Telephone Healthcare Assessment and Consultation Skills (continued)

Sam Thompson
Senior Lecturer: St Georges, University of London

FREQUENT CALLERS

Facing the challenges with compassion….

Frequent Callers

- Represent 3 % of callers but make 60 % of calls
- Are are generally isolated with little social support
- Sometimes incredibly frustrating

However,:

- They are not “time wasters”.
- Often have major mental and physical health problems
- Often in crisis.

Frequent Callers (**Vulnerable Callers)**

The circumstances under which they use telephone helplines vary, but current service models reinforce their calling behaviour.

It may also encourage a dependency on the service in frequent callers that is not in their best interests

The evidence

The problem

- More likely to be male and unmarried than other callers,
- Other key variables like age, mental health conditions or suicidality were unrelated to calling patterns.

Potential Strategies

- Limiting the number and duration of calls permitted,
- Assigning a specific telephone crisis support to the caller,
- Implementing face-to-face contact,
- Initiating contact with the caller rather than waiting for him or her to call,
- Providing short-term anxiety and depression treatment programs over the telephone,
- Creating individualised management plans.

Managing Frequent Callers

- Strategic solutions required
- Limiting the number and duration of calls and assigning a key worker were evaluated and showed promise in terms of reducing the number and/or duration of calls made by frequent callers and, to a lesser extent, in terms of reducing callers' suicidality
- The remaining strategies are as yet untested.

- Follow your normal call structure to the letter
- Don’t take shortcuts
- Don’t be lulled into a false sense of security

Managing Frequent Callers (Vulnerable callers)

MENTAL HEALTH AND ABUSIVE CALLERS

Facing the challenges with compassion….

Mental Health Triage

A brief mental health assessment to determine:

- if the person has a mental health related problem,
- the nature and urgency of the problem
- the most appropriate service response
- May also involve the provision of brief support and/or advice
- Exclude physical cause

UK Mental Health Triage Scale

UK Mental Health Triage Scale

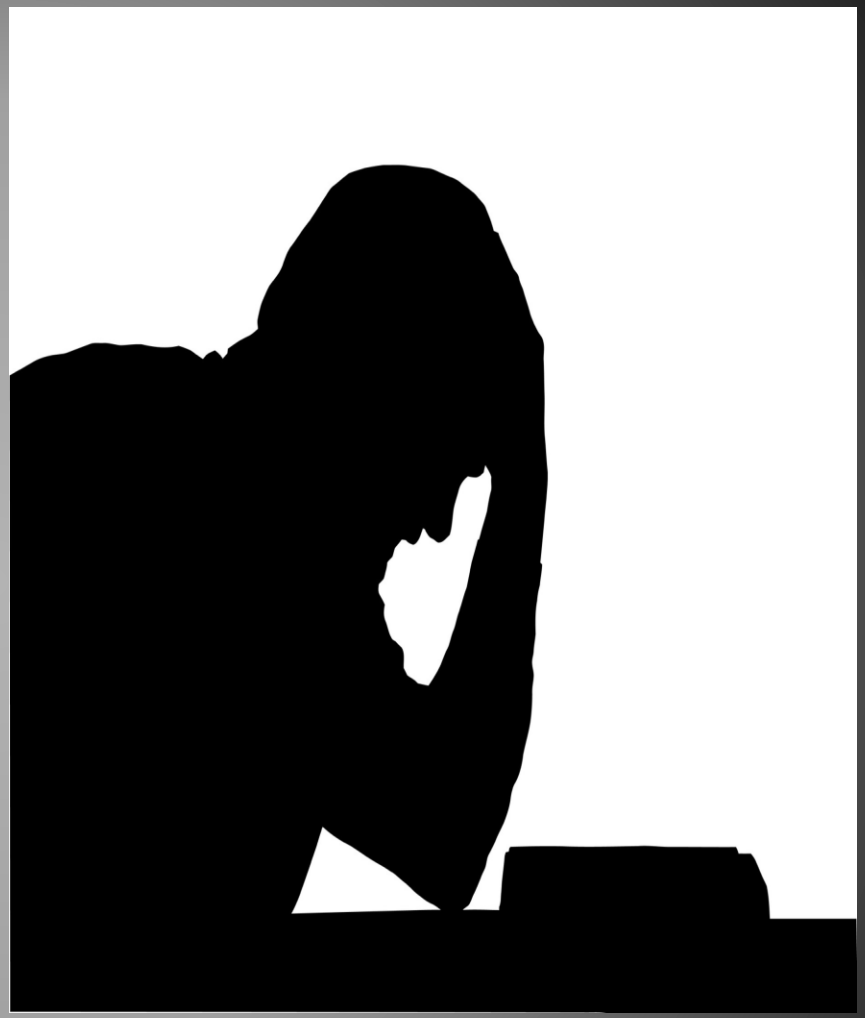
Triage Code /description	Response type/ time to face-to-face contact	Typical presentations	Mental health service action/response	Additional actions to be considered
A Emergency	**IMMEDIATE REFERRAL Emergency service response**	Current actions endangering self or others Overdose / suicide attempt / violent aggression Possession of a weapon	**Triage clinician to notify ambulance, police and/or fire service**	Keeping caller on line until emergency services arrive / inform others Telephone Support.
B Very high risk of imminent harm to self or to others	**WITHIN 4 HOURS Very urgent mental health response**	Acute suicidal ideation or risk of harm to others with clear plan or means Ongoing history of self harm or aggression with intent Very high risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control Urgent assessment under Mental Health Act Initial service response to A & E and 'front of hospital' ward areas	**Crisis Team/Liaison/ face-to-face assessment AND/OR Triage clinician advice to attend a hospital A&E department** (where the person requires medical assessment/ treatment)	Recruit additional support and collate relevant information Telephone Support. Point of contact if situation changes
C High risk of harm to self or others and/or high distress, especially in absence of capable supports	**WITHIN 24 HOURS Urgent mental health response**	Suicidal ideation with no plan or ongoing history of suicidal ideas with possible intent Rapidly increasing symptoms of psychosis and / or severe mood disorder High risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control Overt / unprovoked aggression in care home or hospital ward setting Wandering at night (community) Vulnerable isolation or abuse	**Crisis Team/Liaison/ Community Mental Health Team (CMHT) face-to-face assessment**	Contact same day with a view to following day review in some cases Obtain and collate additional relevant information Point of contact if situation changes Telephone support and advice to manage wait period
D Moderate risk of harm and/or significant distress	**WITHIN 72 HOURS Semi-urgent mental health response**	Significant patient / carer distress associated with severe mental illness (but not suicidal) Absent insight /early symptoms of psychosis Resistive aggression / obstructed care delivery Wandering (hospital) or during the day (community) Isolation / failing carer or known situation requiring priority intervention or assessment	**Liaison/CMHT face-to-face assessment**	Telephone support and advice Secondary consultation to manage wait period Point of contact if situation changes
E Low risk of harm in short term or moderate risk with good support/ stabilising factors	**WITHIN 4 WEEKS Non-urgent mental health response**	Requires specialist mental health assessment but is stable and at low risk of harm during waiting period Other services able to manage the person until mental health service assessment (+/- telephone advice) Known service user requiring non-urgent review adjustment of treatment or follow-up Referral for diagnosis (see below) Requests for capacity assessment, service access for dementia or service review / carer support	**Out-patient clinic or CMHT face-to-face assessment**	Telephone support and advice Secondary consultation to manage wait period Point of contact if situation changes
F Referral not requiring face-to-face response from mental health	**Referral or advice to contact alternative provider**	Other services (outside mental health) more appropriate to current situation or need	**Triage clinician to provide advice, support Advice to contact other provider and/or phone referral to alternative service provider** (with or without formal written referral)	Assist and/or facilitate transfer to alternative service provider Telephone support and advice
G Advice, consultation, information	**Advice or information only OR More information needed**	Patient or carer requiring advice or information Service provider providing information (collateral) Initial notification pending further information or detail	**Triage clinician to provide advice, support, and/or collect further information**	Consider courtesy follow up telephone contact Telephone support and advice

