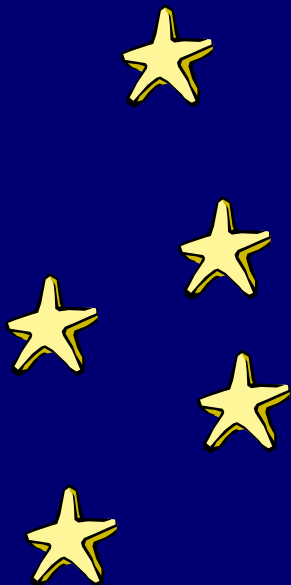


West Vic Division of General Practice Inc
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NURSE TELEPHONE TRIAGE AFTER HOURS SERVICE DELIVERY



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DISCLAIMER

Any representation, statement, opinion or advice, expressed or implied in this publication is made in good faith but on the basis that the West Vic Division of General Practice, its agents and employees are not liable (whether by reason of negligence, lack of care or otherwise) to any person for any damage or loss whatsoever which has occurred or may occur in relation to that person taking or not taking (as the case may be) action in respect of any representation, statement, or advice referred to above.

The protocol prototypes shown in this report are intended as examples only.

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EXECUTIVE SUMMARY

Australian society values and expects a health care system that can provide high quality medical care regardless of the nature of illness or time of day. The provision of after hours care is complex. There is however, an obligation for GPs to provide a level of care. More importantly rural Australians have a right to quality, accessible after hours care. The West Vic Division of General Practice has trialed the Nurse Telephone Triage model of after hours care and believes that this model provides a solution to many of the issues faced in the provision of after hours care. The Division believes the model offers quality, acceptable care and service provision to patients after hours, whilst minimising the workload and demands on GPs.

The Grampians' (West Vic Division of General Practices) model of nurse telephone triage involves GPs switching their phones through to a dedicated 1800 after hours telephone number. Calls are automatically diverted to a trained telephone triage nurse located in a rural hospital. The nurse takes the patient details and via a set of agreed evidence based protocols, assesses the level of care the patient requires and where appropriate gives nursing advice and reassurance. The telephone triage nurse does not make a diagnosis over the phone.

The Division believes that the nurse telephone triage model can be replicated in rural Australia and therefore has presented key components on commencement, governance, quality assurance, training, protocols, documentation and other key lessons learnt within this document.

The components outlined in this documentation are designed to stimulate thought processes and assist other organisations in the implementation of a nurse telephone triage service. The components are not to be viewed as prescriptive, any service implemented needs revision and flexibility to ensure local applicability, GP ownership and success.

It can be indicated, as evidenced from this document, that the West Vic Division of General Practice has undertaken substantial work in order to successfully trial the nurse telephone triage model and progress it to a service. The service has become entrenched as a valuable service to those involved.

Introduction to After Hours Service Delivery

Australian Society values and expects a health care system that can provide high quality medical care regardless of the nature of illness or time of day. We therefore value and expect quality after hours medical care. Traditionally, General Practitioners (GPs) have provided after hours care for their own patients. Providing 24-hour access to general practice can place an unreasonable burden on GP's working in an environment of workforce shortage.

GPs cannot physically and mentally cope with such expectations, but there are also concerns about other surrounding and often unnoticed issues. Issues such as safety of doctors, concerns about patient access to services, standard of care and training of doctors, workforce requirements, lifestyle issues for doctors and remuneration have been identified as problems with the current after hours arrangements (Karabatos, 1999).

Nurse Telephone Triage provides a solution by offering quality, acceptable care and service provision to patients after hours, whilst minimising the workload and demands on GPs.

Defining After Hours Care

After hours service provision can have differing definitions depending on service and location. Many general practice clinics define after hours as anything other than their normal consultation time.

The definition taken for the After Hours Primary Medical Care Trial is that used by the Health Insurance Commission (HIC) who currently define after hours for the purpose of the Medicare Benefits Payments as:

“An after hours consultation or visit is a reference to an attendance on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or anytime other than between 8am and 8pm on a weekday not being a public holiday.”

The Medicare Benefits Schedule has also acknowledged the difference between social and unsociable hours of consultation and divided after hours consultations into two categories, with unsociable consultations between 11pm and 7am receiving a higher rebate.

There is, however, a condition that if a practice routinely opens during defined after hours times it needs to be an emergency service initiated outside the practice normal operating hours to attract after hour consultation rates.

Whilst after hours consultations are well recognised, consultation rates are only available if after hours consultations have been held at the clinic, the patients home or nursing home. This therefore excludes the large number of telephone consultations, which regularly occur.

Duty to provide After Hours care in Australia

The Royal Australian College of General Practitioners (RACGP) indicates that in order for GPs to maintain Vocational Registration they must:

“Accept direct responsibility to ensure that practice patients have access to care by an appropriately qualified medical practitioner at all times.”

There is therefore no obligation for the GP to be personally involved in the provision of after hours services, provided some form of formal after hours service has been made available.

After Hours in Rural Australia

In Australia after hours medical provision varies between locality and practice. Whilst GPs have traditionally provided 24-hour care in metropolitan, urban and rural areas, there has been a widespread move against individual doctors providing this level of care for their clients. The move against providing 24-hour care is largely from the disruption to personal life and poor remuneration.

GPs have an obligation to ensure that practice patients have access to care by an appropriately qualified medical practitioner at all times. In metropolitan and urban areas deputising services and access to 24-hour emergency departments are accessed to meet this obligation. This obligation is significantly more difficult for rural GPs who have limited access to alternative sources of a qualified medical practitioner other than themselves.

Mira et al. (1995) conducted a random telephone survey of GPs to ascertain their after hours arrangements. Almost all rural GPs (95%) provided after-hours care whereas 50% of urban practices provided after-hours care for their patients. In metropolitan practices 35% provided their own after hours care exclusively compared to 52% in the rural sample.

Whilst rural GPs may provide a large percentage of after hours care exclusively, as indicated, this may not be due to choice but rather the limitation of alternative options. In the rural environment, after hour service demonstrated the bridge between a private business and a public good (Pegram, 2000).

Rural GPs not only differ in their obligations to after hours care but often have highly demanding clinic days, visiting rights to the local hospital, and are often on call for other after hour rosters (for example, the surgeons' roster, the anaesthetists' roster and the obstetricians' roster).

After-hours can be segmented into being “oncall” being ‘called’ or “called out”. Being on call means taking your turn on the roster, being accessible to patients either by phone or through the hospital. This may be a regular roster with ratio of one night in two etc depending on the number of GP's participating. Being on call has impact on family life. The GP is restricted in distance away from the hospital and needs to be in telephone contact. The unpredictability of after-hours means that the GP and the family have to make calculated risks on family and social activities, such as beginning home tasks, gardening or hobbies that could be interrupted and for an unspecified time, accepting dinner invitations and travelling to functions in two vehicles. If the spouse/partner wishes to attend a commitment outside the house, babysitters may be needed on an on call basis or the spouse is called home if the GP is called out. Not taking risks can lead to some frustration when tasks are left undone and no calls occurred.

Being called refers to a patient or hospital contacting the GP. Some calls can be dealt with on the phone and some require the GP to visit the patient. GP's talk of "good or quiet nights" and "bad or busy nights" referring to the family and sleep interruptions including the hours away from family.

The number of female GPs is increasing, however with demanding work commitments and child rearing, lifestyle issues are more important and many chose not to participate in an after hours roster.

The provision of constant access to medical services is compounded when rural GP's wish to take leave. Even for short periods of time. The traditional method for providing "cover" has been to employ a locum GP. The shortage of locums is well documented, especially those with expertise and skills required for rural practice (Wilde, Maclsaac Snowdon undated). Rural GP's tell of situations of paying for a locum to "sit in the town" so that they can have a long weekend away just in case a GP is needed. The very nature of after-hours is unpredictable.

The role of a rural GP is highly demanding, strenuous and potentially stressful. From a GPs' perspective, providing their own after hours care can lead to fatigue, sleep deprivation, increased stress and disruption to their home life (Cragg et al., 1994; Livingstone et al., 1989; Dale et al., 1996; Hallam, 1994; Pitts & Whitby, 1990; Foster et al., 1996). In a UK study, GPs describe out of hours work as being "the most important stress in their professional lives" (Dale et al., 1996). Clearly the commitment to Rural General Practice can be a significant burden, be time consuming and impact on both professional and personal life and can decrease both quality of care and job satisfaction.

A recruitment and retention project undertaken by the West Vic Division of General Practice found that there were four main reasons GPs left the region. These related to local hospital conflicts, on-call difficulties, poor after-hours remuneration and secondary schooling for children (Maclsaac, et al., undated).

"Left the area due to reduce after-hours demands, especially casualty calls which were poorly remunerated and source of conflict."

Despite a complex array of issues, there is an obligation to provide a level of after hours care, but more importantly rural Australians have a right to a quality, assessable after hours service.

Introduction: Nurse Telephone Triage After Hours Service

There are a variety of after hour service provision models currently in place in Australia and overseas. These models include GPs on call, GP cooperatives, GPs in emergency departments, GP extend hour practices, deputising services, rural hospital models and telephone triage services. There is also considerable debate around these models as to which model provides the best after hours care in terms of sustainability, community acceptance, workforce, GP satisfaction and financial viability. The West Vic Division of General Practice has trialed the Nurse Telephone Triage model and believes it can be replicated throughout rural Australia. The model is essentially a Telephone Triage model, although components of other models are also present.

Telephone Triage is the practice of conducting a verbal interview to assess a patient's health status and to offer recommendations and/or advice for treatment and referral (Department of Human Service, 2001). Telephone advice has been identified as a valid form of primary care service provision (Karabatsos, 1999). In Australia providing telephone advice to patients is seen as a normal component of General Practice. GPs however do not encourage this practice as it impacts on their lifestyles and there is currently no remuneration for such activity.

The Grampians After Hours Primary Medical Care Trial has received anecdotal information that the provision of telephone advice is not unusual to GPs in Australia and that they respect the supervising nurses with whom they work. They view nurse triage as advantageous in providing a quality after hours service that involves the GP but with reduced calls.

The model also has a component of the co-operative after hours model, a common arrangement in rural areas, with most GPs in the trial regions sharing the after hours roster. The General Practice Profile study found that the use of co-operative rosters varied according to rurality, with rosters participated in by 52% of major rural, 39% of other rural, 17% of remote and 11% of metropolitan practices (Campbell, 1997).

How does the Grampians Nurse Telephone Triage Service work?

The Grampians (West Vic Division of General Practices) model of nurse telephone triage involves GPs switching their practice phones through to a dedicated 1800 after hours telephone number. When a patient calls a practice after hours the call is automatically diverted to a trained telephone triage nurse located in a rural hospital. The nurse takes the patient details and via a set of agreed evidence based protocols, assesses whether the patient requires nursing advice and reassurance, a medical appointment the next day, advice/treatment from the doctor on call or emergency care. It is important to note that the Telephone Triage Nurse does not make a diagnosis over the phone.

