Telephone Healthcare Assessment and Consultation Skills

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Programme for the Day

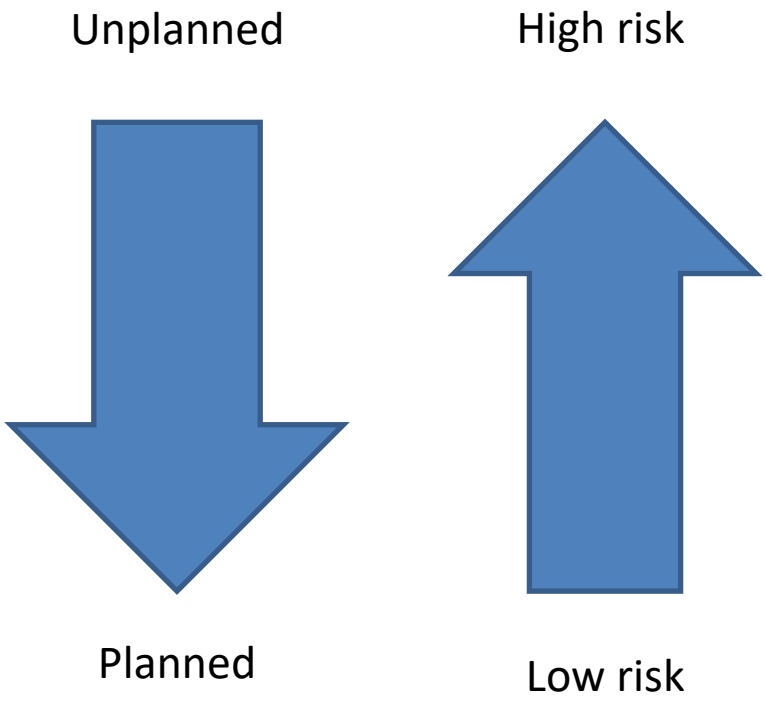
- Background to telephone healthcare
- NHS Pathways
- Risk and ethical issues in telephone healthcare
- Structure of a telephone healthcare encounter
- Quantum telephone healthcare /
- Documentation / Information governance
- Quality control and the audit process
- Medicines Management
- Telephone healthcare in action
- Clinical decision making, history taking and red flags
- Frequent Callers
- Mental health and abusive callers
- Case based scenarios
- (Paediatrics)
- A final word

BACKGROUND TO TELEPHONE HEALTHCARE

What is it and why do we need it?

Types of telephone healthcare assessment

- 999
- 111
- GP
- Mental health
- Long term conditions
- End of life



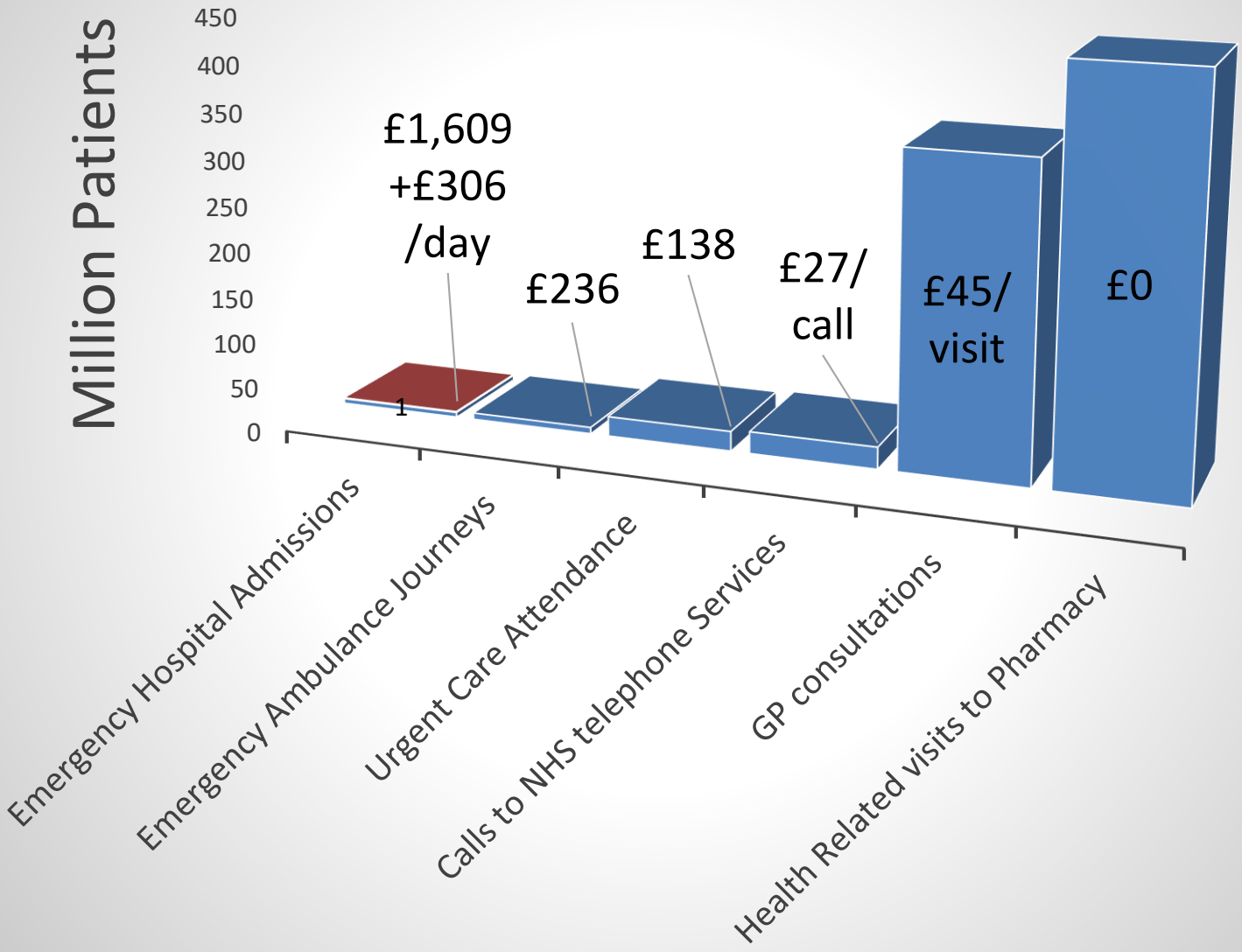
Background to telephone healthcare (Keogh 2013)