Sands, N. Elsom, E, Colgate, R & Haylor, H. (2016) Development and inter-rater reliability of the UK Mental Health Triage Scale (In Press). *International Journal of Mental Health Nursing.*

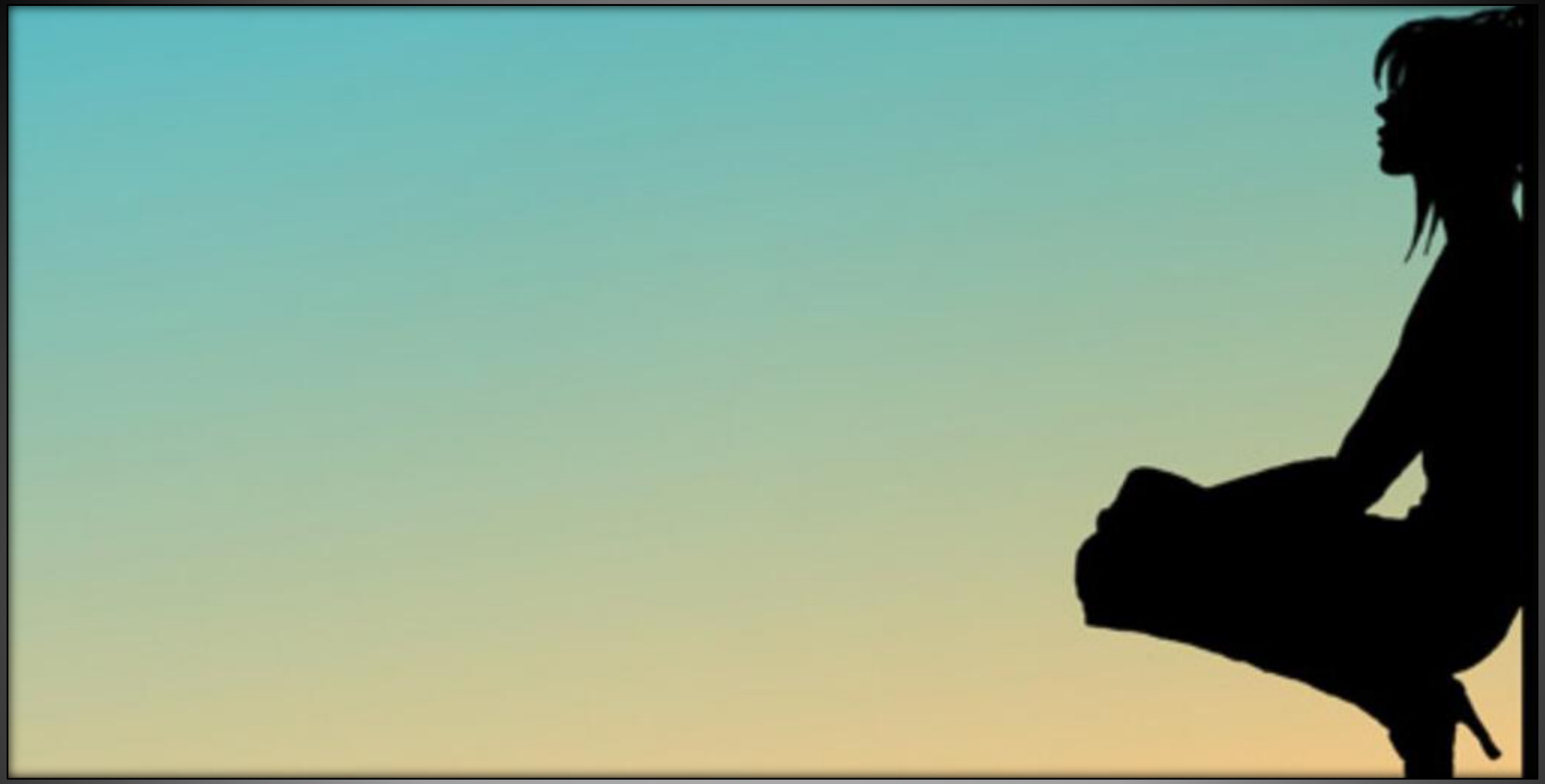
"I started self-harming age 9; I'm now 70 and still do it. It's how I cope. It doesn't bother me any more, but upsets other people. Some smoke and hurt their lungs, or drink alcohol and hurt their liver, I cut and get a few scars that hurt no one.

"I wish people realised it's how we cope. I'm a product of an abused childhood and it would have been nice to have help to stop very many years ago. Now we are just looked upon as attention seekers, even though many self harmers do it in private."

"I want folk to respect my right to cope in the only way I know how. Mental health staff just become hysterical and don't know how to cope with us. A little understanding is all that we ask for!"



"We need support not ridicule, we need a kind word not harsh judgment, we need to talk, but who will listen?"