The telephone system permits calls to be transferred from the telephone triage nurse to the on call doctor in the appropriate area for the patient or for the nurse to put the patient on hold, speak to the doctor and then relay the doctor's advice to the patient. Should a patient require assessment they are directed to their local hospital. Diagram 1 outlines, this process. The remainder of this document will focus on the critical steps and components required to implement a successful telephone nurse triage after hours service.

The primary objective of the Nurse Telephone Triage Model presented in this kit is to offer the community an after hours service that is confidential, reliable and a consistent source of professional advice on health care.

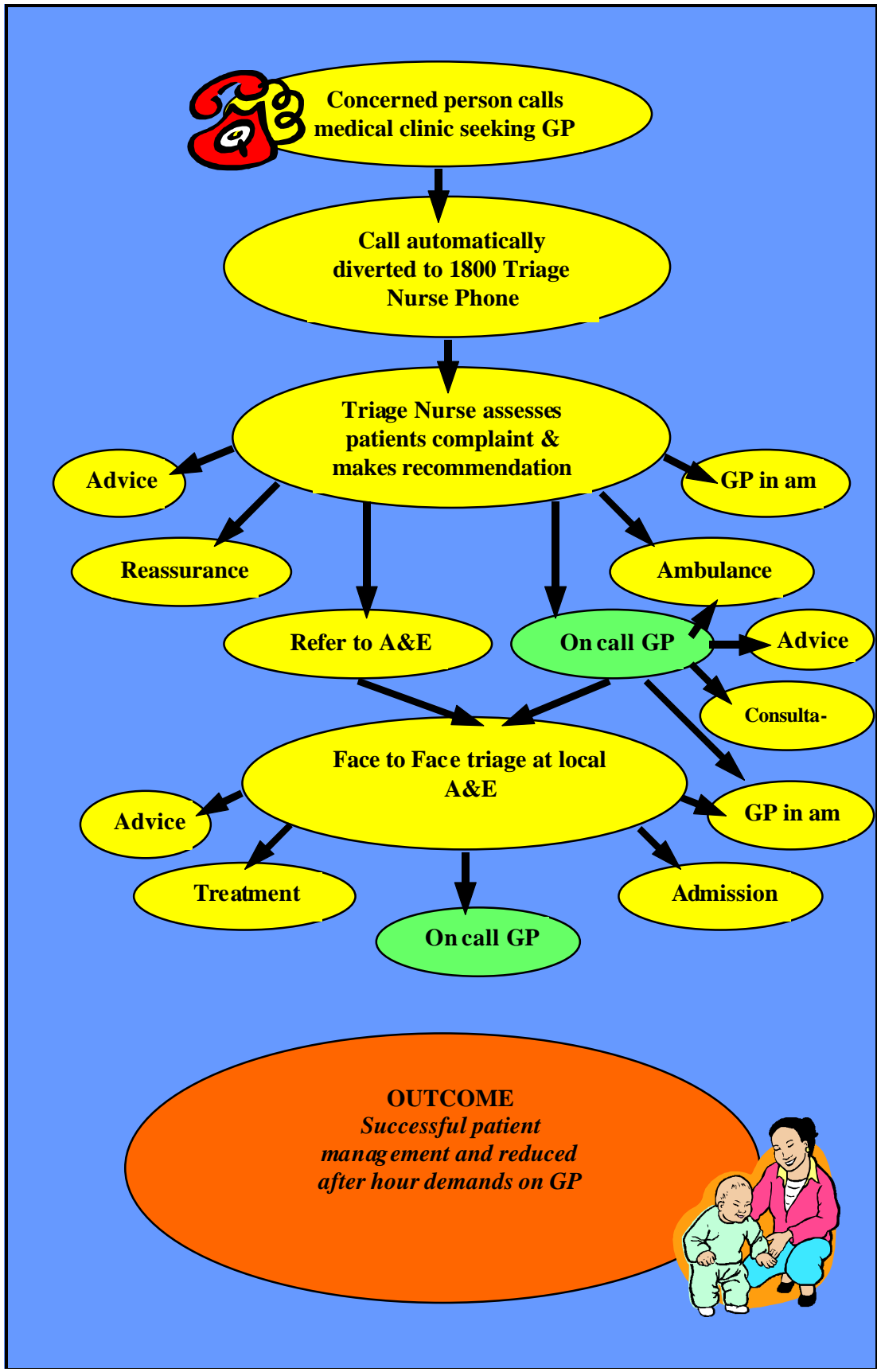


Diagram 1: Telephone triage process

The Need For An After Hours Service

General Practitioners (GPs) are often phoned after hours for both serious and non-serious matters. Whilst GPs acknowledge the need to be contacted for serious matters, non-serious matters can be largely dealt with by suitably qualified nurses and therefore reduce the workload on GPs. As outlined in earlier sections GPs have significant demands both in and out of normal business hours that influence both their professional and personal lives.

In order to support GPs in small communities, hospitals especially emergency departments and supervising nurses have responded to community need as a means of protecting their GPs from overwork and retaining them in the community. Whilst it is acknowledged that GPs and hospitals often have established patterns for covering after hour demands, there are a number of positive and valid reasons for conducting telephone triage.

From a GP perspective Nurse Telephone Triage:

- Reduces work demands placed on GPs
- Aids in the retention of GPs. As reported in *General Practice in Australia (2000)* the areas of general practice mainly experiencing shortages are those with the less attractive working hours (ie. after-hours and weekend shifts in metropolitan areas, for which the level of remuneration is also considered to be inadequate compared with rates charged by tradespeople in service industries, and the potential personal dangers of which were highlighted by the murders in 1998 and 1999 of GPs providing night-time house calls. Also higher average weekly working hours for rural and remote GPs, with most continually on call after hours and on weekends); and
- Is an excellent marketing tool for recruitment of GPs
- Reduces GP fatigue
- Reduces the potential risk of medical error

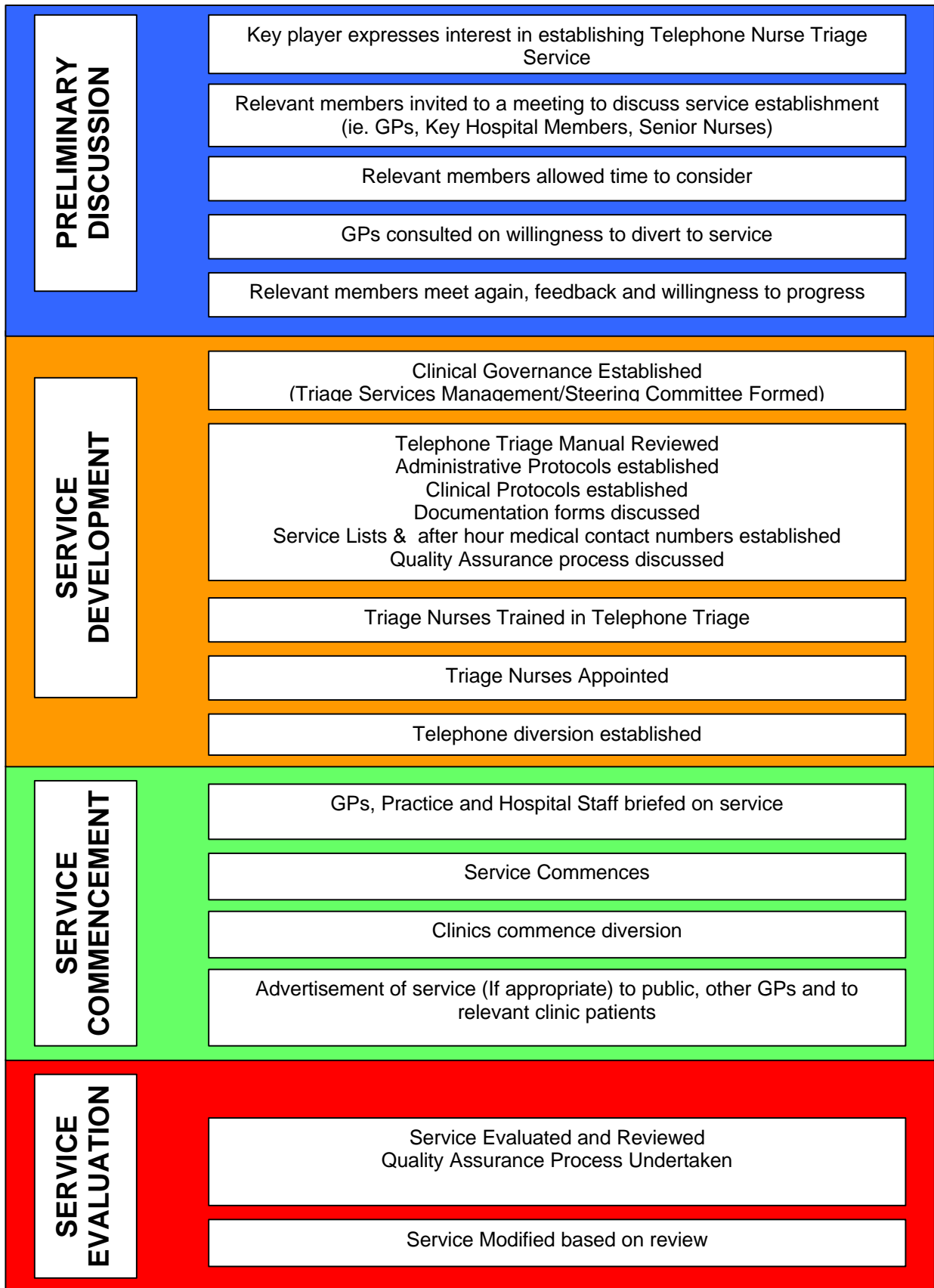
From a hospital perspective Nurse Telephone Triage:

- Assists with reducing the numbers of inappropriate A&E presentations
- Recognises that rural hospitals are often perceived by the community as a 24 hours community service, this supports hospitals in one of the roles
- Formalises supports to GPs
- Supports nursing staff, recognises their skills, experience and capabilities.
- Recognises the role nurses take while giving out phone advice (one they have often taken for many years)
- Recognises telephone triage as an expanded and different nursing role.
- Ensures nurses follow administrative and clinical protocols when giving advice and are adequately educated to do so.
- Ensures quality assurance processes are followed.
- Ensures better documentation and relay of information when patients are referred to hospital for further assessment or to their GP for follow-up the next day.