- 5.2 million emergency hospital admissions
- *Over 1 million* ***considered avoidable***
- 7 million emergency ambulance journeys
- *50% of 999 ambulance calls transported* ***could have been managed at scene***
- 21.7 million attendances at A&E, Urgent care and minor injuries units
- *40% of patients who attended A&E were discharged needing* ***no treatment at all.***

Background to telephone healthcare (Keogh 2013)

- 24 million calls to NHS urgent and emergency care telephone services
- *Only 4% resolved and closed on the telephone*
- 340 million GP consultations
- *20% of GP consultations relate to minor injuries which could largely be dealt with by self care with care and support from the community pharmacy*
- 438 million health related visits to a pharmacy.
- 324 millions visits to NHS Choices

Keogh 2013


Million Patients
450
400
350
300
250
200
150
100
50
0
£1,609
+£306
/day
£236
£138
£27/
call
£45/
visit
£0
1
Emergency Hospital Admissions
Emergency Ambulance Journeys
Urgent Care Attendance
Calls to NHS telephone Services
GP consultations
Health Related visits to Pharmacy

Self care

A range of common illnesses can be treated with a well stocked medicine cabinet or plenty of rest.

NHS 111

Call NHS 111 free if you need medical help advice, but it is not a 999 emergency.

Pharmacy

Provides local confidential, expert advice and treatment for a range of common illnesses.

GP

For expert medical advice, medical examinations and prescriptions for illnesses.

Minor injury unit/urgent care centre

Offers access to a range of treatment for minor illnesses and injuries, including broken bones.

Emergency Department or 999

These services should be used in an emergency, a critical or life-threatening situation.

Choose well.

Get the right care, in the right place, at the right time

NHS

Kernow Clinical Commissioning Group

NHS PATHWAYS

- Triage software
- Used by 111 and most 999 services now
- Reduce unnecessary emergency attendances
- Universal application
- Operates on a diagnosis of exclusion

NHS Pathways

NHS Pathways uses a medical, symptom based approach to assessment of clinical problems and comprises:

1. Individual flows of linked questions which are age and gender specific.
2. Each flow is designed to: “rule out”, rather than “rule in”, in exactly the same way you do in your day to day practice with patients.
3. Operates on a diagnosis of exclusion with a series of: “core” questions which lead to additional ‘stem’ questions if they are indicated.
4. If a particular stem is completed with no sign of the conditions it covers, the caller returns to the “core” at a defined point for continued assessment
5. Complete documentation of all clinical conditions considered for every flow.

NHS Pathways

- Module 0 – Obvious immediate and imminent threats to life are excluded. This module covers the vast majority of the ambulance service business.

- Module 1 – Conditions requiring non-emergent care are excluded. This module primarily leads to primary care and home care dispositions.

- Module 2 – Clinician assessment module where there is no obvious emergency, but the call is complex or has arrived at a home care disposition. The call is transferred to a nurse or paramedic for further assessment or provision of care advice accordingly.

NHS Pathways

Pathways includes:

- **In-call advice** for delivery during a call to manage the situation – for example CPR.
- **Interim / worsening advice**: Information on managing symptoms until non-emergency ambulance or primary care response is accessed or delivered.
- **Home care advice** – where the call is suitable to be managed by the individual at home and detailed care advice is provided to support the patient in looking after themselves.

NICE National Institute for Health and Care Excellence

Improving health and social care through evidence-based guidance

Right care, right place, right time

Focus is on providing patients with the service with the most appropriate care which:

- Meets the clinical need
- Is delivered by the most appropriate clinician
- Provided at a location that is most suitable to the needs of the patient and of the wider health community.