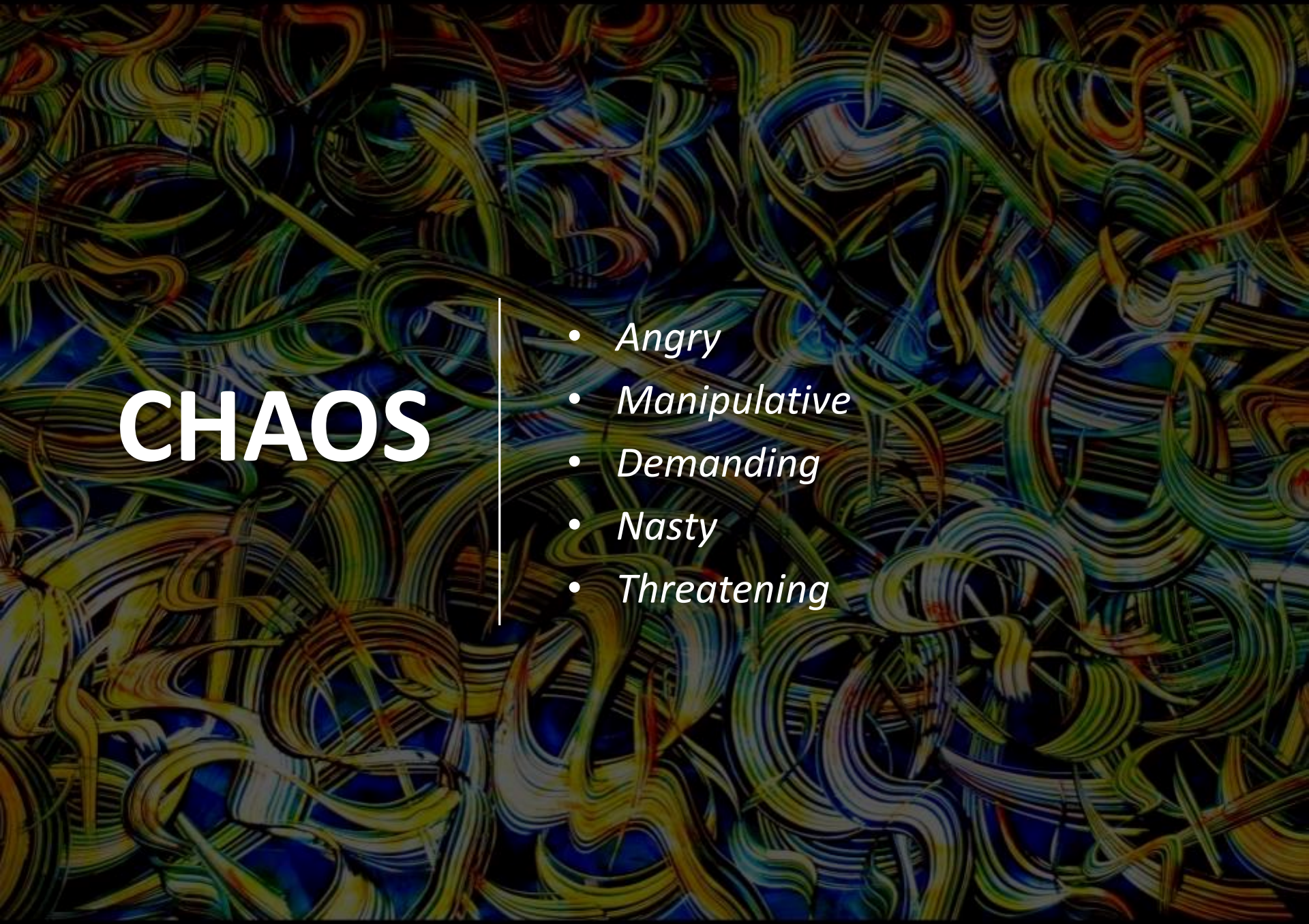


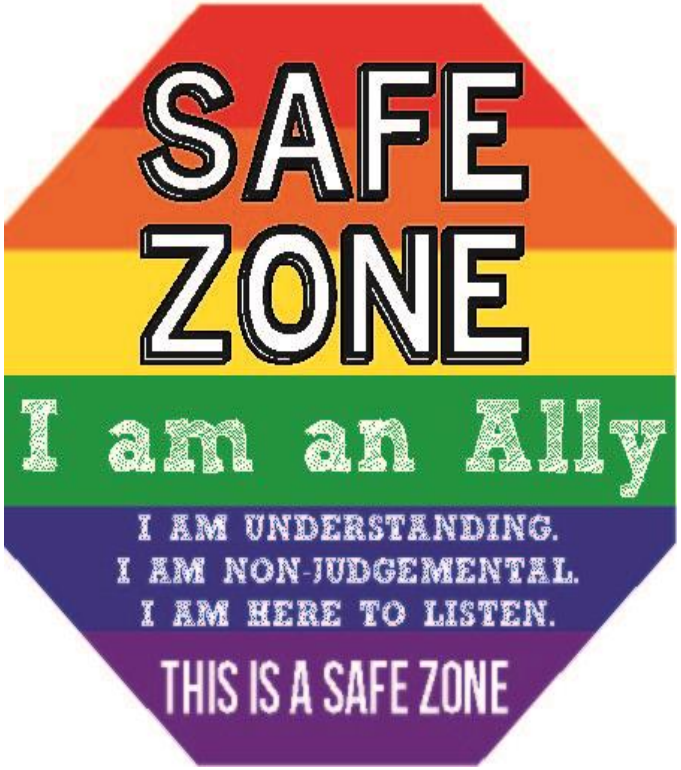
The only friend I have is my self-harm. It's there when I need it and comforts me when no one else will!

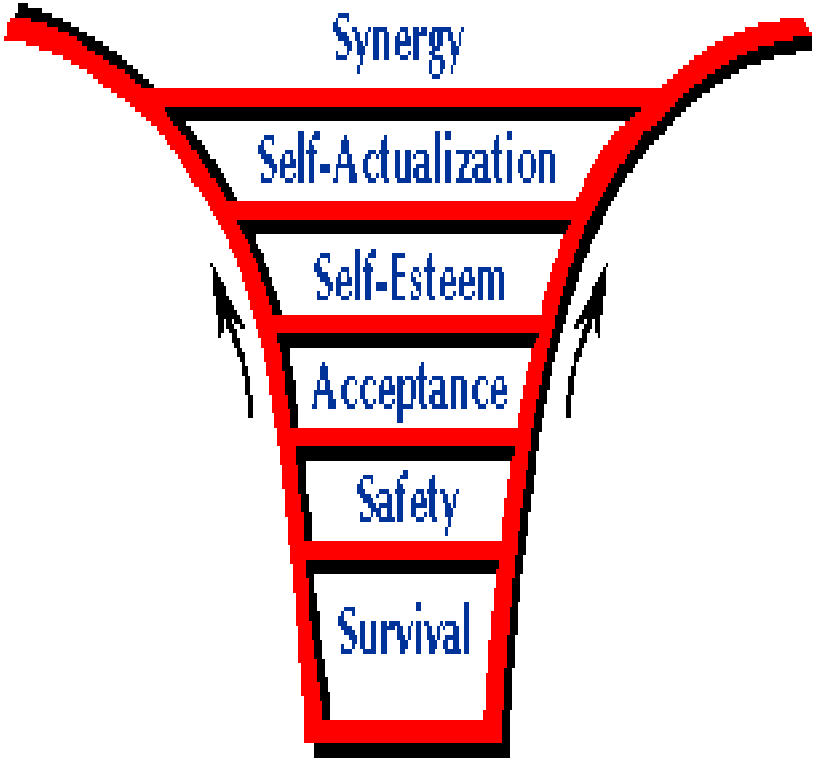
Hearing voices (1)

Hearing Voices (2)

BE GENTLE!!!!!!!!


CHAOS
Angry
Manipulative
Demanding
Nasty
Threatening





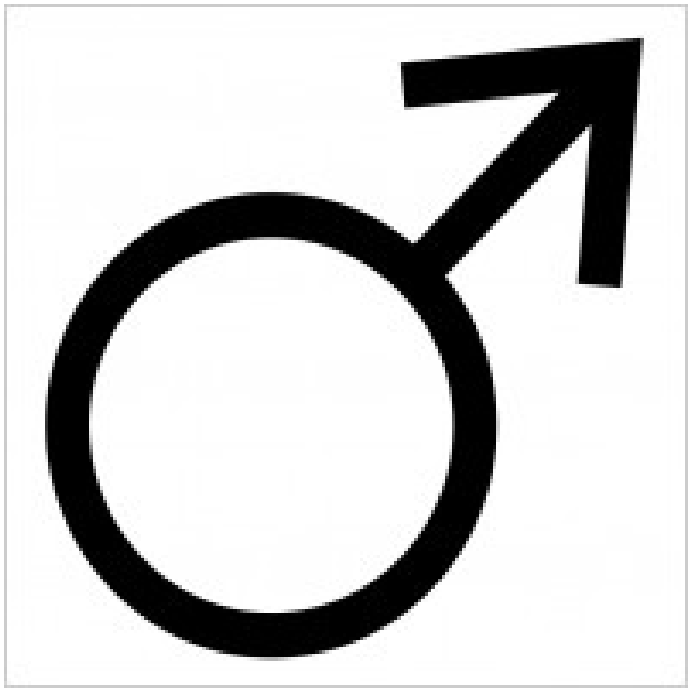
Crisis management

- Establish immediate safety
- Be honest about what you can do
- Agree a care plan together
- Do they have a crisis plan?
- Can you create a crisis plan together?
- Are both parties happy with the plan
- Negotiate a mutually accepted solulation

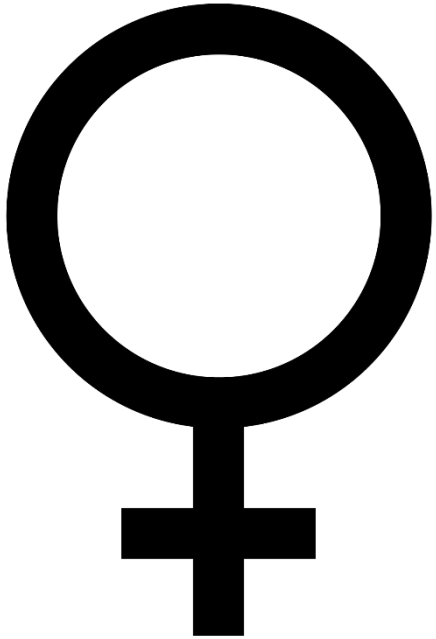
Collaborative solutions

Your turn!!

70 year old patient



3 month old old patient



TELEPHONE HEALTHCARE AND PAEDIATRICS

Paediatric Panic?

- Dread?
- Little adults?
- Get rid of them quick!!!!!

Compensation/ decompensation

Paediatrics:

- Compensate very well
- Risk of overlooking / underestimating severe illness
- When compensatory mechanisms fail they often do so **rapidly, catastrophically and irreversibly.**
- Index of suspicion **higher**; threshold for admission **lower**.

