# Amy Elizabeth Johnson

September 5, 1979 - January 11, 2023

"To know even one life has breathed easier because you have lived. This is to have succeeded."

Ralph Waldo Emerson

# TELEPHONE TRIAGE – CALL FLOW BASICS

Alissa Haycraft MSN, RN, CPNP, Answer Line Staff Educator

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

# WHAT IS TELEPHONE TRIAGE?

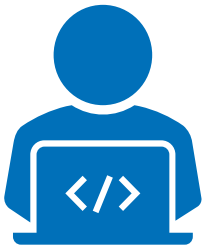
An encounter with a patient/caller in which a **specially trained nurse** → utilizing **clinical judgment** and the **nursing process** → is guided by **medically approved decision support tools** to determine:

- The urgency of the patient's problem
- Direct the patient to the appropriate level of care

The plan of care is developed in **collaboration** with the caller. It includes:

- Patient education and/or advice as appropriate
- Follow-up as indicated to assure a safe outcome

# TELEPHONE TRIAGE AND SAFE OUTCOMES



### Decision support tools

Dr. Barton Schmitt's Pediatric Guidelines provide a standard of care that drives better patient outcomes!

### Critical Thinking

Use of guidelines in combination with specially trained RNs.

### Call-back-if

Universal and guideline specific "call-back if" statements ensure the caller knows what to watch for and when to connect with us again or seek care.

### Collaboration

RNs working in partnership with the caller and Providers in the best interest of the child/teen.

# SCHMITT-THOMPSON CLINICAL CONTENT

What are the benefits of using Schmitt-Thompson guidelines as your triage decision support tool?


Schmitt-Thompson Clinical Content https://www.stcc-triage.com/

# TELEPHONE TRIAGE – A UNIQUE FORM OF NURSING

*"Nursing is cognitive, not psychomotor"* (Rutenberg & Greenberg, 2012, p. 43)

# CRITICAL THINKING AND NURSING JUDGEMENT

The National League for Nursing Accreditation Commission defines **critical thinking** as:

- *"The **reasonable**, **reflective**, **responsible**, and **skillful thinking** that is focused on deciding what to believe or do."*

**Nursing judgement** entails:

- Using our **education**, **experience** and **clinical insight** in decision making to provide safe effective care.

## PRACTICE!

**Scenario:** Office staff or exchange staff send message to triage nurse stating, “needs albuterol refill”.

Kendra is a 13yr old with history of asthma. Mom is calling this AM… *“all I need is a refill on her albuterol inhaler”*

The nurse asks the caller to clarify the pharmacy and sends over the script, letting her know to call back if Kendra becomes worse.

# Let’s discuss

## POLL?

Who feels:

**A – Comfortable.**

**B – Not comfortable.** I’m left with a few questions.

# LET'S DISCUSS

**Yes! We have more questions!**

**We are using our critical thinking and judgment to alert us of potential asthma symptoms.**

## Let's see how it plays out if I ask assessment questions:

- **Starting with an open-ended -** *"How is Kendra breathing today?"*
- **Followed up with clarifying -** *"Is she having any symptoms of her asthma or feeling the need to use her albuterol?"*

*“Oh no, no symptoms, Kenda is getting ready to go to sleep away camp and she hasn’t needed her inhaler in a while. The one I have is expired. By the way… that reminds me, I think I need a form filled out for camp”*

## PRACTICE!

**Scenario:** Mom is calling about her 2yo daughter. Child also has medical hx of hydrocephalus, with VP shunt placed a birth.

They were in to see the PCP 2 days ago for sick visit. Dx Constipation. Had abdominal x-ray same day that showed mild amount stool - no impaction.

Mom is calling today. She gave a rectal suppository this am, and child passed decent amount of stool. Child is irritable, not eating and vomited.

# Let's discuss

## POLL?

Who feels:

**A – Comfortable sticking with constipation concern.** She was just seen 2 days ago in the office and dx constipation.

**B – Not comfortable triaging a concern without more information.** I'm left with a few questions before I decide my triage path.