From a consumer perspective Nurse Telephone Triage:

- Provides a confidential and reliable source of health care advice after hours
- Provides prompt access to health advice
- Provides a non threatening service
- Provides advice, when travelling to a doctor or hospital may involve long distances or difficulties for a variety of reasons
- Provides a service whereby the consumer is not disturbing a sleeping health professional
- Assists the growing elderly population in rural areas
- Assists those discharged from hospital under the shortened hospital stay policy
- Assists the maternal and child population who often seek care

How to Commence



Governance

Clinical Governance is as important in the delivery of this service as it is in any other health care setting and/or service. Clinical Governance is a framework, which assists all clinicians to continuously improve quality and safeguard standards of care. The overall aim of clinical governance is to establish a culture, system and ways of working to ensure quality of care.

A simplified framework of Clinical Governance can be categorised into the following key areas:

- Systems for accountability and responsibility
- Contractual agreements
- Quality improvement and assurance

The Clinical Governance framework for Nurse Triage Services will be outlined in relationship to these categories

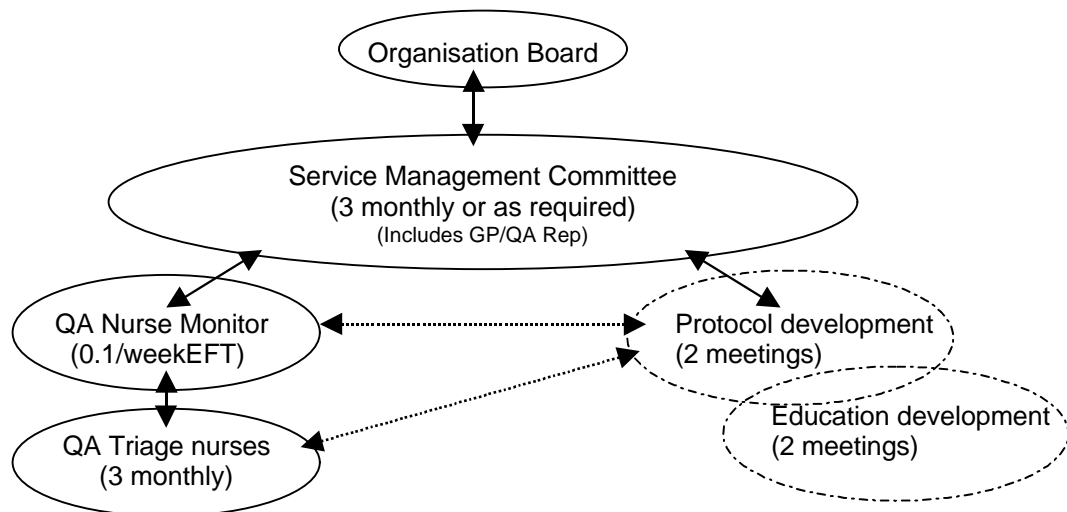
Systems for accountability and responsibility (Committee Structure and Terms¹)

All program/projects should have a system or structure that outlines accountability and responsibility. This requires the establishment of committees comprising of key representatives with specific roles.

It should be recognised that committee requirements vary over the life of a program. Initially the emphasis is developmental, identifying the key requirements for testing and designing a model that meets the needs of key stakeholders. Thereafter an implementation phase evolves in which the main emphasis is on the 'doing' of the project, identifying the successful and core elements and codifying these. The third or mature phase centres on the monitoring of ongoing provision of a successful service to ensure consistent quality outcomes.

Consequently, it is expected that the roles that committee members will undertake will change in line with service requirements at any given time, and the organizations overall need for flexibility and adaptability. For the purposes of an After Hours Nurse Triage Service we will outline a proposed structure.

Committee structure



¹ Modified from Central Bayside Division of General Practice Knowledge Management Project

The generic role and accountability requirements of different committee types can be outlined as follows:

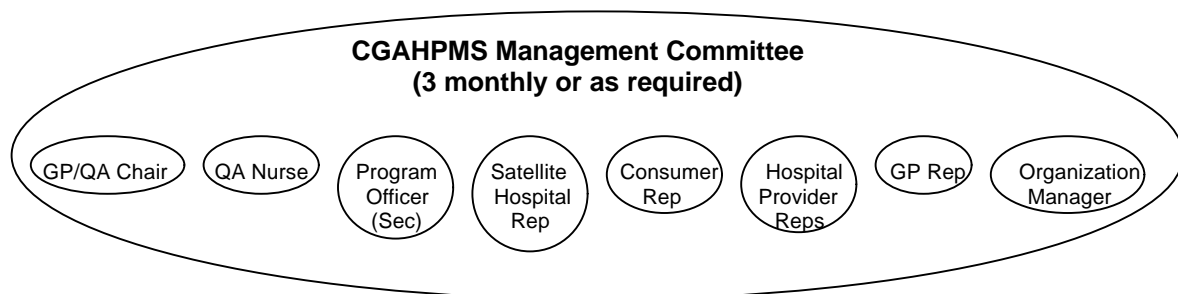
Organisation Board

The Organisation Board is:

- Responsible for the delivery of the service in accordance with the funding agreement.
- Responsible for the delivery of the service in accordance with relevant Federal, State, and Local Government laws and regulations.
- Responsible for service expenditure within budget targets, and the accountability for funds.
- Available to deal with any issues and problems as they arise, and provide necessary support and assistance.

Under the Central Grampians After Hours Trial this functions as the Board of Management of the West Vic Division of General Practice.

After Hours Medical Service Committee



The After Hours Medical Service Management Committee is expected to:

- Manage the service in accordance with stated objectives, and in a manner that is consistent with the Organisations Mission Statement and Strategic Goals.
- Manage the service in line with any funding agreements signed by the Organisation, and ensure that the conditions of any such agreements are followed.
- Ensure that the service expenditure is within budget targets, and that funds are properly accounted for.
- Ensure that the service operates in accordance with relevant Federal, State, and Local Government laws and regulations.
- Ensure that the service operates in line with the outlined goals and objectives of the service
- Determine, as required service policies.

- Ensure that agreed service tasks are undertaken in an effective and responsible manner.
- Ensure that the service objectives are delivered ethically and safely.
- Ensure that the best and most appropriate human resources are recruited, selected, and allocated in support of achieving the service outcomes.
- Ensure that external representatives, such as satellite hospitals and consumers for example, are appropriately utilised as valuable resources in support of the service goals and objectives.
- Deal with any issues and problems as they arise, and provide necessary support and assistance.
- Coordinate problem-solving and planning processes and functions.
- Organise, plan, and monitor the services implementation.
- Determine if sub-committees and/or adhoc are needed, and establish them where necessary.
- Coordinate and monitor sub-committee and/or adhoc groups activities.
- Appoint representatives to external forums and groups relevant to the service goals, objectives, and activities.
- Record and/or document all relevant activities, events, developments, and decisions, etc.
- Advise the Organisation Board on priorities and implementation strategies.
- Advise on service policy and strategic planning issues.
- Draw on the expertise of committee members and other external sources for advice and recommendations.
- Review reports and recommendations of sub-committees, adhoc committees or program staff, in particular relating to quality assurance issues and protocol development.
- Act as sounding boards for proposals and ideas.
- Record and/or document all relevant activities, events, developments, and decisions, etc.
- Act as a promotional voice for the service to Commonwealth representatives, other GPs, hospitals and Divisions.
- Report to the Organisation Board of Management through the GP representative who will be both a participant in the project and on the Organisation Board.

GP QA Representative

The GP QA Representative who is a member of the overall committee will also

- Assist in the design and review of triage records for quality assurance process.
- Provide practical directions for implementing change in triage recommendations or protocols as required.

- Supervise and consult regularly with the QA Nurse monitor around protocol usage.
- Recommend, and/or endorse additional protocol development as required.
- Monitor, assess, and evaluate implementation processes and results.
- Act as a link where necessary between the telephone triage nurses and the Service Management Committee.
- Report to the Organisation Board.

Consumer Representative

The inclusion of a community representative into the after hours project is a way of engaging the community in identifying ways to improve health outcomes. Community consultation has the advantages of :

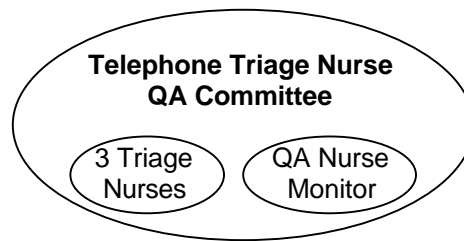
- ◆ Ensuring services are more aware of and responsive to consumer demand.
- ◆ Ensuring service providers are accountable for the services offered,
- ◆ Provide consumers with necessary information to make informed decisions
- ◆ Contribute to a broadening of the definition of health
- ◆ Improve health outcomes through consumer empowerment

Specifically the consumer representative must present to the steering committee the feelings and attitudes of the population being serviced in relation to the after hours services being provided in the area. It is important to have a consumer representative at the strategic end that also understands issues around privacy and confidentiality.

Further the consumer representative must provide a brief activity report on their activities and the extent to which service arrangements have contributed to improved regional after hours services. These reports must be forwarded to the service manager. Specifically these reports could include:

- ◆ Number of committee meetings attended.
- ◆ Broader community activities and liaison, in which it may be possible to have heard consumer points of view in relation to the afterhours service.
- ◆ What consumer's views or concerns are in relation to afterhours services.
- ◆ Fears or expectations of the community in relation to afterhours services.
- ◆ Possible resolution to areas of concern, or why it is not possible to have then resolved.
- ◆ Consumers ability to access after hours services, the reliability, the responsiveness and the courtesy of the services.

Telephone Triage Nurse QA Committee



- Systematically review approximately 25% of triage records and triage process every 3 months for quality assurance processes.
- Establish if triage protocols are being followed.
- Provide practical directions for implementing change in triage recommendations or protocols as required.
- Recommend additional protocol development or training as required.
- Actively monitor, assess, and evaluate implementation processes and results.
- Record and/or document all relevant activities, events, developments, and decisions, etc.
- Attend committee meetings

QA Nurse Monitor

- Systematically review triage records and triage process monthly for quality assurance processes.
- Establish if triage protocols are being followed.
- Provide practical directions for implementing change in triage recommendations or protocols as required.
- Actively assist those affected by implemented changes to learn how to make the adjustments that are necessary to their triage decision making process.
- Recommend additional protocol development as required.
- Actively monitor, assess, and evaluate implementation processes and results.
- Record and/or document all relevant activities, events, developments, and decisions, etc.
- Act as a representative for telephone triage nurses to the Service Management Committee.

Special/Ad Hoc Sub-committees

In order to develop and implement the program specially assembled, expert, short-term committees may need to be established. These committees may be needed as these areas are complex and require more thought, inquiry, or experimentation to resolve.

For example, in order to advance the Central Grampians After Hours Trial it has been necessary to establish protocol and educational sub committees.