Nares and oral cavity and nasopharyngeal smaller

Tongue larger

Lymph tissue (tonsils and adenoids) larger; atrophy after age 12

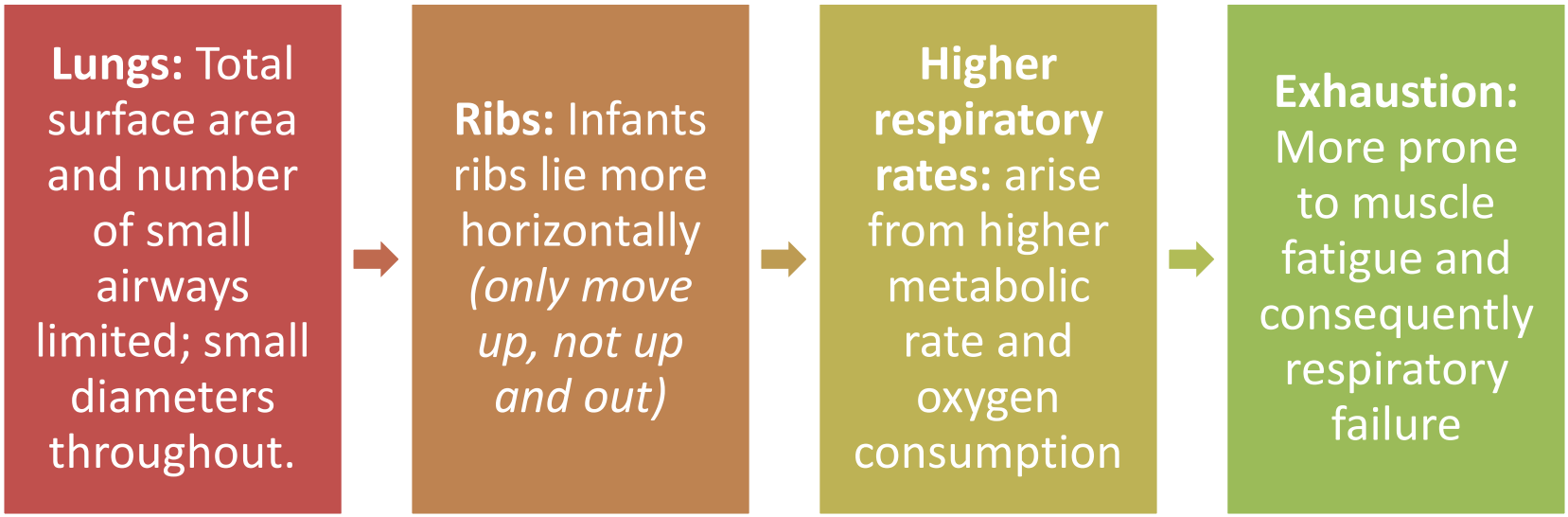
Epiglottis long and floppy; vulnerable to swelling

Larynx and glottis anterior, superior and cone shaped.

Paediatric variance: Airway (1)

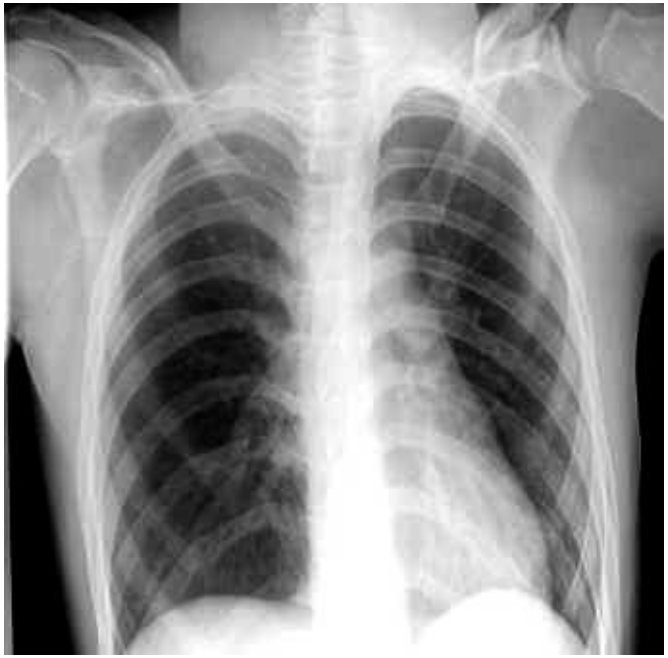
Paediatric variance: Airway (2)

- Thyroid, cricoid and tracheal cartilages immature; collapse with flexion
- Large amounts of soft tissues and loosely anchored mucous membranes lining the airway increase risk of oedema and obstruction.
- Fewer functional muscles; less able to compensate for oedema, spasm and trauma