# LET'S DISCUSS

**Yes! We have more questions!**

**We are using our critical thinking and judgment to cause us to question the triage path.**

- **The patient was seen in the office recently.**
  - Why are they calling back now?
  - What's different / changed / or not going according to care plan?
- **The patient has chronic medical condition.**
  - Could her condition relate to her current symptoms?

# Telephone Triage Process




# WHY DO WE HAVE A PROCESS FOR TRIAGING?

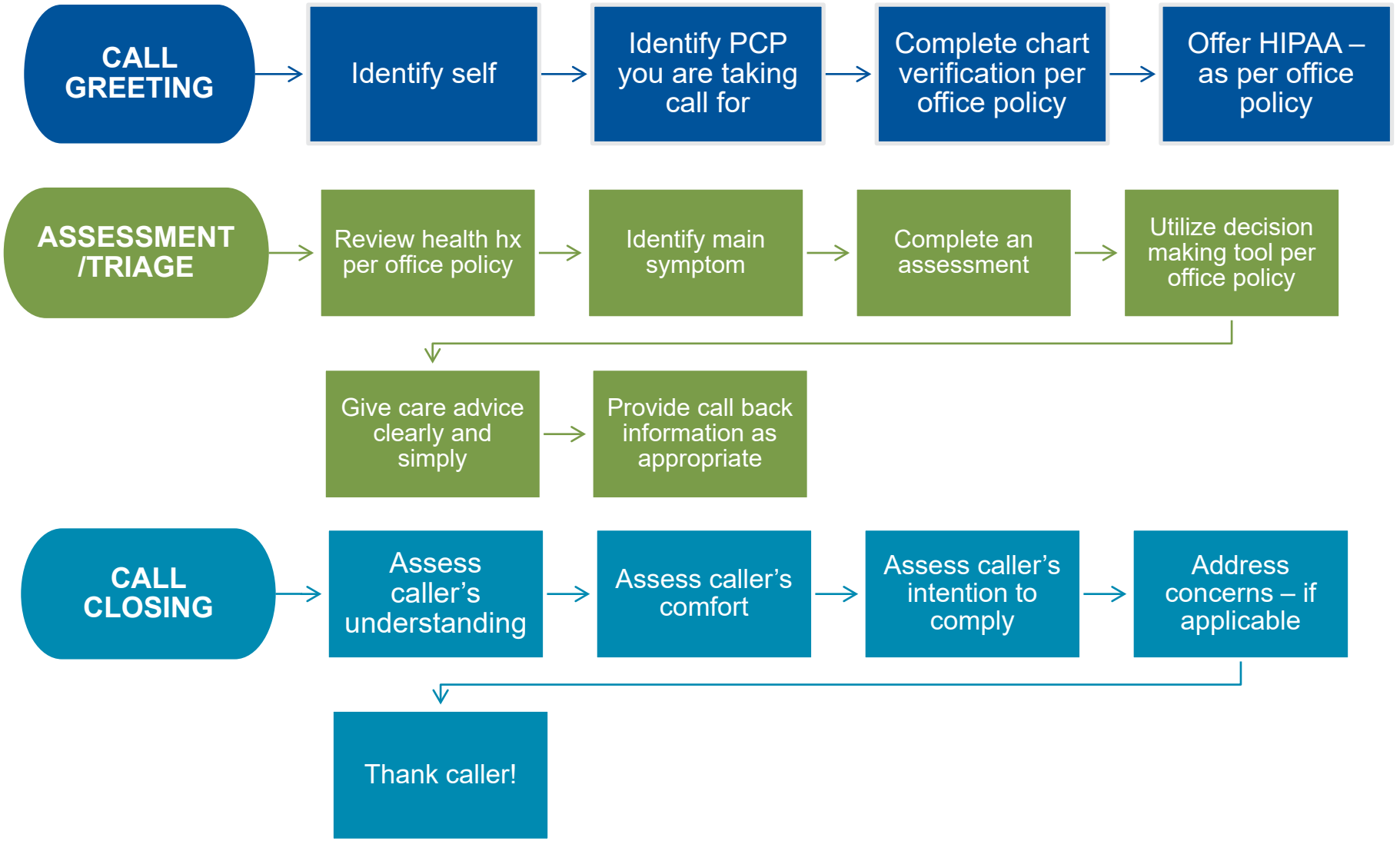
Keeps the patient safe **and** nurse safe