These special or ad hoc sub committees will therefore be expected to:

- Systematically identify or clarify the nature of the issue(s) in question using recognised research methodologies and techniques.
- Actively search for knowledge, information, expertise, and other internal or external resources as required for advice, insight, and guidance in addressing the issue(s) in question.
- Develop possible solution options.
- Identify and evaluate the potential, or actual, impact(s) of solution options on other aspects of the service, or organisational system(s) that are implicated, and make adjustments or modifications where necessary.
- Report back to the relevant oversight committee.
- Record and/or document all relevant activities, events, developments, and decisions, etc.

Contractual agreements between service providers

It is recommended that those involved in the after hours service provision should enter into service delivery contracts. Contracts should be developed for the Telephone Triage Nurses, General Practitioners, Medical Clinics and the Service Delivery Organisation.

Telephone Triage Nurse contracts should include details relating to the requirement to meet shift times, that administrative and clinical protocols are used and that quality assurance processes are undertaken.

The General Practitioner contract should include details indicating that the GP must be contactable at all times after hours should they be on call. Further, the contract should indicate that they must be willing to take calls from the telephone triage nurse.

Medical Clinic contracts are required to ensure that they agree to transfer the calls to and from the service at the dedicated times and to inform the telephone triage nurse of the GP on call.

Service Delivery Organisations should also have a contract to supply the telephone triage nurse with an adequate working environment (dedicated space and computer) and professional support. The Service Delivery Organisation should also have a contract indicating that they will deliver a service in line with the aims and objectives of the service.

Quality Assurance and Quality Improvement

Quality Assurance leads to improvement in service delivery in updating clinical and administrative protocols and policies. These improvements can then be measured through the assurance process, which leads to further refinement and improvement.

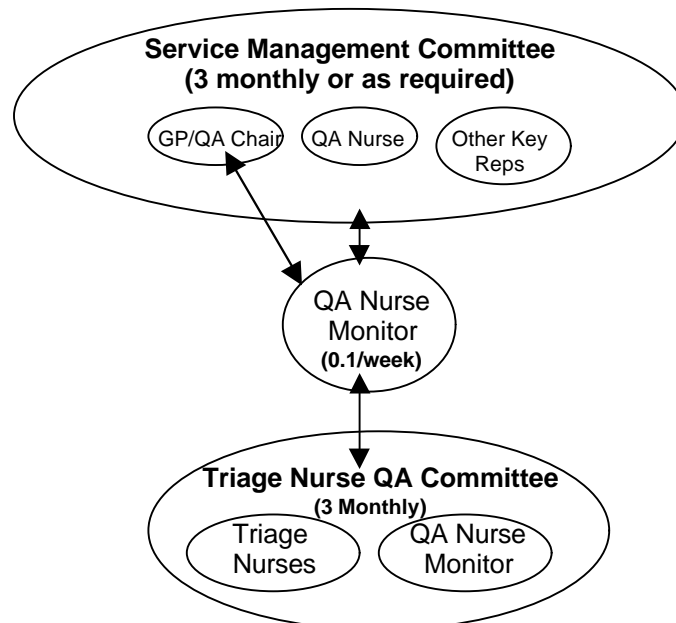
Nurse telephone triage is a function of the nursing process, which involves assessment, and the formulation of a plan of intervention. As Wheeler (1992) indicates the standards of safe, effective and appropriate care applicable to nursing practice in general, apply to telephone triage.

Experts stress three procedures to help protect telephone triage nurses from legal liability: use of protocols, documentation of calls, and quality assurance checks ([Dunn, 1985; McGear & Simms, 1988; Scott & Packard, 1990; Tennenhouse, 1991; Wood, 1986] cited in Wheeler, 1992)

Quality Assurance is therefore a critical component to be covered and included in implementation and continuation of a nurse triage service.

The proposed Quality Assurance Committee structure and processes are recommended. Processes include: telephone triage record quality review processes, maintenance of clinical and administrative protocols, training for new telephone triage nurses, documentation of continued training, meetings, customer surveys.

Quality Assurance - Committee structure



How this structure works

The QA Nurse Monitor will systematically review a sample of records as per the quality assurance process. The QA Nurse Monitor will establish if triage protocols are being followed and ascertain the level of variance from protocols or any issues of clinical concern.

Further, the QA Nurse Monitor will feedback to telephone triage nurses through the Nurse Triage QA Committee held every three months. The QA Nurse Monitor will provide practical directions for implementing change in triage recommendations or protocols as required and actively assist those affected by implemented changes to learn how to make the adjustments that are necessary

to their triage decision making process. This committee also provides the opportunity for telephone triage nurses to seek protocol development and/or review.

The QA Nurse Monitor will act as a representative for telephone triage nurses on the Service Management Committee. Within the Service Management Committee will be a dedicated QA GP who will supervise and consult regularly with the QA nurse monitor around protocol use, refinement and development. The process functions in a top down, bottom up approach, thereby providing recommendations to the telephone triage nurse QA Committee, nurse process representative and in turn discuss recommendations made from these players to the QA GP. Should it be deemed that a protocol is required or needs review, the QA GP will have the power to implement changes between scheduled meetings. Should a QA issue be deemed very serious it may be feed back into the hospital QA Committee for further discussion and resolution.

Telephone Triage Record Quality Assurance Processes

The detection of potential adverse events or new protocol requirements involve a number of approaches to ensure a number of events have been identified. Approaches include detection by triage record review, clinical incident reporting, General Practitioner reporting and patient satisfaction (see Diagram 2).

Telephone triage record review

A 25% sample of all telephone triage records and records of patients who have called the service more than once per night will be reviewed monthly by the QA Nurse Monitor. The QA Nurse Monitor will complete a quality assurance review form for discussion with Telephone Triage Nurses at the Nurse Triage QA Committee meetings held every 3 months (See Appendix 1). The review will assess if protocols are being followed and ascertain the level of adverse event potential.

The QA Nurse Monitor will provide practical directions for implementing change in triage recommendations or protocols as required and actively assist those affected by implemented changes to learn how to make the adjustments that are necessary to their triage decision making process.

Should review deem concern or the need for protocol development the Triage QA Monitor Nurse will present the forms for review and discussion to the GP QA Representative as required.

Should a serious problem arise, which requires immediate action, the QA Monitor Nurse and GP/QA Representative can work towards resolution.

It is recommended that the working sheets (Appendix 1) are kept until the report is presented at the regular Nurse Triage QA Committee meetings and/or as necessary the Service Management Committee meetings in case findings are challenged. After the report has been presented the working sheets can be destroyed or maintained in a locked filing cabinet. All photocopies of documentation forms required for quality assurance process can also be shredded to ensure strict confidentiality.

Clinical incident reporting

Telephone Triage Nurses should be educated about the clinical review / quality assurance process and encouraged to report areas of potential concern that require discussion and/or protocol development or for which other telephone triage nurses can learn from in a non punitive environment. In this case a clinical event can be defined as any event that has harmed or has the potential to harm a patient, any event which does not have a sufficient protocol and any event that may lead to a patient complaint.

Telephone triage nurses can request that records are reviewed by ticking the review section at the end of the triage record (See Appendix 2). The triage record also allows space to write additional comments around reason for review.

An additional request form has also been developed (See Appendix 3) which allows telephone triage nurses to anonymously report a clinical incident relating to a record or concern around the potential for an adverse event to occur in a situation which is not related to a specific record. Such requests will be raised at Telephone Triage Nurse QA Committee Meetings.

General Practitioner reporting

As quality issues and/or patient concerns may be recognised by General Practitioners, a quality reporting form has been developed for General Practitioners, not the QA/GP to detail their concerns around any patients management through nurse triage (See Appendix 4). These forms are to be forwarded to the QA Nurse Monitor to be raised with the Telephone Triage Nurse Committee and GP QA Committee where deemed necessary. Previously discussed actions can be implemented. The QA Nurse Monitor will also need to make a formal response to the concerned GP outlining the action taken

Patient satisfaction

A formal patient complaint process is an essential part of a service. A complaint can either be in writing or verbal and forwarded to the service, their regular GP or the service provider hospital. Complaints are referred to the appropriate committee and where possible resolved at that level to the satisfaction of the complainant. Consumer concerns will be, where relevant, feed back to local hospitals and/or clinics. Consumers will also be sent a formal letter from the service, acknowledging the complaint and indicating the action taken regarding their complaint.

Potential event analysis and action

When it has been determined that the potential for a adverse event is high and or that there is a need for a new protocol the following actions can be taken:

- Review / Modify / Develop Clinical Protocols (within 3 months and endorsed by GP/QA Representative and/or Service Management Committee)
- Review / Modify / Develop Administrative Protocols (within 3 months and endorsed by GP/QA Representative and/or Service Management Committee)
- Discussion with staff involved (QA Monitoring Nurse to follow up with triage staff immediately)
- Education (Minimum 3 monthly, QA Triage Monitor Nurse)
- Increase in supervision of new staff (QA Monitor Nurse and/or Experienced Telephone Triage Nurses)
- Regular feedback to telephone triage nurses about events and the results of actions taken. (QA Monitoring Telephone Triage Nurses, minimum of every three months)

Clinical and Administrative Protocol Maintenance

As a result of the Telephone Triage Record Quality Assurance Process amendments may be required to the Clinical and Administrative Protocols. Amendments must be recognised and accepted by the QA Nurse Committee and the GP/QA Representative before being implemented. All amendments should also be reported to the Steering Management Committee. Amendments do not require initial endorsement by the Steering Management Committee due to timelines for meetings.

Should locally developed protocols be based on a published source, they should be updated as the published source is. Regardless, Protocols should be completely reviewed every 2 years or earlier if deemed clinically appropriate.

All changes should be documented and maintained for 25 years. Documentation needs to be kept for this time as Telephone Triage often relates to children.

Training Program

All telephone triage nurses need to undertake specialised training to undertake their role.

The Grampians After Hours Trial accessed training through the Collaborative Health, Education and Research Centre, Bendigo, Victoria.

Telephone Triage Nurses need to demonstrate competencies before they start handling calls. New Telephone Triage Nurses should also spend at least one week with an experienced Telephone Triage Nurse before working individually.

Continuing Education and Documentation

Regular education sessions combined with QA Nurse Committee Meetings or in isolation should be undertaken by Telephone Triage Nurses. Educational activities can include revision on protocol use, revision on documentation or relate to specific call handling. For example, depressed patients or other areas of concern or for which there has been a recent local outbreak i.e. Chicken pox.

Each Telephone Triage Nurse along with the service delivery organisation should maintain record of education sessions attended.

Meetings

Telephone Triage Nurses are required to attend regular Telephone Triage Nurse QA Meetings and other meetings as required in order to maintain and improve the quality of the service delivered. Minutes of the meetings should be maintained.

Customer Surveys

A customer survey should be conducted annually. It is recommended that 10% of patients are randomly selected for involvement. It is also recommended that General Practitioners who access the services are also surveyed annually.