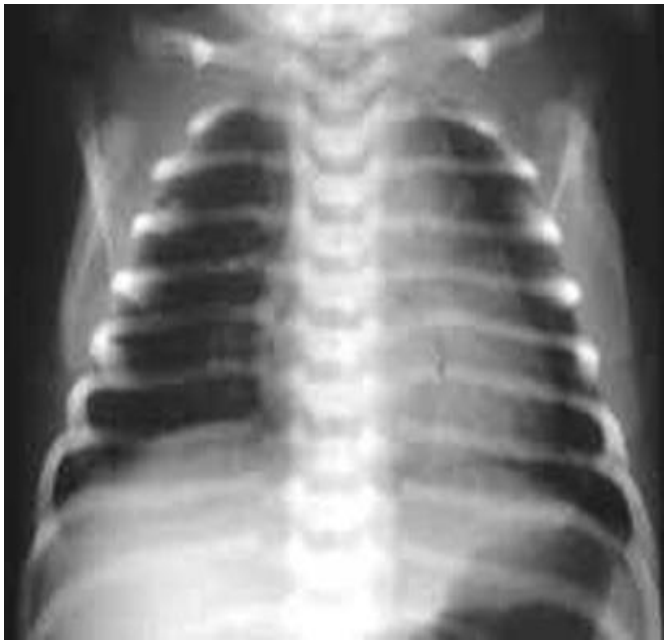


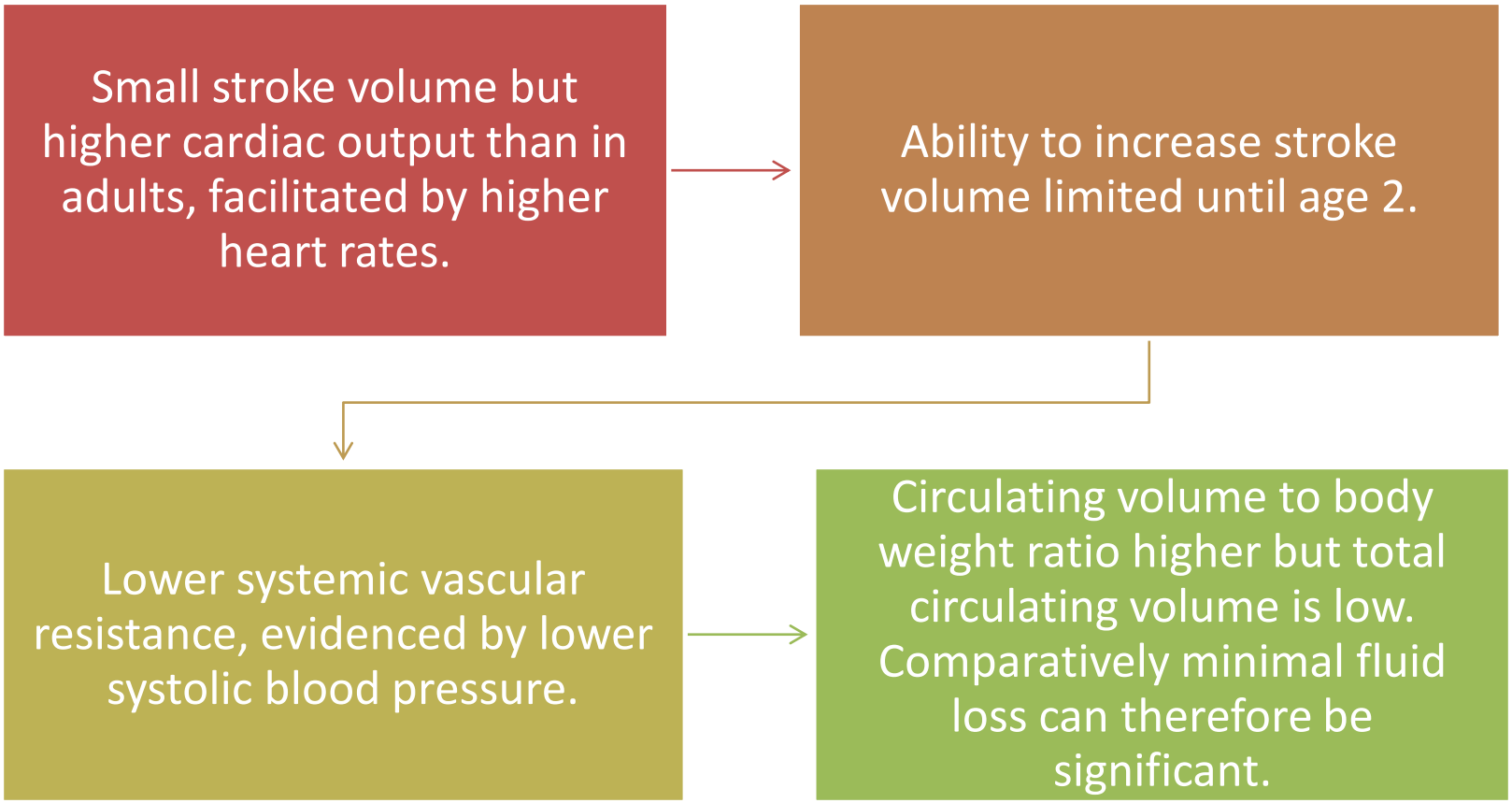
Paediatric variance: Breathing

Adult Ribs



Child's (flatter) ribs





Paediatric variance: Circulation

Large surface area coupled with immature thermoregulation presents an increased risk of hypothermia.

Limited glycogen stores and/or hypoglycaemia can be present in any paediatric patient that has been too ill to feed or subjected to high metabolic demands because of illness.

Paediatric variance: Other factors

Blind assessment of the Paediatric patient.

Breath sounds: stridor, wheeze, snoring, croupy

Rate of breathing: slow and fast are worrying.

Eye contact and interaction.

Appearance (cyanosis, skin mottling) abdominal breathing

Temperature (core and extremities) and **T**racheal tug

Head bobbing and heavy breathing

Inner rib retractions: substernal and intercostal

Nasal flaring

Grunting: precedes respiratory failure.

What is grunting?

- Caused by forced expiration against a partially closed glottis.
- Increases end-expiratory pressure and keeps terminal airways open.
- Associated with primary lung disease or systemic illnesses, such as sepsis.
- Localises respiratory disease to the lower respiratory tract, ie: pneumonia, asthma, or bronchiolitis, and not upper respiratory obstruction.

Grunting is an ominous sign of impending respiratory failure.

My babies breathing sounds funny….

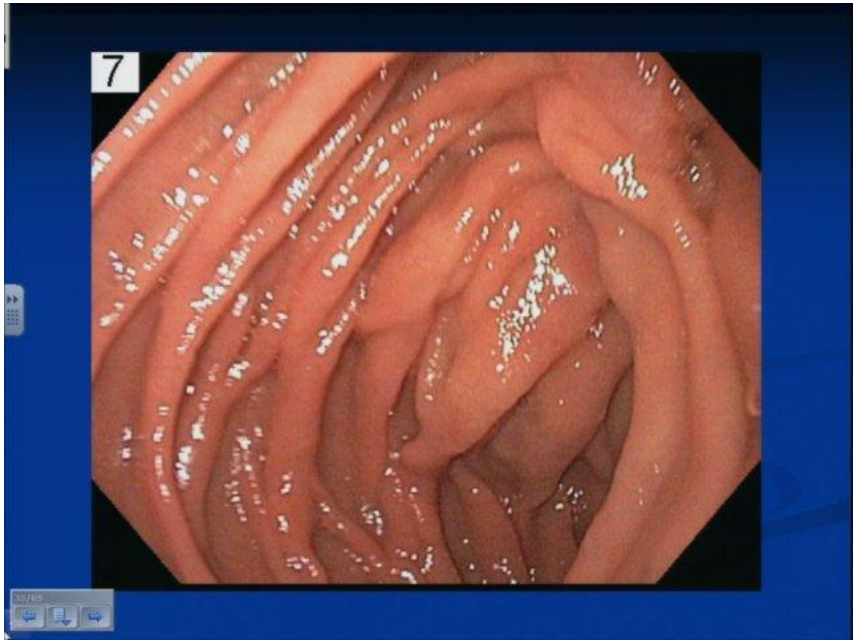
Head Bobbing

Questions not to forget ….

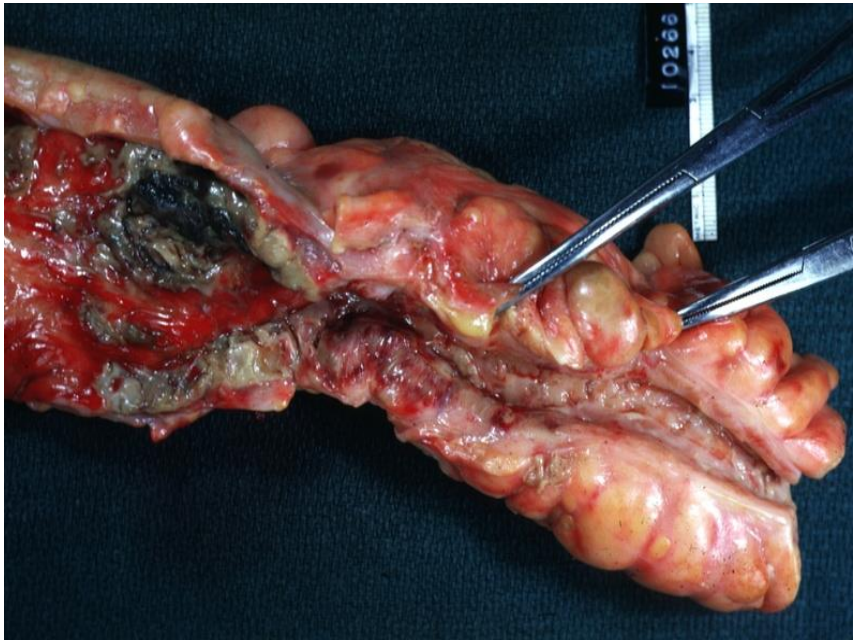
- Were they normal pregnancy, delivery and birth?
- Were they completely well after birth?
- Have they been completely well since?
- Have they had all their vaccinations?
- Are they under the supervision of any doctors or hospital for anything?
- Do they take any regular medication?
- What was the last thing you took them to the doctors for?
- Are they feeding well?
- Are they breast or bottle fed?

Was it a normal pregnancy, delivery and birth?

Normal Intestine



Necrotic Intestine



Risk factors for necrotising enterocolitis

- Maternal polyhydramnios
- Prematurity
- Failure to pass meconium on the first day of life
- Enteral feeding (although approx. 10% of cases occur in infants **never** fed)
- Formula feeding (6 times more common than breast fed)
- Bowel ischaemia

Prematurity and low birth weight

- The risk of complications increases with increasing immaturity. Infants born before 25 weeks have the highest mortality (50%) and if they survive, the highest risk of morbidity.

Prematurity and low birth weight: Respiratory complications.

- Respiratory distress syndrome and chronic lung disease,
- Injury to the intestines,
- Compromised immune system,
- Cardiovascular disorders,
- Hearing and vision problems,
- Neurological insult.
- SIDS

NICE Traffic Light System

Table 5.2 Traffic light system for identifying risk of serious illness.* [new 2013]

Children with fever and **any** of the symptoms or signs in the red column should be recognised as being at high risk. Similarly, children with fever and any of the symptoms or signs in the amber column and none in the red column should be recognised as being at intermediate risk. Children with symptoms and signs in the green column and none in the amber or red columns are at low risk. The management of children with fever should be directed by the level of risk.

