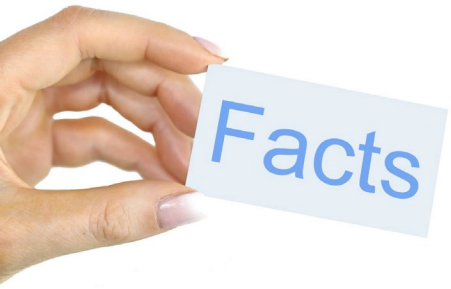
CHARACTERISTICS OF DOCUMENTATION

Our notes should be:

Clear – use only approved abbreviations in the record. Use proper grammar & correct spelling. Improper grammar & misspelled words may cause you to appear less professional.

Concise – Keep documentation brief and to the point. No need to type everything parent says. Part of our job is to identify the “important info” from the parent & add it to our note in a professional way. As triage nurses, we translate “parent speak” into medical terms.

- Correct – Documentation should be factual and accurate. If you aren't certain you have something correct, ask the parent.
  - Avoid reading back your note – "Ok, this is what I have…"
  - Avoid emotion, personal interpretation and subjective descriptions.
  - Consider use of military time to avoid mistakes with AM/PM
  - "Just the facts, ma'am."



- Complete – For a call to be safe, we must have a complete assessment and the documentation must contain any relevant information.

AVOID…

- Criticizing the care the child has previously received
  - Why would they do that?
  - He didn't have a COVID test?

- Subjective descriptions
  - Patient's blood pressure is very high

- Including **your** thoughts about why a patient may have done something

- Including too much detail. Important facts can get lost in all the words if you document a lot of "fluff"