Both surveys should aim to determine acceptance and satisfaction of the service, along with aspects requiring improvement. Hard copies of survey reports need to be kept for 5 years.

Storage of Quality Documentation

The following quality assurance documents should be stored for a minimum of 25 years from the date of approval or updating either in hard copy, on disk or electronically.

Records of complaint

Telephone Triage Record Book

Meeting Minutes

Clinical and Administrative Protocols

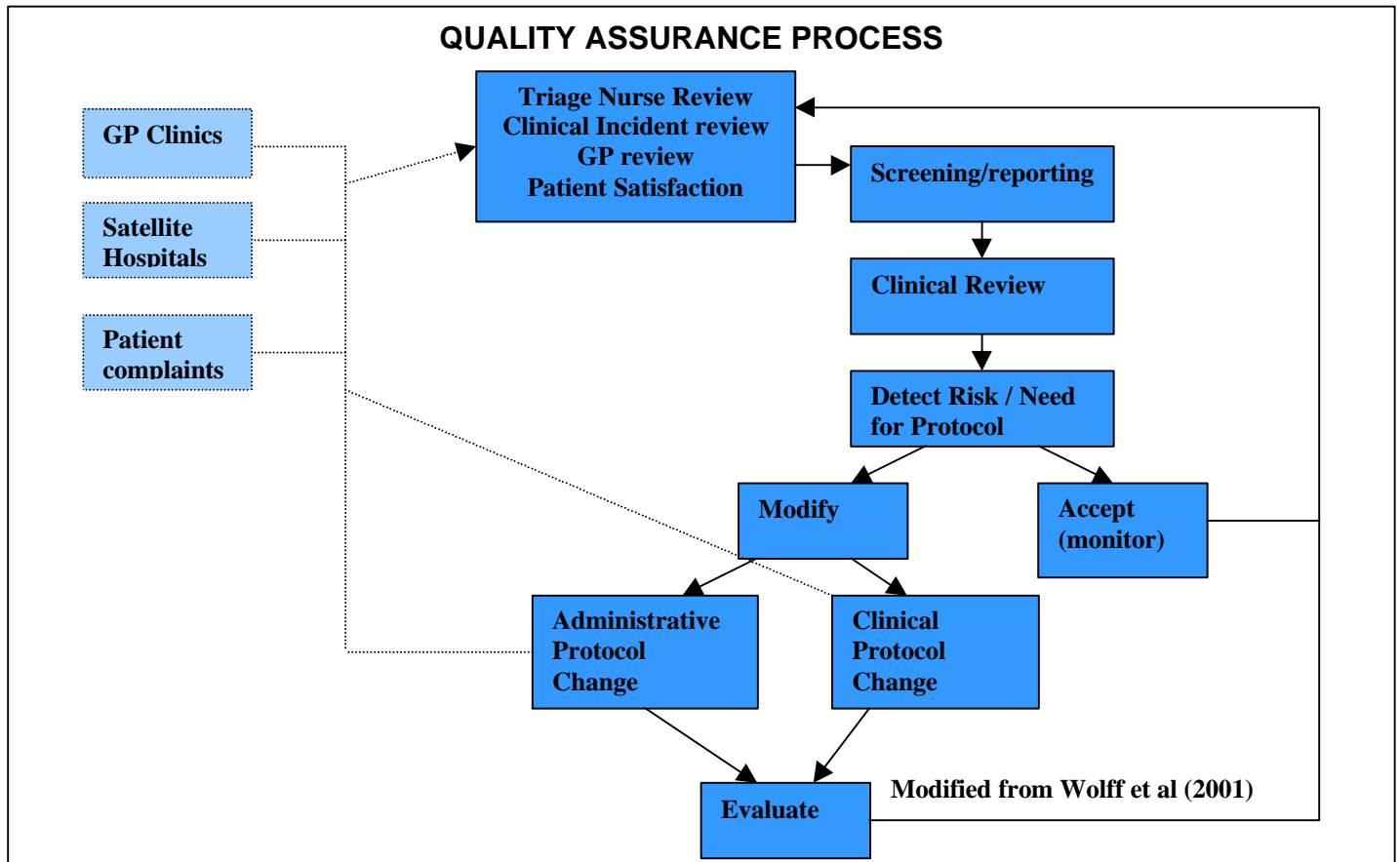


Diagram 2: Quality Assurance Process

Complaint Processes

A formal complaint process must be established as part of the service. As outlined in the Quality Improvement Process there is the opportunity for GPs involved in the service to complete review forms and feed these back to the QA Triage Monitor Nurse and the QA/GP representative for action.

Consumers may feed complaints through their local GP who should in turn complete the review form. Should there be any complaints regarding the service, they can also be directly reported to the service provider in the format required by the provider (ie. hospital process) to be managed appropriately. Consumers can also contact the Ombudsman or the Health Services Commissioner, Complaints & Information (Melbourne - Ph: (03) 8601 5200 Or 1800 136 066)

The complaint process should also be outlined on advertising material and supplied to the Medical Practices.

Funding Options

In order to establish a sustainable telephone triage service the service delivery organisation and participating organisations need to assess budgetary needs both in terms of initial implementation and sustainability costs. Budgets need to include payments to the telephone triage nurse (recommended Div 1 and loading), key stakeholder payments for time and resource gathering and infrastructure costs.

Sources of funding can vary from service to service. However, the following options in isolation or in combination may be suitable.

Fee for service

General Practitioners currently receive a Practice Incentive Program (PIP) payment. The PIP aims to recognise general practices that provide comprehensive, quality care, and which are working towards meeting the Royal Australian College of General Practitioners Entry Standards for General Practices. The after hours PIP payment was initially introduced to compensate for the limitations of the current fee-for-service arrangements after hours. GPs who become involved in the After Hours Nurse Triage Service may be willing or required to contribute a proportion of their PIP payment or other funding to facilitate the service. The limitation of this approach in a rural area is the GP will still remain on call to attend to cases which the telephone triage nurses have deemed require GP consultation.

State Government Financing

Whilst obtaining specific funding through a state government for the facilitation of a Nurse Triage Service may be difficult, it should be remembered that the State Government funds group a and b hospitals for A&E attendances. Other group hospital need to submit data to obtain funding for A&E attendances. In rural areas the hospitals have VMOs who are also the local GPs. Thus an allowance is provided to cover the hospital and GP after hours. Discussions are required at the State level regarding allocation of this or part of this funding towards a Nurse Triage Services.

Private Financing

In a similar way to Deputising Services funding arrangements it may be appropriate to implement a call cost (ie. for the phone diversion), charge referring GPs with a subscription fee or gain support from private medical related companies.

Hospital in-kind support

Many hospitals in rural regions currently provide a degree of nurse triaging in order to retain their local GPs. It may be that this in-kind support continues, but that this process becomes more formalised.

Commonwealth funding

A further option for developing a telephone triage nurse service is to seek a Commonwealth Government seeding or development grant.

Phone Diversion Processes and Telephone Issues

The Telephone Triage Model presented functions by clinics diverting their phones to a 1800 number, to be answered by a telephone triage nurse.

Clinic phones and other phones as required can be diverted to a 1800 number or any other number either directly from the handset or remotely. In the West Vic Division the Telstra Corporation serviced the majority of medical clinics and therefore the information presented is based on features available through this service provider. Each phone provider functions independently, therefore functions will relate to those available through this service, should a different service provider be used, it is recommended that you consult the sales representative and seek a similar service.

The following information was correct as of 30th December 2001.

Establishing a 1800 number

Freecall 1800 - allows callers to ring the triage service free of charge. You can nominate where calls are answered based on the call origin, time or day, and overflow calls to alternative locations. Charges for the service and calls are billed to the service telephone account. The cost to purchase a Freecall 1800 service includes an initial connection fee, rental charge plus call costs. To establish a Freecall 1800 number contact your Telstra Account Representative or call 13 1191

Diverting the clinic phone

Call Forward has the ability to transfers calls to the 1800 triage line or to another phone as required. This allows the practice to control when the call forwarding is turned on and off. There are no monthly charges. With Call Forward, you simply pay for any forwarded calls at the applicable rates. Phones can be directly diverted by picking up the practice phone and dialing *21 (the number to be diverted to) #21. Whilst this will be successful you cannot remotely re-divert or change diversion (i.e. if at the home, you cannot remotely re-divert the clinics phone). This may be an issue for Saturday and Sunday diversion.

Remote Access allows you to activate or change your diversion, from an external location. To establish remote access send a fax to 1800 814 240 (fax management easy call remote access) or call 1800 652 422 seeking connection and confirmation. Current and diversion phone numbers will be required. You will then be sent a phone number and pin to access remote diversion. Remote Access is available from tone phones anywhere in Australia. At the time of publishing this kit, Remote Access costs \$2.20 incl.GST* per month, plus call charges to your Remote Access Number at applicable rates. To order this product call Telstra on 132200.

Diverting 1800 number to varies locations

The 1800 phone number can be diverted to different locations (ie. if triage nurses are in different sites on different nights) using the Freecall 1800 feature. Freecall 1800 - allows you to nominate where calls are answered based on the call origin, time or day, and overflow calls to alternative locations. Charges for the service and calls are billed to your Telstra account. The West Vic Division found this service only to be useful if the triage nurses were working a set non-rotating roster.

If a rotating triage roster was in place, it is recommended to use the In-Control feature. This feature allows the customer (the service manager or triage nurse) to access, update and modify

where the 1800 number is directed via their own internet. Confirmation can be received on service changes and call traffic statistics obtained.

Overcoming Problems

Should the clinic have an extremely old Commander System the ability to divert calls may be limited. It is therefore recommended that you contact your local telephone technician when establishing diversion process. Alternatively it may be advantages to contact your nearest Telstra Country Wide or alternative service sales representative.

It is beneficial that once the clinic line is diverted that the clinic receptionists using an additional line and checks the diversion.

When establishing the Triage Service, telecommunication issues can be very time consuming and complex, it is therefore recommended that you consult your local telephone technician at the commencement of service establishment.

Rural Telephone Triage Training and Experience

Whilst it is acknowledged that those undertaking the role of a Telephone Triage Nurse may vary in terms of accident and emergency experience and related educational activities it is critical that all Telephone Triage Nurses complete specific training in the telephone triage.

Telephone triage training for the nurse must encompass instruction on how to:

- structure and frame a telephone encounter,
- use protocols to assist with decision making,
- function safely
- effectively triage
- document
- use and access resources unique to telephone triage

The philosophy underpinning the role of even a specifically trained telephone triage nurse is that an experienced emergency nurse undertakes the role. Telephone triage is a nursing function based on the nursing process (Scott & Packard, 1990; McGear & Simms, 1988 in Wheeler, 1993). This process involves assessment, diagnosis, formulating a plan, intervention, and evaluation (Wheeler, 1993). The use of protocols may be invaluable to assist with organised decision making or to structure and frame a telephone encounter but a framework of knowledge and experience must underpin these protocols. In this regard it may be appropriate to clinically assess those wishing to undertake the role in addition to work experience.