	Green – low risk	Amber – intermediate risk	Red – high risk
Colour (of skin, lips or tongue)	• Normal colour	• Pallor reported by parent/carer	• Pale/mottled/ashen/blue
Activity	• Responds normally to social cues • Content/smiles • Stays awake or awakens quickly • Strong normal cry/not crying	• Not responding normally to social cues • No smile • Wakes only with prolonged stimulation • Decreased activity	• No response to social cues • Appears ill to a healthcare professional • Does not wake or if roused does not stay awake • Weak, high-pitched or continuous cry
Respiratory		• Nasal flaring • Tachypnoea: RR > 50 breaths/minute, age 6–12 months RR > 40 breaths/minute, age > 12 months • Oxygen saturation ≤ 95% in air • Crackles in the chest	• Grunting • Tachypnoea: RR > 60 breaths/minute • Moderate or severe chest indrawing
Circulation and hydration	• Normal skin and eyes • Moist mucous membranes	• Tachycardia: > 160 beats/minute, age < 1 year > 150 beats/minute, age 1–2 years > 140 beats/minute, age 2–5 years • CRT ≥ 3 seconds • Dry mucous membranes • Poor feeding in infants • Reduced urine output	• Reduced skin turgor
Other	• None of the amber or red symptoms or signs	• Age 3–6 months, temperature ≥ 39°C • Fever for ≥ 5 days • Rigors • Swelling of a limb or joint • Non-weight bearing limb/not using an extremity	• Age < 3 months, temperature ≥ 38°C • Non-blanching rash • Bulging fontanelle • Neck stiffness • Status epilepticus • Focal neurological signs • Focal seizures

CRT capillary refill time; RR respiratory rate

* This traffic light table should be used in conjunction with the recommendations in this guideline on investigations and initial management in children with fever.

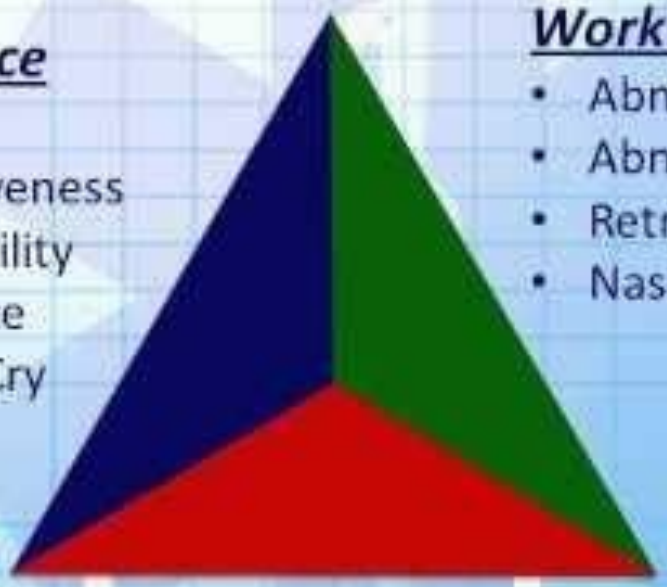
NICE Guidelines: Traffic Light System

- Assess children with learning disabilities using the traffic light table, taking into account their disability
- Children who are assessed as low risk ‘green’ can be cared for at home with appropriate advice
- If any ‘amber’ features are present and no diagnosis has been reached, provide parents or carers with a ‘safety net’ or refer to specialist paediatric care for further assessment
- Children assessed remotely with ‘red’ features should be sent for urgent referral
- Antipyretics should not be used with the sole aim of reducing fever

Pediatric Assessment Triangle

Appearance

- Tone
- Interactiveness
- Consolability
- Look/Gaze
- Speech/Cry



Work of Breathing

- Abnormal Breath Sounds
- Abnormal Positioning
- Retractions
- Nasal Flaring

Circulation to the Skin

- Pallor
- Mottling
- Cyanosis

TELEPHONE HEALTHCARE AND SEPSIS

Epidemiology

- 18 Million world wide cases each year
- 100,000 admission each year in the UK
- 37000 – 42000 deaths each year in the UK
- £20,000 per case
- 30 Bed Days
- Incidence is rising

Risk Factors

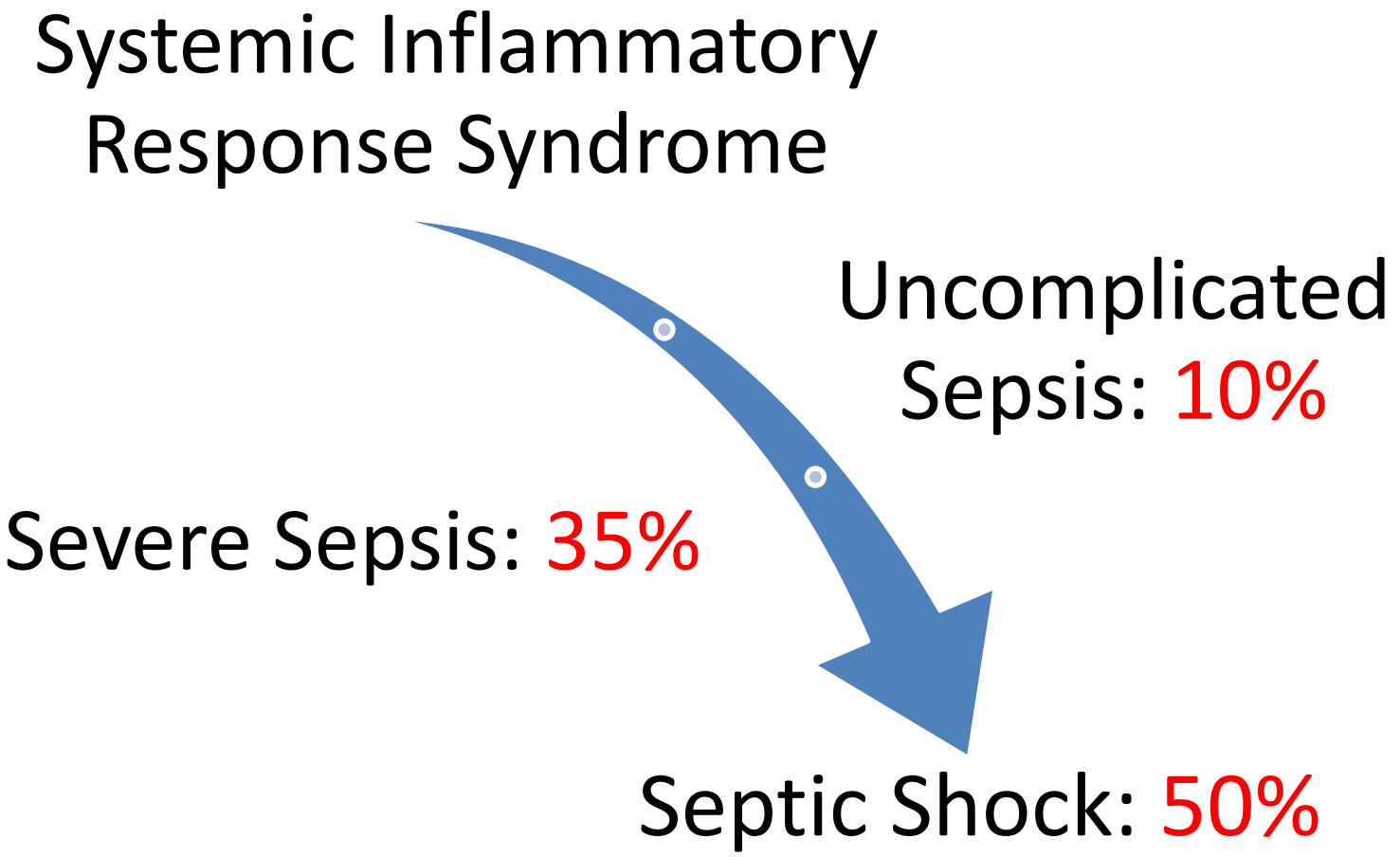
- Under 1 years old / Over 75 years old
- Frail patients with co-morbidities
- Recent trauma or surgical procedure in past 6 weeks
- Impaired Immunity (cancer, diabetes, splenectomy, sickle cell)
- Long term steroid use or DMARDs
- IV Drug misuse
- Indwelling lines or catheter
- Breach of skin integrity

