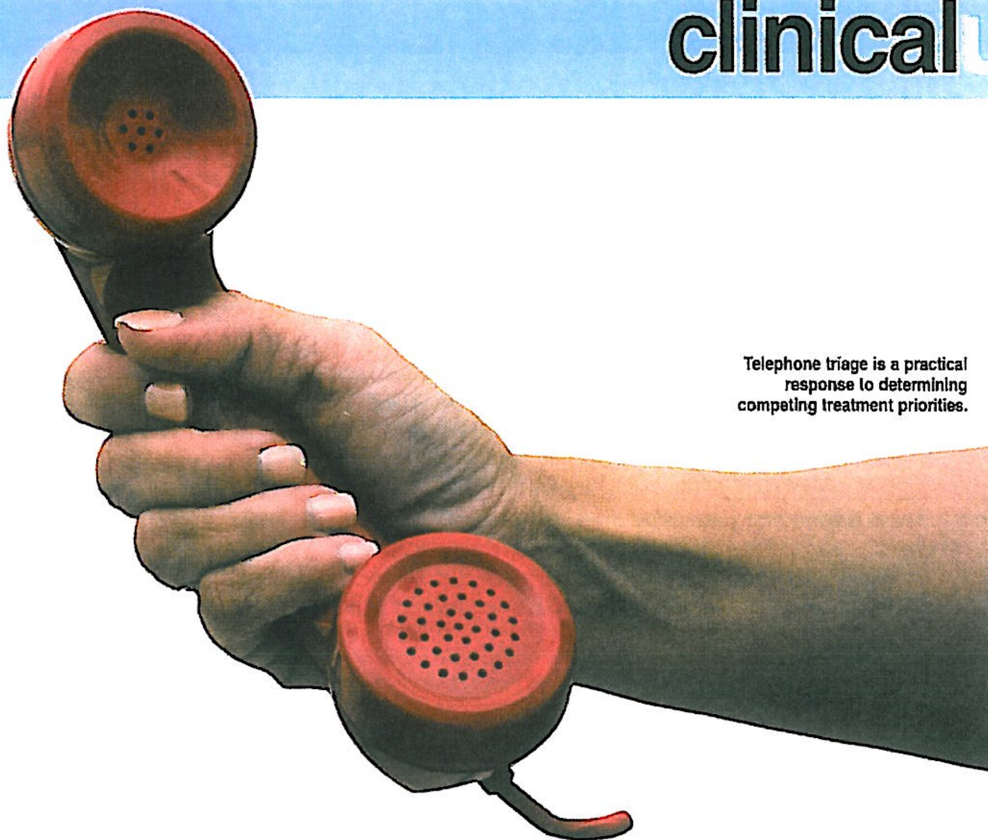

Telephone triage is a practical response to determining competing treatment priorities.

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The author has no disclosures. Any reference to products throughout this review does not constitute endorsement.

Triage in primary care

This Clinical Update outlines the role of the practice nurse in primary care triage.

WHEN we are sick, we all want to be well again as soon as possible. We require healthcare promptly with the expertise required to provide the best treatment by qualified health professionals.

Triage is the process of prioritising patients by the severity of their condition to receive appropriate healthcare in a timely way. Done well, triage results in the right person receiving the right care, at the right time, in the right healthcare setting.

Increasingly, general practice is relying on triage to manage its own workload.

Triage occurs both in the practice and by telephone. Triage in general practice may be undertaken by reception staff and/or practice nurses and GPs.

Receptionists, practice nurses (PNs) and GPs will be familiar with the rush of phone calls first thing in the morning when phones are turned over. The rush is particularly noticeable after long weekends. Many patients call general practice for reassurance.

Telephone triage is a practical response to determining competing treatment priorities.

A Guide to Urgency for Non-clinical Staff in General Practice for Telephone or Patient Presentations is available at: **www.dcgpa.com.au/_cms/CMS_images/resources/Triage%20Kit-Wall%20chart%202010_website%20final.1225.doc**

Telephone triage in general practice

Telephone triage provided by PNs should result in quick and convenient access to care, and result in cost and time savings to the health system.

Triage may occur in general practice as soon as a patient presents at the practice. The PN may observe the patient's colour, breathing (whether laboured and accessory muscles are being used), ease of movement, expression and demeanour.