Provides a framework for **every single call**

Allows the nurse to use her knowledge and own style when triaging calls

Not “rules to follow” but a roadmap to a safe outcome

# CALL FLOW


CALL GREETING
Identify self
Identify PCP you are taking call for
Complete chart verification per office policy
Offer HIPAA – as per office policy
ASSESSMENT /TRIAGE
Review health hx per office policy
Identify main symptom
Complete an assessment
Utilize decision making tool per office policy
Give care advice clearly and simply
Provide call back information as appropriate
CALL CLOSING
Assess caller's understanding
Assess caller's comfort
Assess caller's intention to comply
Address concerns – if applicable
Thank caller!

# CALL FLOW – CALL GREETING

Establishes a rapport or working relationship with caller

Don’t rush – speak slowly and clearly

Address caller by name

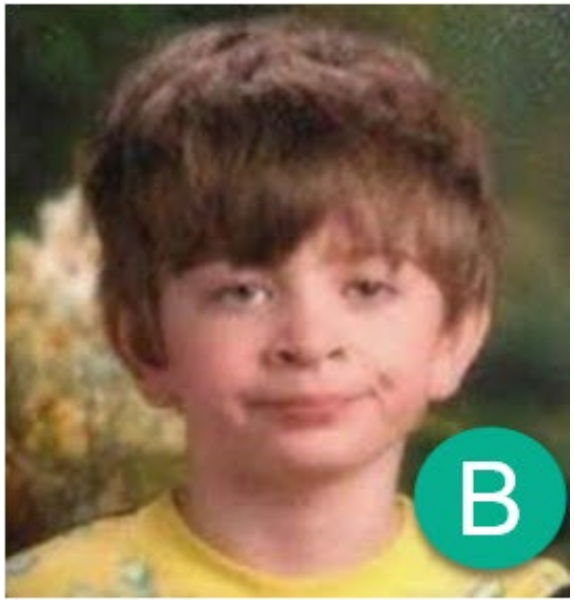
**Tone** of voice is very important

Ensures right patient/right PCP

## CALL GREETING

- Tone sets the stage for the whole conversation.

## WHO WOULD YOU RATHER HAVE WALK INTO YOUR EXAM ROOM?

# CALLERS

**It's helpful to remind yourself why an individual could be calling…**

- What's going on at home for them?
- Do they have access to everything they need?
- Have they been up all night with a sick child?
- Is this their first baby and they feel scared and alone?
- Do they have a child with chronic conditions?

# Nursing Process

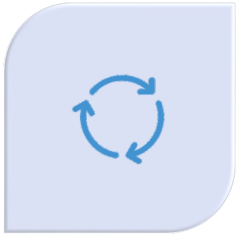



# STEPS OF THE NURSING PROCESS

ASSESSMENT

DIAGNOSIS

PLANNING



IMPLEMENTATION

EVALUATION

# ASSESSMENT

- Involves the nurse evaluating the caller's concern
- Let caller tell you, in their own words, about the concern
- Ask follow-up questions
- Individualize your assessment to fit the call

# OPEN ENDED QUESTIONS

- Allows the caller to explain in own words what they see/hear
- Ensures the caller feels heard when expressing concerns
- Helps prevent caller from disregarding questions with simple yes/no response
- Prevents leading the caller

## PRACTICE!

**Scenario:** Kevin is an 8-month-old with cough, runny nose and fever for past 2 days. Dad is calling because he is concerned about Kevin's breathing.

**We will approach this in two ways and see where each path takes us:**

- Yes/no questions
- Open-ended questions

# Let's discuss

# YES/NO QUESTIONS

**RN:** “Is your child retracting?”

**Father:** “What does that mean?”

**RN:** “Do you see pulling in around Kevin’s ribs when he breathes?”

**Father:** “Let me look, umm, I think so, yes…I mean maybe he always does that I’m not sure, so I guess he is…”

**Where does this lead us…**

# OPEN-ENDED QUESTIONS

**RN:** Can you describe Kevin's breathing to me?

**Father:** *"He's next to me in his highchair eating some puffs. He looks ok to me, but I called because after he woke up, I noticed his breathing seems a little faster. His fever was also 102 but when I took it right before you called it was down to 99.4 so the Tylenol probably helped."*

**RN:** We'll talk about his fever too, right now let's look at his chest and belly, what does it look like when he's breathing?