NICE 2016

Pregnancy and Sepsis

- Pregnant in last 6 weeks
- have gestational diabetes or diabetes
- needed invasive procedures (for example, caesarean section, forceps delivery, removal of retained products of conception)
- had prolonged spontaneous rupture of membranes
- have been in close contact with people with group A streptococcal infection
- have continued bleeding or an offensive vaginal discharge

Sepsis Cascade
(College of Emergency Medicine)



Systemic Inflammatory Response Syndrome (SIRS)

SIRS is present if there are at least 2 of the following present:

- Temperature >38.3 or <36.0 degrees centigrade
- Pulse >90 beats per minute
- Respiratory rate >20 per minute
- New confusion or drowsiness
- WBC >12 or <4.0
- Blood glucose >7.7mmol/l in non-diabetic patients

Sepsis

Condition	Definition	Group Mortality
Uncomplicated Sepsis	SIRS + presumed or confirmed infection	10%
Severe Sepsis	Sepsis + one or more organ dysfunction criteria (other than shock)	35%
Septic Shock	Sepsis + shock criteria	50%

Decline into Septic Shock

- *Bilateral lung Infiltrates + New need for oxygen to maintain saturations >90%*
- *Lactate >2.0mmol/L*
- *Serum Creatanine >127.8umol/L or Urine output <0.5ml/kg/hr for 2 successive hours*
- *INR >1.5 or aPTT >60 seconds*
- *Platelet count <100 X 10^9/L*
- *Lactate >4mmol/L at any time point*
- *Hypotension persisting after 30ml/kg intravenous fluid*
- *Persisting hypotension requiring vasopressors to maintain MAP ≥65 mm Hg and having a serum lactate level >2 mmol/L (18 mg/dL) despite adequate volume resuscitation*

Red Flag Sepsis

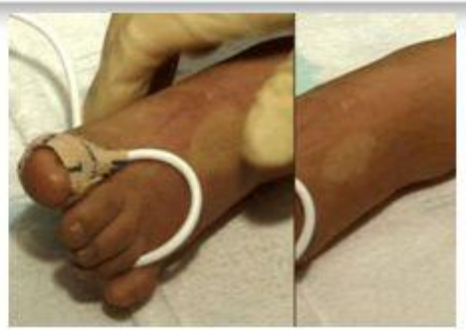
Hyperdynamic Circulation (Warm Shock) 6 Hours – 72 Hours

- Patient presents flushed, hot and dry skin, bounding pulse, tachycardia, tachypnea
- Widening pulse pressure, increased cardiac output, decreased SVR
- Profound dieresis (high osmotic load)
- Diminished plasma volume, catecholamine increase cardiac output and contractility
- Mottling of skin to lower legs/knees

Hypodynamic Circulation (Cold Shock)

- Patient normothermic or hypothermic, skin cool, poor capillary refill time, generally mottled
- Tachycardia and Tachypnea
- Cardiac output low – SVR high
- Catecholamine cause selective vasoconstriction of renal, pulmonary and splenetic circulation. Myocardial depressant factor released from pancreas.
- Multi-system failure, ARDS, liver and kidney failure and DIC
- Death

Septic Shock

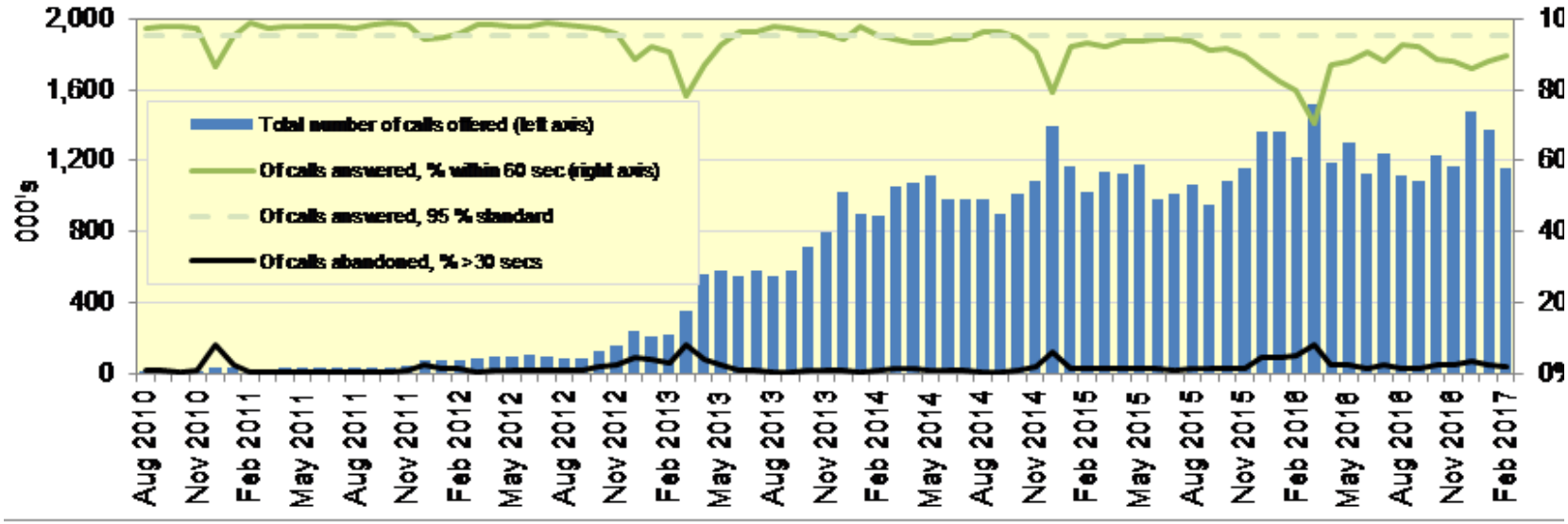


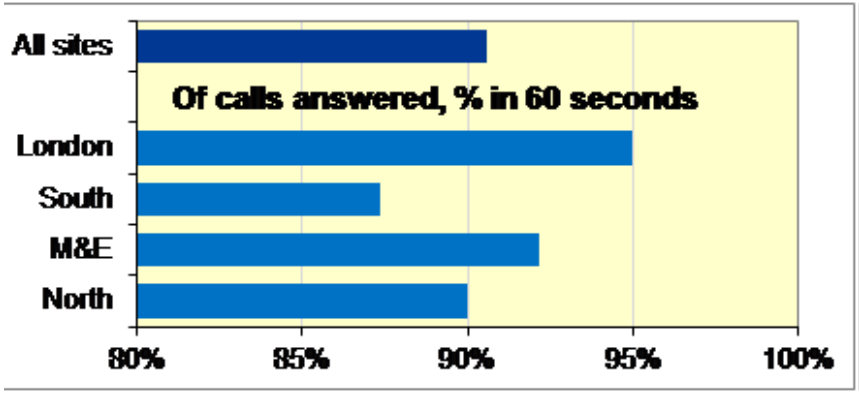
- Hypotension is DECOMPENSATED SHOCK
- Most children have "cold shock"
  - Decreased cardiac output and increased systemic vascular resistance
  - Poor perfusion, cool extremities, delayed cap refill
- Adolescents more likely to have "warm shock"
  - Low systemic vascular resistance
  - Bounding pulses, wide pulse pressure

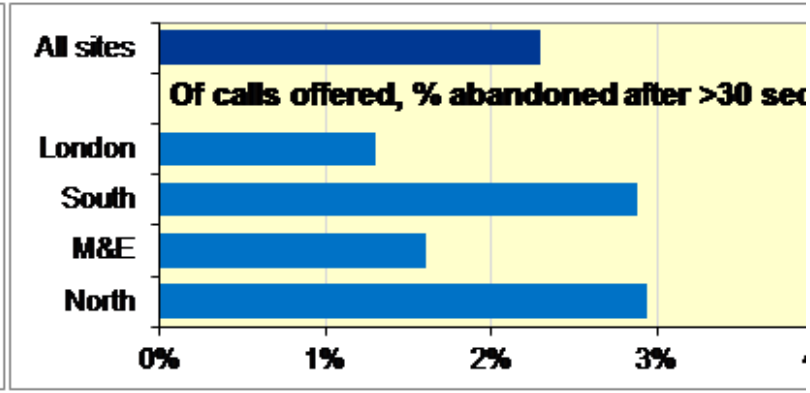
A FINAL WORD…..