Once telephone triage nurses have been educated it is recommended that they receive ongoing training in identified areas of need (ie. dealing with depressed people) and continue to be offered clinical upskilling in the area of accident and emergency and telephone triage.

The West Vic Division of General Practice, despite contacting a number of state and national organisations and Universities was unable to identify any specific accredited module of telephone triage training. The only training available was through the Collaborative Health, Education and Research Centre in Bendigo, Victoria. The West Vic Division of General Practice is facilitating the development of the training into an accredited module, accessible to all appropriately qualified nurses across Australia through distance education.

For information relating to the course available by the Collaborative Health, Education and Research Centre refer to appendix 5.

Telephone Triage Protocols

Nurse telephone triage protocols are the core of telephone triage function. Protocols assist telephone triage nurses in asking appropriate questions to quickly assess the severity of a problem and to help the caller make an informed health care decision concerning health service utilisation (Briggs, 2002).

Experts stress three procedures to help protect telephone triage nurses from legal liability: use of protocols, documentation of calls, and quality assurance checks (Dunn, 1985; McGear & Simms, 1988; Scott & Packard, 1990; Tennenhouse, 1991; Wood, 1986 in Wheeler, 1993). It has been established as a standard of care that access to approved protocols substantially reduces the risk in giving advice over the phone. Protocols provide a mechanism to address potentially serious conditions in a consistent manner when unable to see of the person (Briggs, 2002).

As indicated by Briggs (2002) nurses are not all equal in terms of education, knowledge base, assessment skills, and communication skills. Thus giving advice based on what the nurse “thinks” is inappropriate. Approved protocols help to ensure the assessment is thorough and the nothing significant is missed. Protocols are a sorting or prioritising tool designed to eliminate common practice errors (Wheeler, 1993).

There are a small number of specific telephone triage protocols available in both paper and computer form. Computersied protocols are beneficial for larger call centres with dedicated nurses based at a desk. Computerised protocols are also expensive. In this regard they do not suit a rural telephone triage model. Paper protocols are less expensive and have the ability to be carried by nurses who may be involved in other tasks around a hospital setting.

The development of protocols can be extremely labour intensive and thus the option of adapting existing books and protocols is a good idea rather than reinventing the wheel (Wheeler, 2002). In adapting protocols it is critical that they are locally relevant, have GP involvement and the involvement of the nurses who must use them.

Details around computerised protocols can be obtained through the WA Health Direct Managers based within the Health Department of the Western Australian Government and through an United Kingdom Company called the PLAIN SOFTWARE Company Limited, the basis for the NHS system. The most applicable paper based protocols identified have been those by Briggs (2002) and Wheeler (1997). The amazon website (<http://www.amazon.com>) is also beneficial in identifying sources of additional or new protocols.

The Grampians After Hours Service identified a range of paper based protocols and received feedback from both GPs involved in the service and the telephone triage nurses. As a result protocols developed by Briggs (2000) were accessed. The top 25 reasons that patients contact the service after hours were identified and these protocols were selected and modified from Briggs (2000) with both GP and telephone triage nurse input. Modification was necessary for local issues and as the protocols often referred to pharmaceutical items not available or referred to in the same terms in Australia. For an example of these protocols see Appendix 6.

These protocols are only to be used by nurses trained in telephone triage with a minimum of 6 months Accident and Emergency and 3 years post registration experience. It is further noted that the protocols do not replace skilled clinical judgement.

Triage documentation

Experts stress three procedures to help protect telephone triage nurses from legal liability: use of protocols, documentation of calls, and quality assurance checks (Dunn, 1985; McGear & Simms, 1988; Scott & Packard, 1990; Tennenhouse, 1991; Wood, 1986 in Wheeler, 1993).

Accurate documentation of calls and advice given increases defensibility should a legal case arise, as it augments memory and offers proof of advice (Scott & Packard, 1990; Daugrid & Spencer, 1988; Dunn, 1985, McGear & Simms, 1988; Willett, 1977; Wood, 1986 in Wheeler, 1993).

A range of organisations and/or individuals have developed documentation forms.

Through experience and trialing, the Grampians After Hours Trial has found that the form found in Appendix 2 is sufficient to record triage call details.

It is required that each form be uniquely sequentially numbered. This ensures that records cannot be removed. Further, it may be required that all organisations participating in this program sign off on the privacy agreement between themselves and other organisations involved in the program. With any quality activity it may be appropriate and recommended to establish this process as part of the organisations existing quality assurance processes.

Information kits for key players

It is essential that all key players involved in the provision of the service have relevant documentation presented to them in an easy to use kit form. These personalised kits should also be in a format that is easy to update as the service progresses or new administrative or clinical protocols are reviewed or developed. The following information outlines the key players who require kits and suggested contents.

Telephone Triage Nurse

Shelf referral kit

- Introductory information about the service
- Protocols for involvement (for an example see Appendix 7)
- Clinical Governance Processes (as outlined in this report)
- Quality Improvement Processes (as outlined in this report)
- Complete Triage Protocols (ie. book from which protocols have been extracted and locally modified)
- Service List (refer to section on service list requirements)
- Reporting form (proforma) (See appendix 2)
- Details on how to report or enter data into computer reporting database
- Coding reference (ie. ICPC-2, ICDC-10)
- Information on phone diversion processes

On hand kit for telephone triage nurses when undertaking telephone triage

- Minimum of top 20 protocols, including emergency crisis processes (for an example see Appendix 6)
- Service list
- Reporting forms

GP Kit

- Introductory information about the service
- Protocols for involvement (for an example see Appendix 7)
- How to commence details
- Telephone diversion information
- Summaries Quality Improvement Process with additional GP review request forms (as attached in Appendix 4)
- Top 20 or so protocols (Example, appendix 6)
- Contact details for service provider, telephone triage nurse, QA/GP representative

Medical Practice Kit

- Introductory information about the service
- Protocols for involvement (for an example see Appendix 7)
- How to commence details
- Telephone diversion information

Consumer information

- Flyer promoting service and how to access (for an example see Appendix 8)
- Potential to do regular media updates around common or seasonal medical issues to improve consumer knowledge
- Information relating to complaint process

Medico-Legal Issues

This document details and recognises the Australian Nursing Federation (ANF) policy on telephone advice.

ANF adopts policy on Telephone Advice

The ANF Council has adopted the following policy about the provision of health advice over the telephone.

Telephone Advice Line Policy

The Australian Nursing Federation (Vic. Branch) notes: -

- that Telephone Advice Lines are those which have been formally established and are specifically funded to provide staff and resources to provide telephone advice with regard to health issues.
- that Telephone Advice Lines should be established only where there is limited access to 24-hour health services. Telephone Advice Lines are intended to provide advice in situations where a client is seeking verbal advice on a health issue and/or how to access appropriate health services.
- that Telephone Advice Lines are not a substitute for presentation to an appropriate health professional for assessment and/or treatment but, rather, are for circumstances where a person is seeking guidance and has no other source of advice on a health related matter.

Where Registered Nurses (RNs) respond to any enquiries on Telephone Advice Lines, the following principles and processes are to be in place to protect both the client and the RN.

The Advice line must be formally established with: -

- clear lines of responsibility and accountability
- clear scope of practice
- a Minimum Data Set (MDS) including an accurate record:-
 - of the caller and for whom advice is being sought (child, self or other);
 - the problem as described by the caller and any advice given;
 - the time of call, and details of caller;
 - The data from the Telephone Advice Line should be secured (privacy provisions stated and complied with).

In addition: -

- Consent must be sought from the caller should there be a need to transmit the information to another health professional.
- Any referral must be recorded and the information collected passed on to that person as soon as possible (by fax or email).
- The name of the RN and a covering statement (or disclaimer) must be given to the caller that *if the caller has any concerns they should consult the relevant health professional as advice given is without physical assessment and is therefore limited.*
- Advice is to be based on evidence-based guidelines developed by a multi-disciplinary committee (utilising the NHMRC Guidelines process for the development of clinical practice guidelines).
- RNs providing advice must be given the appropriate education including that they must give advice within their scope of practice (legislative and the nursing profession's Codes of Ethics and Professional Conduct).

Advice guidelines (protocols) must be reviewed every 12 months or sooner if required.

Evaluation of the Telephone Advice Line must be carried out every 12 months and a formal report be written and made public.

RNs should **not** be giving telephone advice unless there is a specific agency policy on provision of telephone advice, which includes the following

- who can give advice (appropriately educated and within competence)
- what advice can be given (preferably utilising evidence-based guidelines)
- an accurate record of that advice is recorded including, where possible, for whom the advice is sought (child, self or other)
- the problem as described by the caller
- any advice given (including referrals)
- the time of call and details of caller and a disclaimer if the caller has any concerns they should consult the relevant health professional as advice given is without physical assessment and is therefore limited.

In addition the policy must make reference to where the recorded information is kept and, if the caller has a health record with the agency, when a copy should go to the health record.

Adopted by ANF (Vic Branch) Council
Council Meeting No. 11/2000 (12/12/00)

Formal legal opinion obtained by the Victorian Emergency Department Association from Mr John Snowdon of Phillips Fox Solicitors has been outlined in an article by Fatovich and Jacobs², the following points of the opinion regarding medico legal concerns of telephone advice are outlined below as they appear in the article.

² Fatovich, D & Jacobs, I (1998) Emergency department telephone advice: a survey of Australian emergency departments. *Emergency Medicine*, 17: 117-121

- The mere asking of questions over the telephone provides no guarantee that the information gained in response will be accurate or meaningful.
- By offering specific advice or recommendations over the telephone, the hospital accepts a legal duty of care to the caller and/or the person in respect of whom the caller is ringing.
- The substance of the primary message conveyed by the person responding to a telephone enquiry should be: telephone diagnoses and recommendations are a poor substitute for clinical examination and assessment. If you have any concerns about the person subject of the call, have him or her seen immediately by a general practitioner. Alternatively, bring that person in for assessment at our emergency department.
- If the message is stressed consistently and habitually, the prospect of both medicolegal complications and an adverse health outcome are significantly reduced.
- Less harm is likely to result from the hospital staff member declining to become involved in providing specific recommendations or advice.
- Having said that, common sense dictates that in many instances, emergency advice can and should be given as steps which should assist that patient and the caller, on a short term basis, pending the obtaining of formal, medical assistance.
- In summary, proper use of the telephone can facilitate patient care and maximise the availability of human resources. On the other hand, inadequate, inaccurate or thoughtless but well meaning advice and recommendations delivered over the telephone, without the benefit of clinical assessment (and often without the benefit of adequate knowledge or experience) can create rather than solve problems.

