Safe Practice Advisory from the OPWDD Central Mortality Review Committee

TELEPHONE TRIAGE FOR TIMELY AND EFFECTIVE COMMUNICATION
JULY 2015

Breakdown in communication and delays in seeking medical care can result in worsening illness and even death. In recognition that timely and accurate communication is critical especially in health emergencies, the Central Mortality Review Committee, in collaboration with the Division of Quality Improvement, is issuing a Safe Practice Advisory outlining the basic elements of effective telephone triage procedures. The OPWDD Administrative Directive 2003-01 requires that a Registered Professional Nurse (RN) be either onsite or available by telephone at all times that nursing tasks and activities are being provided by unlicensed direct care staff in certified residential settings.

OPWDD strongly recommends every provider of certified residential and day program services develop a formal telephone triage program that includes but is not limited to the features outlined in this advisory.

Telephone Triage is a "systematic process in which a nurse screens a caller's symptoms", for themselves or others (Briggs, 2012, p. 1). The nurse assigns a level of 'urgency', based on the described change in health status, and directs the appropriate action, using standard protocols. The nurse directs the caller to the most appropriate health care setting or gives advice for care at home (Briggs, 2012). It does not result in a diagnosis.

Providing telephone triage in support of persons with developmental disabilities may present challenges. Some individuals may have communication or cognitive challenges limiting their ability to report symptoms. Changes in health status may only present initially as changes in behavior. Therefore, accurate, objective and detailed reporting by care providers to the triaging nurse and inquiry by the triaging nurse is critical.

Successful telephone triage must be highly organized, use standardized protocols, be well documented, and be routinely evaluated for accuracy, consistency and quality (Briggs, 2012). Accordingly, a formal telephone triage process should include policies and procedures that:

- Ensure direct support professionals are empowered to call 911 whenever they feel there may be a life-threatening situation. **Policies and training should support direct support professionals calling 911 without first seeking permission**.

- Specifically define the qualifications and training needed for the RN who will perform the triage service, based on an assessment of the needs of the individuals being served by the agency. Basic nursing education does not necessarily include telephone triage training and evidence of specialized training may be necessary.

- Ensure that RNs are responsible for telephone triage. In New York State, only RNs are licensed to perform an assessment, which is a critical part of telephone triage.

- Develop and communicate the daytime and after-hours, "on-call" coverage plan. Ensure staff and nurses adhere to policies and procedures for calling the designated personnel. Nurses who take off-duty calls may be asked to defend their triage disposition decisions, directions to staff, and follow-up actions in accordance with professional standards.

- Ensure that RNs are given the appropriate authority to direct actions carried out by direct support professionals, such as “seek emergency care now”.

- Ensure standardized triage protocols are implemented. RNs should use evidence-based decision support protocols for triage. Standard protocols are available for purchase as publications or computer-based programs. Protocols should:

    - Provide rules for handling calls and giving advice based on pattern recognition, or pattern matching to determine a disposition. Standardized protocols and checklists for RNs will help a busy nurse focus and supplement knowledge deficits and can decrease inconsistency in decision making.
    - Guide nurses in asking the right questions to get the most information from staff to make safe decisions over the telephone.
    - Describe how and when an RN should follow up on the status of the individual, including the adequacy of treatment being provided.

- Develop processes to ensure that a nurse’s or doctor’s directives are followed and documented.

- Consider, based on the overall setting needs, a single dedicated phone number for staff to call to reach the RN on call.

- Provide direct support professionals with training on detecting and reporting signs and symptoms, including but not limited to: vital signs (e.g., temperature, pulse, respiration, blood pressure, etc.), any observed or reported pain, and symptoms of illness and injuries.

- Provide direct support professionals training on the specific needs of each person they support and any specific monitoring and reporting requirements.

- Ensure direct support professionals have immediate access to emergency medical information consistent with the “ready to go packet”, which includes: medications the individual is taking, medical diagnoses, allergies, modified diets, treating physician names, and the contact information for the legally authorized person to provide informed consent.

- Provide clear guidance on how training on the telephone triage procedures will be completed and updated for staff.

- Monitor and periodically assess the adequacy of triage processes and training to ensure continued efficacy.

The development and implementation of an effective triage process that addresses all of the above outlined elements not only demonstrates an agency’s compliance with requirements, but is also integral to improving the quality of care to the individuals receiving services and reducing potential fatalities.

For additional resources on the use of triage protocols, please see:

Briggs, Julie K. (2012). *Telephone Triage Protocols for Nurses (4th Edition)*. Lippincott, Williams and Wilkins, Philadelphia.