111 minimum data set - data to February 2017

Chart 1: Volume and access issues





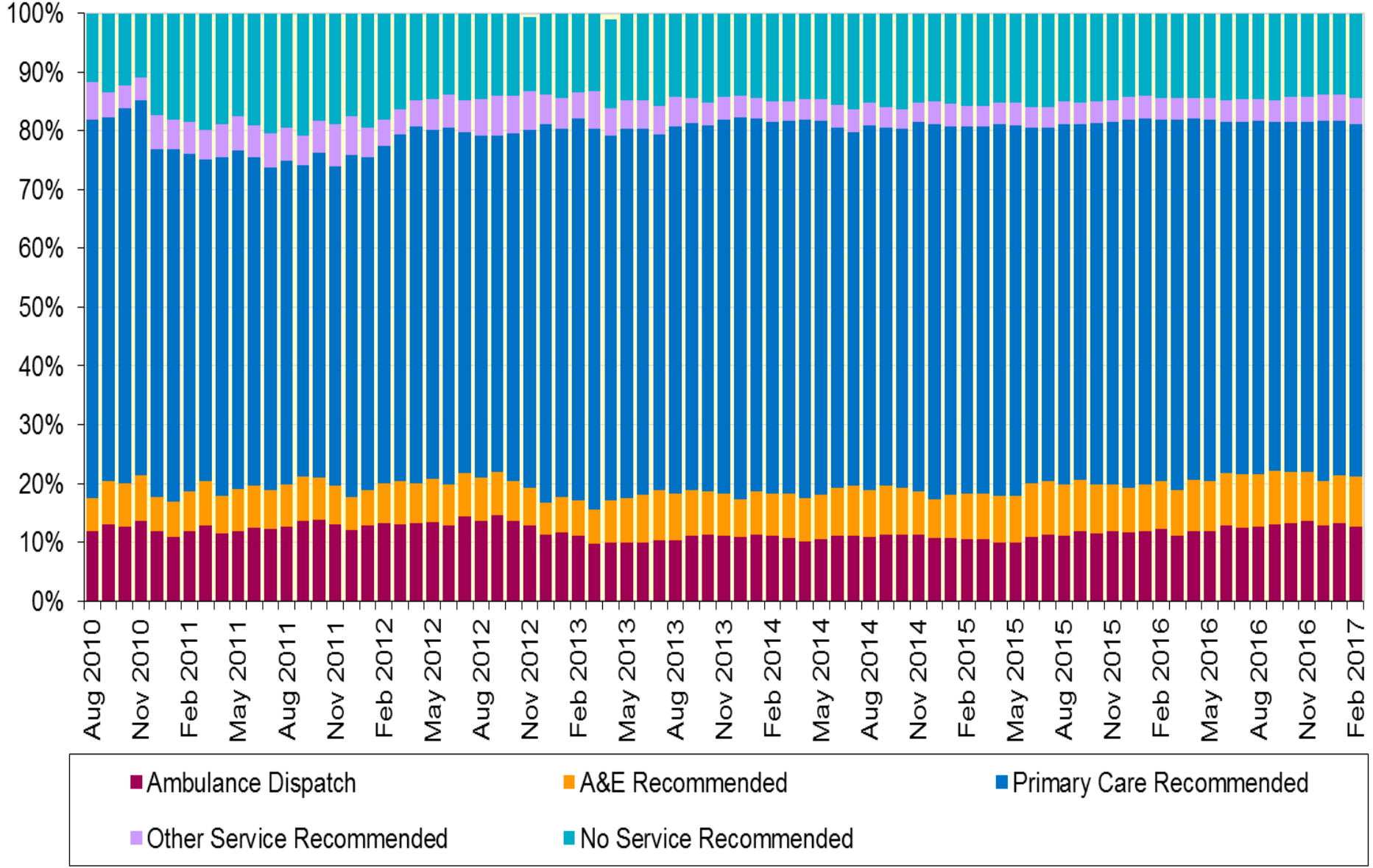


111 minimum data set - data to February 2017

Chart 6: Dispostions as a proportion of all calls triaged

CALL 111 when it's less urgent than 999

NHS England



Questions?


When a teacher wants to know if there are any questions, she doesn't mean any question. She wants to be asked about the thing she's teaching. So if she's teaching you about Mexico, don't ask if "Bubbles" is a good name for a hamster.
RUSS

Take GOOD CARE

The expectation of being immersed in the pain, sadness and suffering of people on a daily basis and not being affected is as unrealistic as being immersed in water and not getting wet.

Further reading

- Brown S, Eberle B, Use of the telephone by pediatric house staff: A technique for pediatric care not taught, Journal of Pediatrics (1974)
- Castells, Maria Alicia, & Furlanetto, Letícia Maria. (2005). Validity of the CAGE questionnaire for screening alcohol-dependent inpatients on hospital wards. *Revista Brasileira de Psiquiatria*, *27*(1), 54-57. https://dx.doi.org/10.1590/S1516-44462005000100012
- DOH Reference Costs 2015/16 – available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/577083/Reference_Costs_2015-16.pdf
- GMC, Good practice in prescribing and managing medicines and devices (2013)
- Greitzer L, Stapleton F, Wright L, Wedgwood R. Telephone assessment of illness by practicing paediatricians, Journal of Pediatrics (1976)
- Higgins, J. et al., 2001. Communication difficulties during 999 ambulance calls: observational study. *BMJ*, 323(7316), pp.781–782. Available at: http://www.bmj.com/content/323/7316/781 [Accessed January 29, 2013].
- Keogh B, (2013) High quality care for all, now and for future generations: Transforming urgent and emergency care services in England - Urgent and Emergency Care Review End of Phase 1. Leeds: NHS England Available at: http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf [Accessed July 8, 2014].
- Leprohon, J. & Patel, V.L., 1995. Decision-making Strategies for Telephone Triage in Emergency Medical Services. *Medical Decision Making*, 15(3), pp.240 –253. Available at: http://mdm.sagepub.com/content/15/3/240.abstract [Accessed December 21, 2010].
- Levy J, et al, Development and Field Testing of Protocols for the Management of Pediatric Telephone Calls: Protocols for Pediatric Telephone Calls, Pediatrics (1979)
- Marklund, B. et al., 2007. Computer-supported telephone nurse triage: an evaluation of medical quality and costs. *Journal of Nursing Management*, 15(2), pp.180–187. Available at: http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2834.2007.00659.x/abstract [Accessed November 14, 2011].
- Montalto, M. et al., 2010. Testing the safety of after-hours telephone triage: Patient simulations with validated scenarios. *Australasian Emergency Nursing Journal*, 13(1-2), pp.7–16. Available at: http://www.sciencedirect.com/science/article/pii/S1574626709002535 [Accessed November 14, 2011].
- Nocera, A., 2010. Death of an infant after contacting a telephone triage call centre: is telephone triage really safe? *Case Reports*, 2010, pp.bcr0820092144–bcr0820092144. Available at: http://casereports.bmj.com/content/2010/bcr.08.2009.2144.full [Accessed November 14, 2011].
- Norman, G.R. et al., 1992. Expertise in visual diagnosis: a review of the literature. *Academic Medicine*, 67(10). Available at: http://journals.lww.com/academicmedicine
- North, F., Muthu, A. & Varkey, P., 2011. Differences between surrogate telephone triage calls in an adult population and self calls. *Journal of Telemedicine and Telecare*, 17(3), pp.118 –122. Available at: http://jtt.rsmjournals.com/content/17/3/118.abstract [Accessed November 14, 2011].
- North, F. & Varkey, P., 2010. How serious are the symptoms of callers to a telephone triage call centre? *Journal of Telemedicine and Telecare*, 16(7), pp.383 –388. Available at: http://jtt.rsmjournals.com/content/16/7/383.abstract [Accessed November 14, 2011].
- Ott J, et al, Patient Management by Telephone by Child Health Associates and Paediatric House Officers, Journal of Medical Education (1974)
- Strasser P, Levy J, Lamb G, Rosekrans J. Controlled Clinical Trial of Pediatric Telephone Protocols. Pediatrics (1979)