**Father:** *"It looks like it always does, it still seems a little fast, but it doesn't look as fast as it did when he first woke up."*

**RN:** Does it look like he is working harder to breathe or struggling?

**Father:** *"No, he can eat and breathe ok."*

**RN:** What does his breathing sound like?

**Father:** *"He's making noises when eating. It sounds normal, oh and he's coughing like every few minutes, but he's been doing that for past 2 days."*

**RN:** Any extra noises specific to his breathing?

**Father:** *"No, I don't hear anything"*

**RN:** Can you put the phone to his mouth so I can listen? Let's try 30sec.

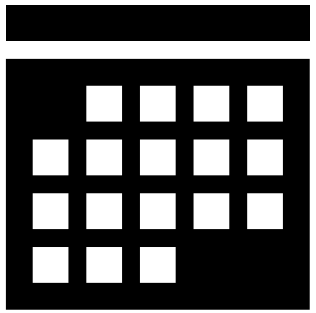
**Where does this lead us…**

# ASSESSMENT TIPS

The information recorded should give the reader an accurate picture of the child's illness or injury.

**ONSET/SEVERITY:**

- What symptoms is the child having?
- When did it start?
- How bad is it?
  - What is it keeping the child from being able to do?
- Is it getting better or worse?
  - Over what period?

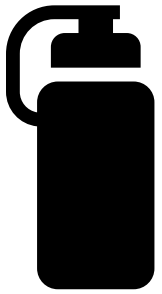


# ASSESSMENT TIPS CONT.

## ACTIVITY LEVEL:

- How is the child acting?
- Is this different from usual?
- What is s/he doing now?
- If sleeping, what was s/he doing prior to going to sleep?
- Did child go to school/daycare today?
- Was it a “normal” day for the child? If no, how was it different?

# ASSESSMENT TIPS CONT.



**OTHER:**

**Intake/Hydration –**

- Is s/he eating/drinking per usual?
- Infant – breast/bottle? Typical pattern/duration/amount. Drive/desire, if appropriate.
- If not drinking well or if GI symptoms are present, consider additional hydration information – mucous membranes moist, tears, willing to drink fluids, amount of fluid over last 12 or 24 hours

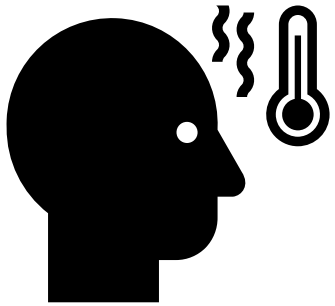
**Urine output specifically –**

- # of wet diapers or # of voids today. Time of last.
- If dehydration is a concern, consider asking about amount/color of urine.

# ASSESSMENT TIPS CONT.

**OTHER:**

- Fever (if applicable):
  - Current temp
  - Duration
  - Tmax in last 24H
  - Behavior when fever comes down
- Medications given
- Any other info needed to provide the reader a clear picture of the child and to support the guideline choice



# Assessment Tips - Respiratory

# RESPIRATORY ASSESSMENT TIPS

- **Begin with open-ended questions to gather clear picture.**
- **Investigate further…**
  - *"Tell me more about that…"*
  - *"Tell me what you mean when you say wheezing…"*

***Infants/toddlers esp:** *"Tell me about how your child has been feeding…how is this different than normal…?"*

**TIP –** Infants will focus on breathing as a priority. Issues with feeding provides clues or pieces to big picture assessment!

# LISTENING TO BREATHING

- **Listen early in the call**
- **Focus on listening –** allow yourself 30 sec to just listen and not type.

**Younger children –**

- If you don't hear anything and they have a pacifier in, ask them to remove it. If child cries (strong cry), you'll get another piece to assessment puzzle!