Closer examination of the patient's signs and symptoms may occur in a treatment room. A patient's vital signs can be gathered, including temperature, pulse rate, respiration rate and blood pressure. Other information, such as whether the patient is cool or clammy to the touch, or a limb feels hot, can be gathered quickly to aid in the assessment. This assists in determining the likely problem and providing relevant information to facilitate appropriate treatment.

These familiar face-to-face assessment methods are not available to the telephone triage provider. Telephone triage requires a different skill set. Information is gathered using an alternative set of cues.

Good listening, communication, decision-making and assessment skills are essential. Knowledge of disease processes and the ability to communicate health information to the caller are necessary telephone triage tools. Accredited training in telephone triage and use of established telephone triage protocols support best-practice principles.

It is important to consider callers who may be at risk: infants, the elderly, children not responding to treatment, callers who have phoned more than once in eight hours, have had recent surgery,

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Australasian Triage Scale with adaptations from specific to general response times for general practice use*			
ATS category	Description of category	Examples	Response
1	Immediately life threatening	Cardiac arrest, respiratory arrest or distress, shock, hypoventilation (< 10 resp/min or hypotension (BP < 80 mmHg in adult)), poor Glasgow coma score (< 9), severe behavioural disorder with immediate threat to self or others	Immediate simultaneous assessment and treatment
2	Imminently life threatening, important time-critical treatment or very severe pain	Stridor, drooling with respiratory distress, hypovolaemia, circulatory collapse (bradycardia < 50, tachycardia > 150 in adults), hypoglycaemia, cardiac chest pain, fever with lethargy, major fracture, acid or alkali splash to the eye requiring irrigation	Assessment and treatment within minutes
3	Potentially life threatening or situational urgency or humane practice mandates relief of discomfort or distress within 30 minutes	Severe hypertension, non-cardiac chest pain, moderate blood loss, moderate shortness of breath (SaO_2 90–95% at room air), seizure, concussion with brief loss of consciousness, crush injury, severe laceration, acute mental illness/behavioural problem with risk of self harm, hyperglycaemia	Assessment and treatment within an hour
4	Potentially serious, situational urgency or significant complexity or severity	Mild blood loss, foreign body aspiration with no respiratory distress, eye inflammation, vomiting and diarrhoea without dehydration, minor limb trauma, non-specific abdominal pain, minor head injury without loss of consciousness, moderate non-specific pain	Assessment and treatment within hours
5	Less urgent	Minimal pain discomfort, minor symptoms of an existing illness, abrasions/ lacerations, immunisation, review of wounds	Assessment and treatment within days

are immunosuppressed, have bleeding disorders, are pregnant, or have chronic disease.

Effective telephone triage in a rural practice may prevent a patient who describes their symptoms as "a bit of a rock sitting on my chest and pain in my neck and left arm" from driving into town to be seen.

Asking the right questions and eliciting good information about the type and severity of pain, and obtaining a concise medical history, may result in arranging an ambulance to be called if it is determined that this might be cardiac-related chest pain.

Effective telephone communication may determine that a request for an 'urgent' medical appointment is not categorised as urgent. The urgency in the caller's voice, for example, may be anxiety about dropping children off at school.

Eliciting relevant information is a valuable skill.

As in all things, some healthcare professionals will be better at phone triage than others. In managing risk, it is important that people who have the right skill set are the ones providing triage services.

Listening skills

Good listening skills are required for safe telephone triage with good outcomes.

Listening skills may include listening for the caller's tone and being alert to background sounds. It is important to check back with the caller for their understanding of what was discussed and their intentions. The treatment plan discussed and what the caller intends to do may not match.

It is essential to be tuned into the call and to avoid distraction, interruptions and 'absent' episodes. Important caller information may be missed and not taken in to consideration. It is necessary that the triage provider develops the ability to block out distractions in their practice or call centre environment in order to remain focused on listening.

Not every caller is able to convey their situation concisely. Extracting necessary, relevant information is a skill. It is important to avoid jumping ahead of the caller or putting words in the caller's mouth, and to develop awareness around tuning out to maximise best outcomes for the caller.

