FNIHB-OR Nursing Policy and Procedure

Section:	**Professional Nursing Practice**	Policy Number:	**II - 24**
Subject:	**Telephone Triage and Advice**	Issued: Revised:	**March 31, 2015**
Distribution:	**All Nursing Facilities**		

1. POLICY:

1.1 Registered Nurses and Nurse Practitioners may provide telephone triage services for the purpose of assessing the severity of the client's symptoms, determining the appropriate plan of care (including immediate or deferred clinic visits), and providing clinical advice.

1.2 Determining the urgency of a clinic visit shall be assessed on an individual basis. It is recommended that the following groups of individuals have their current health concern assessed in the clinic versus over the phone:
- (i) Client's age 65 and older;
- (ii) Children up to five (5) years of age
- (iii) Pregnant women;
- (iv) Women one (1) to two (2) weeks postpartum;
- (v) Clients discharged in the last 48 hour from a hospital or care facility;
- (vi) Clients who just returned to the community following a surgical procedure; and/or
- (vii) Clients with a known chronic illness that could affect the outcome of the current compliant.

1.3 In addition to the client populations listed in policy statement 1.2, the following clients must also be seen afterhours:
- (i) The client requires resuscitation (CTAS 1); or
- (ii) The client's health condition is determined to be emergent (CTAS 2); or
- (iii) The client's health condition is determined to be urgent (CTAS 3).

1.4 Every telephone contact with a client and/or the client's family must be documented in accordance with the FNIHB-OR Documentation Standards.

1.5 With each telephone contact where the nurse provides telephone advice, he/she must advise the client to call back, go directly to the nursing station, or contact emergency services if the signs and symptoms persist or become worse.

2. PRINCIPLES:

2.1 Telephone triage requires the nurse to assess a client's health concern without the advantage of a face-to-face interaction or hands-on inspection. The clinical decisions made by a nurse during telephone triage requires complex critical thinking, which shall largely be based on current evidence and best-practices. Nurses must also rely on their communication skills, knowledge of disease processes, and normal growth and development for all age groups in order to accurately understand the client's presenting concerns. It is expected that the nurse offering telephone advice will have the necessary competence to assess the health needs of the client and provide accurate advice.

2.2 Providing telephone advice is a high risk activity and FNIHB-OR employs risk management strategies to reduce the risk of injury and liability.

2.3 The nurse is professionally and legally accountable for the telephone advice given to the client and/or the client's family.

2.4 Documentation is a legal and professional requirement for nurses when they provide professional nursing services, which includes telephone advice.

3. DEFINITIONS:

3.1 **Nurse:** Refers to Registered Nurses and Nurse Practitioners.

3.2 **Telephone Advice:** is based on the therapeutic nurse-client relationship and involves using a communication device to provide health care advice to clients. The process involves assessment, planning, provision of information as well as support, evaluation, and documentation.

3.3 **Telephone**: refers to the following personal communication devices: Land line telephones, cellular phones, handheld radios, and satellite phones.

3.4 **Reasonable Care:** the degree of care that a prudent or careful RN would exercise under the same or similar circumstances.

3.5 **Triage:** is a process of sorting and prioritizing patients according to the type and urgency of their conditions (National Emergency Nurses Affiliation, 2002).

3.6 **Resuscitation (CTAS 1)**: When there are conditions that are threats to life or limb or there is an imminent risk of deterioration which requires aggressive interventions.
Examples include, but are not limited to:

- Cardiac arrest
- Active seizures
- Respiratory arrest
- Major trauma (shock)
- Shortness of breath (severe respiratory distress)
- Altered level of consciousness (Glasgow Coma Scale 3-9)
- Severe dehydration in pediatric client (Canadian Triage and Acuity Scale (CTAS), 2007)

3.7 **Emergent (CTAS 2)**: When there are conditions that are potential threat to life, limb or function, requiring rapid medical intervention.
Examples include, but are not limited to:
- Chest pain with cardiac features
- Hypothermia
- Fever (Temperature > 38.5 C, appears septic; or infant less than 3 months with fever >38 C)
- Headache (sudden, severe)
- Bizarre paranoid behaviour
- Depression/suicide (attempted suicide, clear plan)
- Chemical exposure to eye
- Shortness of breath (moderate respiratory distress)
- Abdominal pain (severe pain)
- Altered level of consciousness (Glasgow Coma Scale 10-13)
- Moderate dehydration in pediatric client (Canadian Triage and Acuity Scale (CTAS), 2007)