As indicated in the article many of these points are valid but apply predominantly to a city location where there is easier access to medical care.

Further steps that should be taken to reduce risks of medico-legal concern are:

- Continued attention to telephone triage process, with
- Feedback and action on areas of concern
- Attention to complaints of users and providers
- Meticulous documentation

Referral Services

Telephone triage nurses frequently triage patients to alternative services within the community relevant to the patients need. It is therefore recommended that a referral list or database be developed and regularly maintained and updated. The following list provides examples of services, which should be considered in developing a service list/database.

- Medical Emergency Lines
- GP Contact details
- Local/Satellite hospitals
- Pharmacies
- Alcohol Anonymous
- Sexual Assaults Lines
- Psychiatric Services
- Poison Information Line
- Police Stations
- Welfare/social workers
- Maternity Health Lines
- Dentist

Conclusion

The components outlined in this documentation are designed to stimulate thought processes and assist other organisations in the implementation of a nurse telephone triage service. The components are not to be viewed as a rigid way of implementing the service, any service implemented needs revision and flexibility to ensure local applicability, GP ownership and success.

It can be indicated, as evidence from this document, that the West Vic Division of General Practice has undertaken substantial work in order to successfully trial the nurse telephone triage model and progress it to a service. The service has become entrenched as a valuable service to those involved, which they do not want to lose.

APPENDICES

Appropriate Triage and Risk to Patient – Clinical Protocols

1. Please indicate if you believe the clinical protocols have been followed in the problem identification triage process? YES () NO ()

2. If No, what was the level of risk of harm to the patient?

- 0 = Minor risk
- 1 = Moderate risk
- 2 = Significant risk

Score

3. Rate on a 6 point scale the evidence for preventability of the risk.

- 1 = little or no evidence for preventability
- 2 = slight or modest evidence for preventability
- 3 = preventability not quite likely; less than 50-50 but close call
- 4 = preventability more likely than not; more than 50-50 but close call
- 5 = strong evidence for preventability
- 6 = virtually certain evidence for preventability

Score

What further action would you recommend to reduce the risk?

Appropriate Triage and Risk to Patient – Administrative Protocols

1. As far as you are aware were administrative protocols followed? YES () NO ()

2. If No, what was the level of risk of harm to the patient as a result?

- 0 = Minor risk
- 1 = Moderate risk
- 2 = Significant risk

Score

3. What further action would you recommend to reduce the risk?

Result of review

- Under Triage
- Over Triage
- Satisfactory Triage
- No Protocol Available
- Available protocol not followed
- Other: _____

What action is recommended

- None
- QA Nurse to QA/GP (copy form)
- Feedback to nurse via case report
- Feedback to GP via report
- Discussion/education at QA committee meeting
- Develop clinical protocol
- Develop administrative protocol
- Other: _____

Rationale for recommended

action:

Reviewers Name (Print) _____ Reviewers signature _____ Date _____

Appendix 3

CONFIDENTIAL
TELEPHONE TRIAGE NURSE REVIEW REQUEST FORM

Contact Date _____

Reason for contact: _____

Advice given: _____

Reason for review: _____

CONFIDENTIAL
TELEPHONE TRIAGE NURSE REVIEW REQUEST FORM

Contact Date _____

Reason for contact: _____

Advice given: _____

Reason for review: _____

Appendix 4

**CONFIDENTIAL
GRAMPIANS AFTER HOURS TELEPHONE TRIAGE SERVICE
GENERAL PRACTITIONER REVIEW REQUEST FORM**

General Practitioner: _____

Practice: _____

Patients Contact Date with Triage Service: _____

Patient Name: _____

Reason for contact: _____

Advice given: _____

Reason for review: _____

**CONFIDENTIAL
GRAMPIANS AFTER HOURS TELEPHONE TRIAGE SERVICE
GENERAL PRACTITIONER REVIEW REQUEST FORM**

General Practitioner: _____

Practice: _____

Patients Contact Date with Triage Service: _____

Patient Name: _____

Reason for contact: _____

Advice given: _____

Reason for review: _____

Appendix 5

After Hours Rural Telephone Nurse Triage Service

Preparation for Practice: An Education Module for Division 1 RNs

Are you a rural nurse currently providing face to face and telephone triage?

Do you feel educationally prepared for the responsibilities involved in the triage process?

Is after hours access to general practitioners impacting on your role as a triage nurse?

Are you looking for a program that can assist you in managing the realities of after hours telephone triage in a rural centre?

Tertiary Accreditation

CHERC is currently liaising with a number of universities to have this module cross credited within relevant post basic nursing courses.

Structure & Duration

The program is a self-directed learning package that can be undertaken over a one month to three month period.

Relevant exercises, readings and activities will be facilitated throughout the learning period.

Administration

The program will be available from May 2002. It is a full fee paying course.

On successful completion, the participant will receive certificate of completion and cross crediting within relevant university programs.

The Collaborative Health, Education and Research Centre (CHERC) was established in 1994 by Bendigo Health Care Group. CHERC has three principle objectives, one in the area of staff development and education, one in health consultancies and the other in research.

CHERC actively supports and encourages educational opportunity for health professionals, offering a comprehensive range of programs to facilitate continuing professional development.

*To discuss how this course could benefit you and your institution please contact:
Robin Tchernomoroff or Kaye Knight on:*

5454 6415

Collaborative Health Education and
Research Centre (CHERC)
Bendigo Health Care Group
PO Box 126, Bendigo, VIC, 3552
Ph:(03) 5454 6415
Fax: (03) 5454 6420
E-mail: rtcherno@bendigohealth.org.au

Program Aim

The program aims to assist the rural based triage nurse in conducting telephone triage and providing consumer access to medical after hours service when required.

Pre-Requisite

Participants are required to be experienced emergency nurses currently working in the area of emergency and triage.

Program Framework

Participants will bring to the program differing levels of knowledge and experience. To establish a common knowledge base of professional, legal and practical issues surrounding the telephone triage process, the program encourages participants to consider these issues within their own context.

Telephone Triage practice is then further supported and developed through guided experiential and reflective learning within the participants actual practice environment.

The educational framework is founded upon the principles of adult learning and creating an authentic learning environment.

Key Subject Areas

- Introduction to self directed learning & reflection in practice
- Assisting the process of change - introducing a new service
- Limitation & boundaries of telephone triage
- Principles of triage
- Professional communication strategies in telephone triage
- Ethics & advocacy in telephone triage
- Triaging across the life span
- Triaging to the community

Key Learning Outcomes

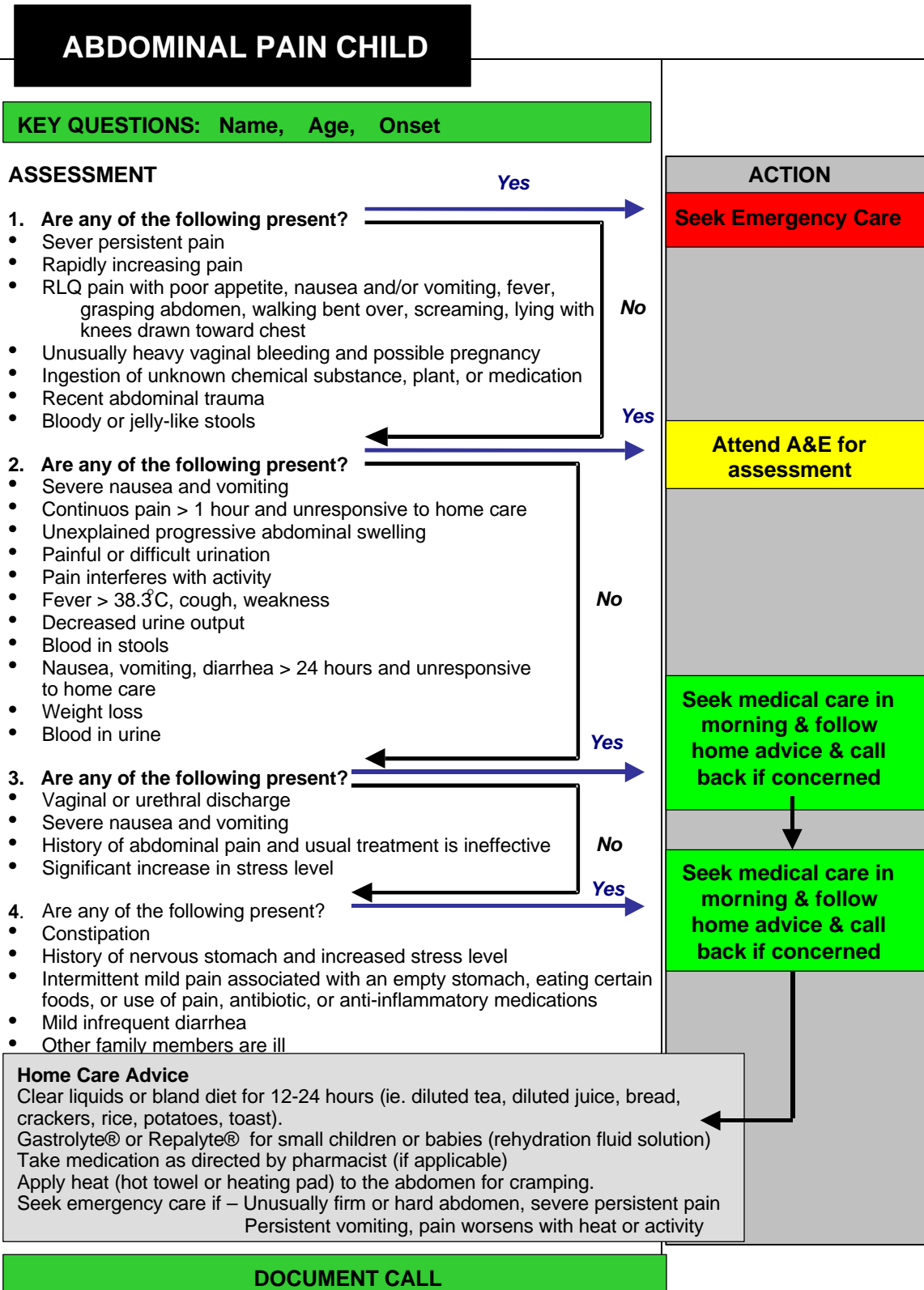
On completion of the program and with clinical practice, participants should/will be able to:

- Discuss legal issues and professional boundaries relevant to telephone triage
- Apply the principles of triage for their telephone triage practice
- Analyse their telephone triage practice and recognise areas of strength and developmental areas in their practice
- Demonstrate effective communication strategies with telephone triage clients
- Discuss the importance of accurate documentation in telephone triage
- Relate ethical issues in telephone triage to their particular context
- Describe the special considerations related to paediatric triage & triage of the older adult