**Older children –**

- Ask them to count to 10, say A,B,C's or sing a song "Happy birthday"

- If you don't hear anything the first time, you can ask the caller to take you off speaker and hold the phone up the child's mouth.
- Listening can provide a piece to assessment puzzle and supplement an already detailed respiratory assessment.

# AVOID

## Attributing rapid resp rate to fever.

- **For ex:** Instead of attributing reported or noted tachypnea to fever, consider potential as earliest sign of resp distress.

## Using medical jargon.

- **For ex:** Instead of “is breathing labored”, consider “is your child breathing harder or faster than usual?”

## Asking leading questions.

- **For ex:** Instead of “he’s not wheezing is he”, consider “what does it sound like when your child is breathing?”

## Allowing the caller to lead triage.

- **For ex:** Instead of sole focus on caller fever concern, consider “We are going to talk about a plan for Sara’s fever, to help gather the whole picture, let’s first talk more about the cough you mentioned…”

# Assessment Tips - Rash




# RASH ASSESSMENT TIPS

## Information gathering:

- Size
- Shape
- Color
- Flat or raised
- Patches vs dots
- Location
- Onset
- Painful/itchy
- Fever
- Fixed or moves around
- Activity level
- Possible causes
  - Medications
  - Foods

## Keep it open ended:

*“Can you tell me what the rash looks like?"* **vs** *"It's not hives is it?”*

*"If you run your hand across, what does it feel like", “How does your child react when you touch the skin?"*

**Petechial -** *"Does it look like blood color dots or bleeding under the skin? "Does it look like a hickey"*

# RASH ASSESSMENT – OBJECTS RELATIVE TO SIZE

- Pinpoint = tiny dot/spot
- Pea = ¼ inch 
- Dime = ¾ inch 

- Quarter = 1 inch 

- Golf Ball = 1 ½ inches 
- Tennis Ball = 2 ½ inches 

# Nursing Process Cont. – Diagnosis, Planning, Implementation & Evaluation

# DIAGNOSIS

- **Not** a medical diagnosis
- RN identifies the **most concerning symptom** and chooses an appropriate guideline if decision support tool available
- Involves analysis of the information gained through the assessment
- Also involves subjective info such as SOB, infant crying in background, etc.
- Influenced by critical thinking skills, nursing judgment and experience

## MULTIPLE SYMPTOM CONCERNS

If multiple symptoms, used ABC's **(airway/breathing/circulation)** to prioritize symptoms and select the decision support tool most likely to result in the **highest-level disposition**.

**Address each symptom listed in the chief complaint.**

- This does not mean you need to use a support tool for each symptom.
- Simply expand on it and show why it is or is not a problem.
- This is enough for most minor symptoms.
- For higher acuity symptoms, use a decision support tool.

## POLL?

Who feels:

**A – Both symptoms sound urgent.** I decide to triage both with detailed assessment of each concern and utilize multiple decision support tools.

**B – Rash sounds more urgent.** I decide to triage with focus on Rash and document caller's comments on stool.

## PRACTICE!

**Scenario:** CC:  Itchy rash, diarrhea for healthy 8yr old

**When you ask how you can help:**

- Caller begins telling you about the rash.
- She has not mentioned the diarrhea yet, so you ask about stools.
- Caller states child had one stool today. You ask what it looked like, and caller says loose, not watery, without blood and didn't seem to cause any pain.

# Let's discuss

## POLL?

Who feels:

**A – Both symptoms sound urgent.** I decide to triage both with detailed assessment of each concern and utilize multiple decision support tools.

**B – Rash sounds more urgent.** I decide to triage with focus on Rash and document caller's comments on stool.

# LET'S DISCUSS

**Yes! We'll focus on the rash!**

**My assessment, critical thinking, nursing judgement are assisting me in decision making.**

## Based on assessment for stools:

- ***My main concern is not leading me toward dehydration or other GI concerns.***
- I will focus on rash for triage while also listening to caller concern and documenting, thus supporting my decision making in triage!