3.8 **Urgent (CTAS 3)**: When there are conditions that could potentially progress to a serious problem requiring emergency intervention.
Examples include, but are not limited to:
- Seizures (resolved, normal level of alertness)
- Diarrhea (uncontrolled bloody diarrhea)
- Active labour; premature rupture of membrane; and/or preterm bleeding after 20 weeks gestation.
- Depression / suicide (suicidal ideation, no plan)
- Shortness of breath (mild respiratory distress)
- Abdominal pain
- Headache (moderate pain 4-7 / 10)
- Chest pain, non-cardiac features (other significant chest pain)
- Acutely ill infants less than one (1) year of age
(Canadian Triage and Acuity Scale (CTAS), 2007)

4. PROCEDURE:

4.1 At the beginning of the call, the nurse shall ask for the name of the person calling, their telephone number and the location they are calling from (in case the call is prematurely disconnected).

4.2 The nurse shall illicit sufficient information from the caller to formulate a list of differential diagnoses and appropriate treatment and follow up plan.

4.3 The nurse shall advise the client to go to the nursing station for further assessment and treatment, as outlined in Policy Statements 1.2 and 1.3 or as clinically indicated by the information gathered during the phone call.

4.4 The nurse shall document the details of each telephone calls, as per FNIHB-OR documentation standards. The minimum requirements to be documented include:

- Date and time of the call
- Callers name and telephone number
- Client's name if different from caller
- Information received from the caller

- Advice or information given by the RN
- Referral and follow-up information
- Name of the RN

4.5 The RN may document the details of the telephone contact directly into the progress notes of the client's health record if immediately available. If the chart is not immediately available, such as when the nurse on call is fielding telephone calls outside the nursing station, the RN must document the telephone conversation onto the FNIHB-OR approved *On -call Telephone Advice Log Sheet*. At first opportunity, the Log Sheet must be placed in the client's health record. Until such time, the Log Sheet must be kept secure while in the nurse's possession.

4.6 The nurse shall make every attempt should be made to talk with clients using a land line. There are special circumstances when a land line is not possible, e.g. clients in outpost camps using hand radios and satellite phones.

4.7 Protect the client's identity and personal information as reasonably possible, especially when fielding telephone calls from outside of the nursing station.

4.8 The nurse must be aware of the common hazards associated with giving telephone advice and minimize those hazards. These include, but are not limited to:

▪ Using leading questions ▪ Using medical jargon ▪ Inadequate data collection ▪ Inadequate time to explore client's symptoms ▪ Jumping to conclusions ▪ Language barriers	▪ Stereotyping callers or problems ▪ Failing to talk directly to the client ▪ Overreacting and under reacting ▪ Accepting client self-diagnosis and second guessing ▪ Nurse fatigue

5. RELATED POLICIES:

Appendix A: On-Call Telephone Triage Log
FNIHB-OR Policy: Confidentiality
FNIHB-OR Policy: Documentation Standards

6. REFERENCES:

Canadian Nurses Association (2007). Telehealth: The role of the nurse. Ottawa, ON.
Canadian Nurses Protective Society (2002). Info Law a Legal Information Sheet for Nurses: Telephone advice. Ottawa, ON.
College of Nurses of Ontario (2004). Telephone Practice Guideline. Toronto, ON
National Emergency Nurses Affiliation (2002). Position Statement A-1-4.
Wilson, B. (2003). Telephone Advice. Nursing BC, June, 27-28.

Approved by:		**Effective Date:** **March 31, 2015**
Director of Nursing, Ontario Region	**Date:**	
Regional Executive, Ontario Region	**Date:**	

TELEPHONE TRIAGE LOG

NURSE ON CALL:	**DATE:**	**TIME:**
CALLER'S NAME:	**RELATIONSHIP TO CLIENT:**	
PHONE:	**LOCATION OF CALLER:**	
CLIENT NAME:	**PHONE:**	**DOB:**

CHIEF CONCERN AND HISTORY OF PRESENTING ILLNESS:

RELEVANT PAST MEDICAL AND SURGICAL HISTORY:

ASSESSMENT:

PLAN:

SIGNATURE:	**DATE:**

Once completed and signed, place this log sheet in the client's health record as soon as reasonably possible