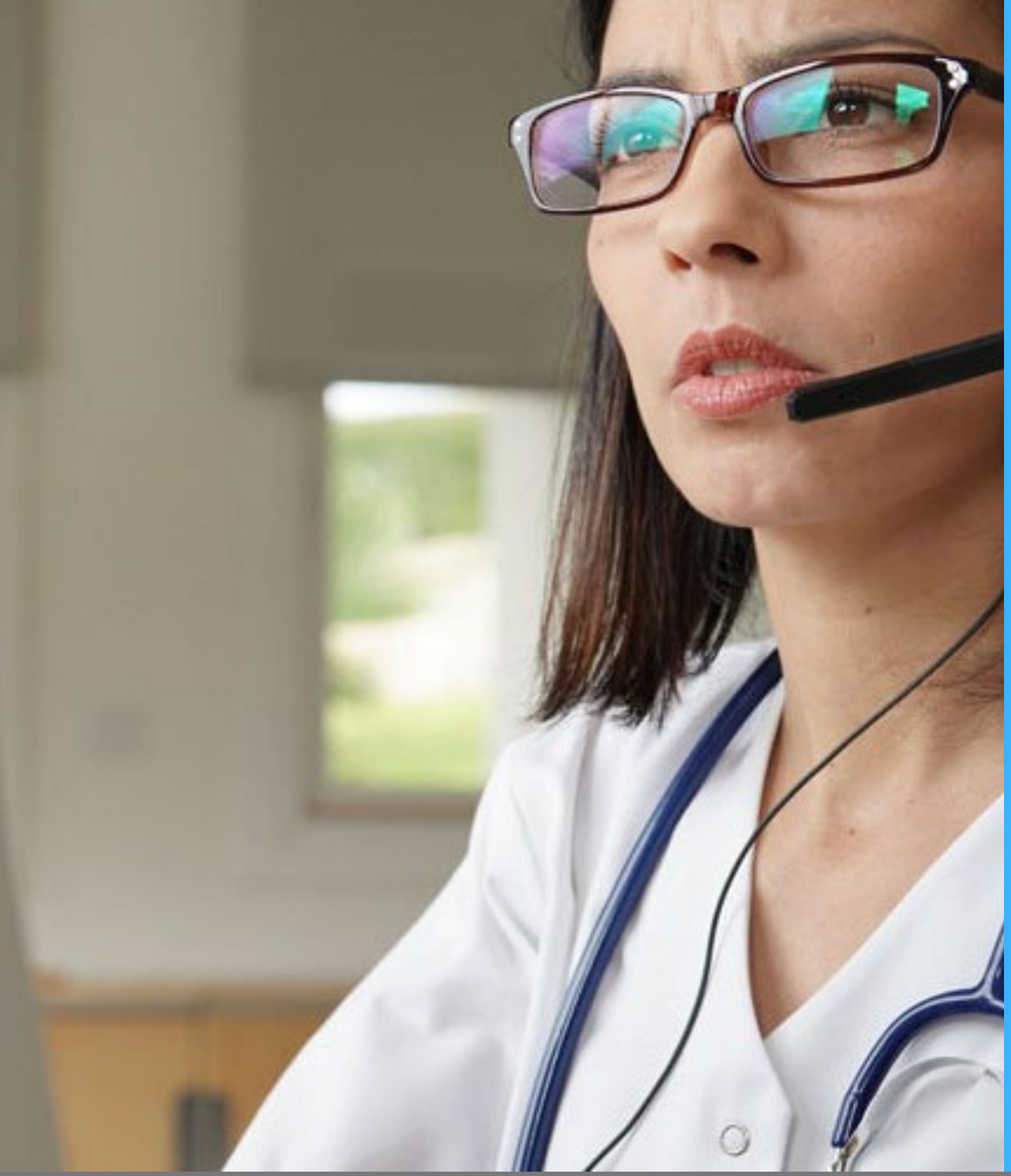
PARENTAL DESCRIPTION OF SYMPTOMS

PARENT DESCRIPTIONS OF RESPIRATORY DISTRESS

- Stomach pumping
- Stomach pulling in
- Having trouble pushing air out
- Pushing air out and I can hear it
- Kind of out of breath a little
- Panting pretty heavily
- Like a pant
- Struggling to breathe because I can see it in his neck
- Trouble catching his breath at times
- Taking short breaths in between talking
- Super hard cough and she has to catch her breath afterwards (3 month old (+) RSV)

PARENT DESCRIPTIONS OF INTUSSUSCEPTION:

- Screaming for an hour in stroller on a walk…very strange…never does that…trying to push himself out of the stroller
- Every time we try to put him down, he pulls his legs up to his chest and screams bloody murder…he wails…like something hurts him
- Awoke from sleep crying and whimpering. Can't get comfortable. Knees are buckled up underneath his stomach as if he's having stomach pains. Every once in awhile he tries to relax and stretch out but seems to hurt him more.
- Awake all night with exception of 40 min period of rest. Wakes up squirming, unable to get comfortable again.
- Pain comes in waves "like contractions"
- Never seen him like this
- Weirdest thing….he pulls his legs up then kicks them out and puts his hands between his legs and cries
- Restless….like a fish out of water
- RN read description of cyclical pain per guideline. Mother's response: "Yes, it's going in spurts like that. That is exactly what he is doing."



COMMON TELEPHONE TRIAGE PITFALLS

COMMON TELEPHONE TRIAGE PITFALLS – PICK THE ONES WE WANT TO DISCUSS?

- Accepting patient self-diagnosis
- Jumping to a conclusion
- Stereotyping the patient
- The frequent caller
- Failure to speak directly with the patient
- Fatigue and haste
- Knowledge deficit
- Failure to reassess
- Failure to perform an adequate assessment
- Failure to use critical thinking and exercise clinical judgement
- Failure to listen and think
- Failure to err on the side of caution
- Failure to anticipate worse possible
- Over-reliance on protocols
- Failure to use protocols
- Failure to facilitate continuity of care
- Failure to advocate for the patient
- Failure to document pertinent negatives
- Failure to follow-up
- Fear of “crying wolf” and being labeled an “over-reactor”
- Functioning outside of scope of practice

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