# PLANNING

Using a decision support tool (if available), RN determines the urgency of symptoms

This is done by ruling out triage statements sequentially

When RN arrives at a positive triage statement, he/she stops and conveys the disposition to the caller

# IMPLEMENTATION

Formation of an individualized plan of care that meets the needs of the caller and child

Involves giving care advice

RN considers barriers to the plan – transportation, weather, financial limitations

# EVALUATION

Reviews call back if statements (the contingency plan)

Call closing

Understanding

Comfort

Intention to comply

## POLL?

Who feels:

**A – Caller can drive.** Mom stated that she was close to the ED, therefore it is safe to agree to her driving and close call as is.

**B – RN should make attempt to have caller contact 911.** Agreeing with driving and closing the call would be example of downgrading the disposition level.

## PRACTICE!

**Scenario:** RN triaged 4-month-old Kassandra. Exposed to RSV at daycare.

RN determines she has frequent cough and per caller, looks like she is working harder to breathe. RN asks to listen and hears constant expiratory grunt.

RN provides the disposition level of **Call EMS/911 Now**. Caller declines and states she will drive to local ED as they are “close”.

# Let’s discuss

## POLL?

Who feels:

**A – Caller can drive.** Mom stated that she was close to the ED, therefore it is safe to agree to her driving and close call as is.

**B – RN should make attempt to have caller contact 911.** Agreeing with driving and closing the call would be example of downgrading the disposition level.

# LET'S DISCUSS

**Yes! To ensure patient safety, we do not downgrade a disposition level.**

**Offer brief explanation and document plan of care.**

- RN offers brief explanation of grunting, how it relates to overall work of breathing and how it guides the decision to call 911.
- When caller continues to state she will drive, RN does not delay care. She provides reasons to pull over and contact 911, documents plan in chart and alerts the on-call provider.

# TIPS

## Caller declines an urgent disposition level:

- Demonstrate respect for caller/patient and keep lines of communication open
- Emphasize concern for person and their safety
- Attempt to remove barriers to compliance
- Provide the caller/patient with understanding of potential consequences

## If the caller/patient still declines:

- Notify the on-call provider – *per office policy*
- Document the 911 or ED recommendation and caller/patient decision to do something else
- Clearly document plan of alternate option

*The patient's PCP contacts the Exchange about an hour later to praise the RN for excellent critical thinking and for attempting to have the caller contact 911.*

*She provides the following information - The patient presented to the ED via car and was immediately taken to the Intensive Care unit in respiratory distress.*

# ONGOING EDUCATION

- Since this is a unique form of nursing, offices can support staff with growth!


- Shadow experienced telephone triage staff in your office.
- Allow for practice with test patient scenarios that are commonly seen in your setting.
- Provide reinforcement with practice. Feedback should be honest and constructive. Avoid judgement!

# QUESTIONS?

Children's HOSPITAL • ST. LOUIS
BJC HealthCare

# RESOURCES AND TOOLS




# EMPATHY VS SYMPATHY – BRENE BROWN

# SAMPLE CALL AUDIO FILES

- Call Greeting 
- Assessment/Triage 
- Call Closing 

# EXAMPLE OPEN-ENDED RESPIRATORY QUESTIONS

- *"Describe your child's breathing"*
- *"What does it sound like? Look like?"*
- *"How is this different than normal?"*
- *"Is he/she breathing harder or faster than usual?"*
- *"Does it look like your child is having a hard time breathing?"*
- *"How frequent is the cough?" "What does it keep your child from doing?"*
- *"Describe your child's breathing when not coughing?"*

# REFERENCES


Brene Brown "The Power of Empathy" video
https://www.youtube.com/watch?v=jz1g1SpD9Zo

Quirin, K. (2018). Call Flow and the Nursing Process

Rutenberg, C., & Greenberg, M.E. (2012) The Art and Science of Telephone Triage: How to Practice Nursing Over the Phone

Schmitt-Thompson Clinical Content Protocols https://www.stcc-triage.com/books

Swerczek, L. & Massaro, K. (2021). Pediatric Respiratory Assessment Refresh. *Clinical Newsletter for Telephone Triage Nurses Schmitt-Thompson Clinical Content*, 1-5.

Image source (Objects Relative to Size) Hertz, A. & Sterkel, R. (2010). Seeing Rashes Over the Phone. Telephone Lines, 7(1), page 2.


**Please reach out with questions:**

Alissa Haycraft

Alissa.Haycraft@bjc.org