Assessments

- Completion of the self directed learning module
- Completion of 2 significant incident analyses
- Strategy Plan to enhance after hours telephone triage within own work environment - can be completed as a group or as an individual.
- Practical assessment of a telephone triage scenarios

Appendix 6



Protocols do not replace skilled clinical judgement

ASTHMA

KEY QUESTIONS: Name, Age, Onset, History of Asthma

ASSESSMENT

1. Are any of the following present?

- Persistent wheezing after treatment
- Difficulty breathing
- Unable to breathe lying down, must sit up to breath
- Dusky or blue lips
- Weakness, listlessness

Yes

No

Yes

2. Are any of the following present?

- Vomiting and unable to retain medication
- Upper respiratory infection symptoms and history of:
 - steroid treatment
 - hospitalisation more than 3 times in past 6 months for asthma
 - intubations

No

Yes

3. Are any of the following present?

- Fever
- Cough unresponsive to medication
- Minimal or temporary relief of asthma problem with current medication
- Yellow or green sputum

No

Seek Emergency Care

** If breathing difficulty is severe, call ambulance*
** Take 4 puffs of reliever medication every 4 mins as needed until Ambulance arrives.*

Attend A&E for assessment

Seek medical care in morning & follow home advice & call back if concerned

Home Care Advice

- Increase fluid intake – water and clear fluids
- Avoid aspirin products and decongestants
- Shower every night to reduce pollen exposure
- Limit exposure to pets, particularly in sleeping areas
- Avoid smoky and dusty environments
- Treat symptoms early to decrease severity of asthma attack
- If asthma symptoms are induced by strenuous exercise, take medication 90 minutes before activity use inhaler 30 minutes before activity (depending on type of inhaler)
- Use a vaporizer, steamy bathroom, or cool damp air to help relieve symptoms

DOCUMENT CALL

Protocols do not replace skilled clinical judgement

Appendix 7

PROTOCOLS FOR INVOLVEMENT

In order to have consistency among the trial and the health care groups involved, the following protocols have been established to ensure each health care group understands their involvement in the valuable services.

Time of service

The after hour service is from 6pm to 8:30am.

Phone line process

Clinic phone lines are to be diverted to after hour's phone at 6pm and un-diverted at 8:30am. The process will vary from clinic to clinic and will be outlined on a separate document.

Regular users

In order for telephone triage nurses to deal with regular users, we request that the GP, clinic or hospital staff report the following:

- ◆ Name of regular user
- ◆ Normal or range of complaints
- ◆ Technique for dealing with patient
- ◆ Should the patient be referred to GP in the morning?

This information will be given to the telephone triage nurses.

Receptionists role

Receptionists at the clinic will be responsible for the following

- ◆ Calling the telephone triage nurse prior to switching the phones through and reporting which doctor will be on call and what telephone number he can be contacted on.
- ◆ Diverting and un-diverting the clinic phones through to the after hours service at dedicated times.
- ◆ Calling the telephone triage nurse in the morning when diverting the phone back to their clinic

Telephone Triage nurses

Telephone triage nurses should deal with regular users in the manner outlined by either the GP, clinic or hospital.

Accident and Emergency Nurses

In the instance that a patient is required to present to A&E, the following approach must be taken by the telephone triage nurses. Telephone triage nurses are to call the appropriate local hospital for the patient and speak to the supervising nurse and inquire that it is a suitable time for a patient to be sent up to A&E for assessment.

Hospital Supervising nurses

We would appreciate it if hospital-supervising nurses could keep track of the number of phone calls they directly receive from patients/consumers. This will help determine if there is any change in the way the community accesses services. We would also like the supervising nurse to report in their register if GPs have been called to consult a patient at the hospital.

TELEPHONE TRIAGE NURSE ROLE AND RESPONSIBILITIES

- Maintain ANF Professional Indemnity Insurance.
- Attend Phone Triage Education Sessions.
- At commencement of shift collect dedicated phone/Triage Protocols/Phone Advice folder. Maintain these within easy access for whole of shift.
- For the night shift ascertain names of clients who have phoned that evening. (Multiple calls must be indicated on subsequent call log sheet).
- Take phone triage calls promptly, document on Phone Advice Sheet. First statement on answering call to be "After Hours Medical Service (Name) (Position) speaking." (Must indicate you are a Nurse)
- Handle calls using the protocols provided.
- Maintain a customer focus throughout the client contact.

OTHER RESPONSIBILITIES:

- Perform routine functions as required.

GP FOLLOW-UP

Telephone Triage Nurse will fax Phone Triage Forms of that or previous evening/nights to clients usual GP.

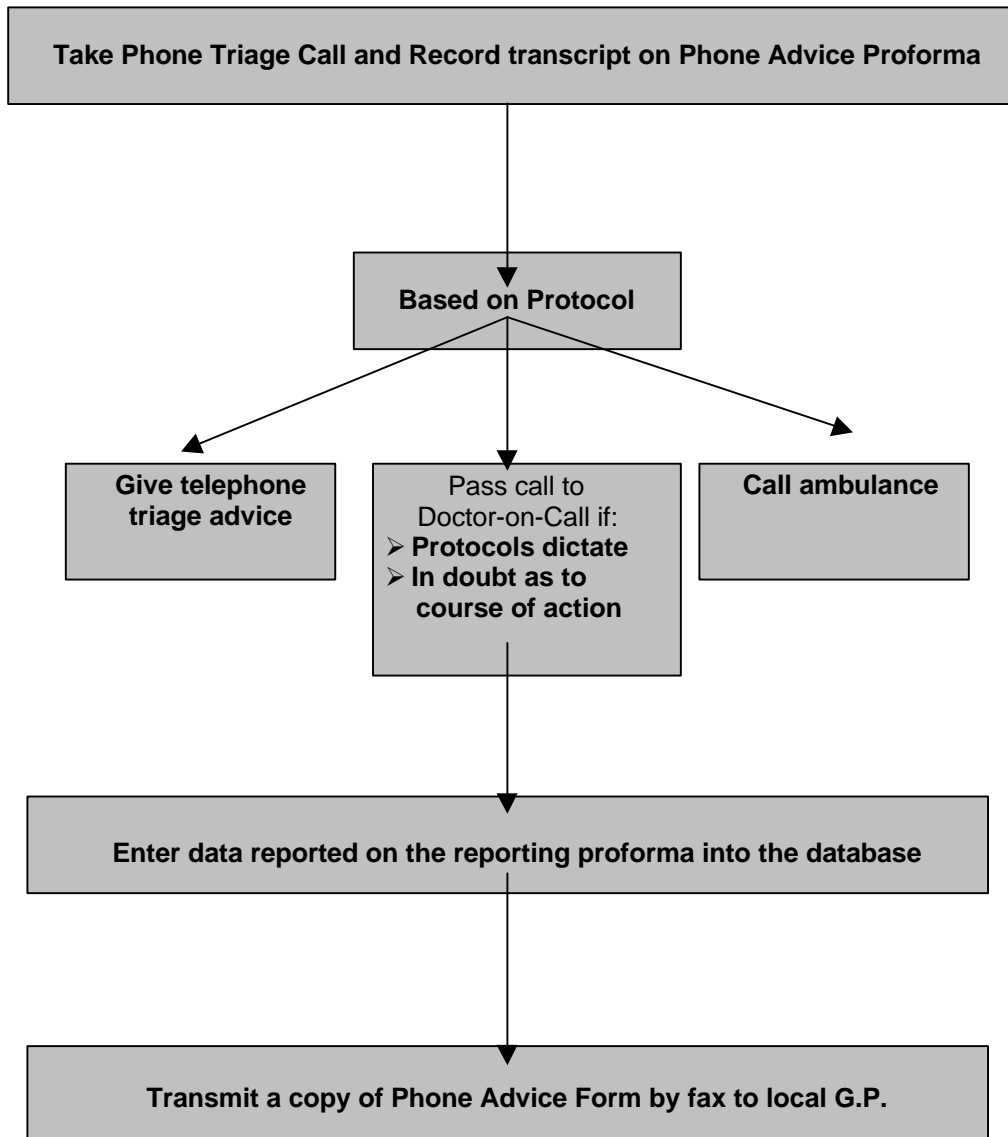
The faxed will then be stored for future reference at the GP clinic.

FOLLOW UP

The Telephone Triage Nurse on duty may follow up with patients from the a previous evening/night if desired to ascertain:

- ◆ Clients current health status / subsequent outcome
- ◆ Need for subsequent action e.g. facilitation of an early Clinic appointment.
- ◆ Clients usual phone number and address to be sought.
- ◆ Service appreciation / feedback

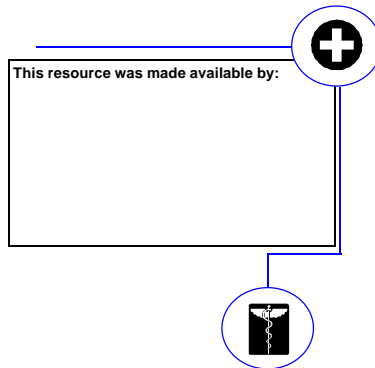
TELEPHONE TRIAGE PROCESS



Appendix 8

NURSE TRIAGE

A confidential and reliable source of medical advice after normal business hours



AFTER HOURS MEDICAL ADVICE

NURSE TELEPHONE TRIAGE



AFTER HOURS ADVICE

Your health and wellbeing is very important to your Doctor. Your Doctor has arranged that if you need medical advice or help

- when the clinic is closed, or
- when you can't wait until tomorrow that you can call a special after hours medical service.

What is this service?

The after hours service is delivered by Triage Nurses. A Triage Nurse is a highly trained nurse qualified to prioritise patients in terms of the care they need. The nurses follow guidelines and use their experience to identify how quickly and what sort of medical help you may need.

The nurse will ask for information about your age and sex and ask you to describe the symptoms that are making you feel unwell.

The nurse will then decide if you need:

- Assurance that everything is alright
- Medical advice on what to do
- To speak to a Doctor
- To speak to the Doctor tomorrow
- To attend Accident and Emergency at the

Why does this practice use triage nurses?

Many of the after hour calls can be managed effectively by trained nursing staff. The nurses are already awake and taking your call is part of their work duties. Triage nurses have a number of skills and backups that allow them to be trusted and to ensure your health. For example

- Training in Nurse Triage
- Work experience in Accident & Emergency
- Years of experience as a nurse
- Doctor developed guidelines to follow
- Documentation which must be completed
- Regular Triage Nurse reviews
- Has local knowledge

A doctor will always be available when needed, but this service allows the doctor to work more effectively.

YOUR DOCTOR TRUSTS THE ABILITY OF THE TRIAGE NURSE

How do I contact the Triage Nurse?

If you call the Doctor's Clinic Phone number after normal business hours the phone will be answered by the triage nurse.

The number and clinic hours are listed on the back page.



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