Other important considerations include the caller's emotional tone and changes in tone. Good listening skills may detect information about the caller's breathing, or voice cues may uncover a mental health crisis. These clues can lead to the right question being asked and therefore to accurate triage. Relevant, well defined questions about the caller's medical history may then assist the triage provider.

The triage provider is reliant on the caller's ability to tell their story and provide a medical history.

Communication

Being able to communicate effectively to provide health information and advice and to refer appropriately is important.

Confirming information with the caller, using paraphrasing techniques, provides a checking mechanism and reassures the triage provider that information is being accurately collected and effective communication is taking place.

Use of open question techniques may assist in eliciting signs and symptoms from poor story tellers. Closed questions may be useful where the situation seems more urgent and quick, concise responses are required, e.g. "Is the patient breathing?".

Rapport with the caller is important, as poor interactions may lead to unsatisfactory outcomes or patient dissatisfaction.

Some callers have difficulty relaying their story and may be uncomfortable discussing their health complaint over the phone. This may apply particularly to generations familiar with seeing their GP in person. Alternatively, callers may enjoy the interaction with someone over the phone, which may pose a challenge to the timeliness of calls and the

gathering of a concise medical history and relevant facts.

Decision-making

The inability to gather the same quality of information as in a face-to-face consultation can lead to uncertainty in triage decision-making.

Good decision-making leads to appropriate and timely interventions. It is recommended that decision-making is guided by approved protocols. Use of protocols provides consistent standards of care and safety for callers.

Where possible, the protocols should be developed to fit the organisation's situation. Protocols may be condition specific.

Triage protocols maximise safe practice and minimise the risk of poor outcomes and inappropriate treatment recommendations.

This means that callers are not over-referred to GP clinics or emergency departments, but neither are callers under-treated or returning to health services unnecessarily.

Barriers to good telephone triage

Patients familiar with and preferring face-to-face consultations may find telephone triage uncomfortable. The result may be poor interaction between the caller and the triage provider.

Triage providers, like all healthcare providers, may find the length of a call impacts on other pending work responsibilities. This may result in ending a call prematurely, with a poor outcome for the caller.

Interpreters may be required where language barriers or hearing impairment exists.

The beliefs and attitudes of the triage provider may influence their perception of symptoms.

Third-party triage should be avoided. Where possible, the triage should be an exchange of information between the patient and the triage provider. Third-hand information is often unreliable due to the complexity of family relationships, misunderstanding of information, reluctance to share information with family members and cultural barriers.

Documentation

Documentation is an accreditation and legal requirement. This does not always occur when providing advice over the phone to callers.

Documentation should include the date, the time, the person triaging, information gathered, urgency of the condition, advice and information provided. Allergies, previous medical history and medications should be recorded. Recommendations made about the timeliness of follow-up should be recorded. It is important to check the caller's intentions and record any variation.

Record information such as asking the caller to ring back if their condition changes and they continue to be worried about their condition.

Lack of documentation may result in delay or denial of care being provided, failure of referral or an unnecessary face-to-face consultation.

It is important to record advice given during telephone triage.

Quality assurance

Training (preferably accredited) hones triage skills and creates awareness of the importance of the role of telephone triage.

In spite of the growing demand for phone triage, there are few accredited courses devoted specifically to triage training.

Quality control by way of regular reviews of telephone triage systems, protocols and care ensures the standard of care provided by telephone remains high and risk is minimised. Items may be discussed by the practice and recorded in incident logs to make improvements to protocols, communication and care.

General practice is required to demonstrate the ability to identify, prioritise and respond to life-threatening health emergencies and provide a flexible care system for determining the order in which patients are seen.

The RACGP Standards for General Practices (4th ed) is available at.
www.racgp.org.au/standards/111

The future

Traditionally, GPs have often cared for whole families. They have been the first port of call when people feel unwell or want healthcare advice, preventive care or referrals.

Telephone triage is likely to become more widely used in general practice and other health services. Some remote areas can now access telehealth.

There is increasing speculation about future engagement of Generations X and Y with healthcare. Recent studies have shown these people may use social media as the first line for health information. This will bring about new challenges to healthcare and new responses may be needed.

In the future, we may be able to access electronic consultations using video conferencing in the home. It will be essential that safety measures and guidelines promoting best practice go hand-in-hand with these new technologies to bring about improved health in our communities.

*References at medobs.com.au/primary-care-nurse