Is pathways safe?

In 2014 a national service review was undertaken to facilitate the principles of the Francis and Berwick reports in terms of learning and sharing to improve patient care and also to:

- Understand the clinical governance of NHS 111 from the perspective of clinical governance leads, commissioners and providers, and to
- identify good practice to inform wider learning.

Robert Francis QC, Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, February 2013.
Don Berwick, Report on Improving the Patient Safety of Patients in England, August 2013.

NHS111 Quality and Safety Report 2014

NHS 111 Quality and Safety report 2014

Key recommendations

1. Identify clinical governance structures and processes that promote and support clinical leadership
2. Develop capability for shared learning and continuous improvement across the whole health community.
3. Develop a universal system for reporting serious incidents and complaints and simplify information retrieval.
4. Develop a package of best practice examples of clinical governance models for regional dissemination

RISK AND ETHICAL ISSUES IN TELEPHONE HEALTHCARE

First do no harm……

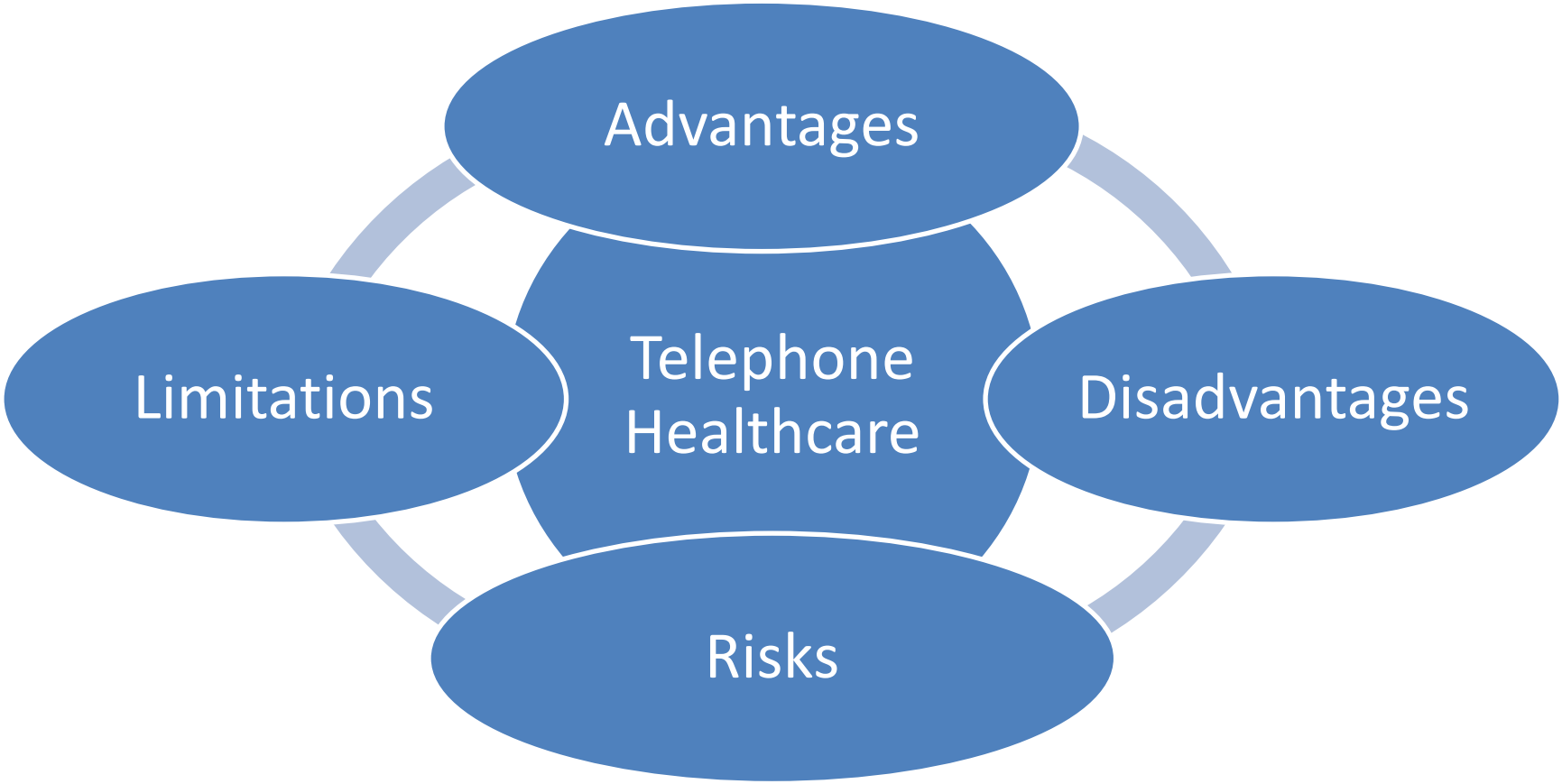
Ethical Issues

Ethical issues arise when the inevitable limitations of telephone healthcare come into play when compared to its gold standard counterpart, the face-to-face consultation.

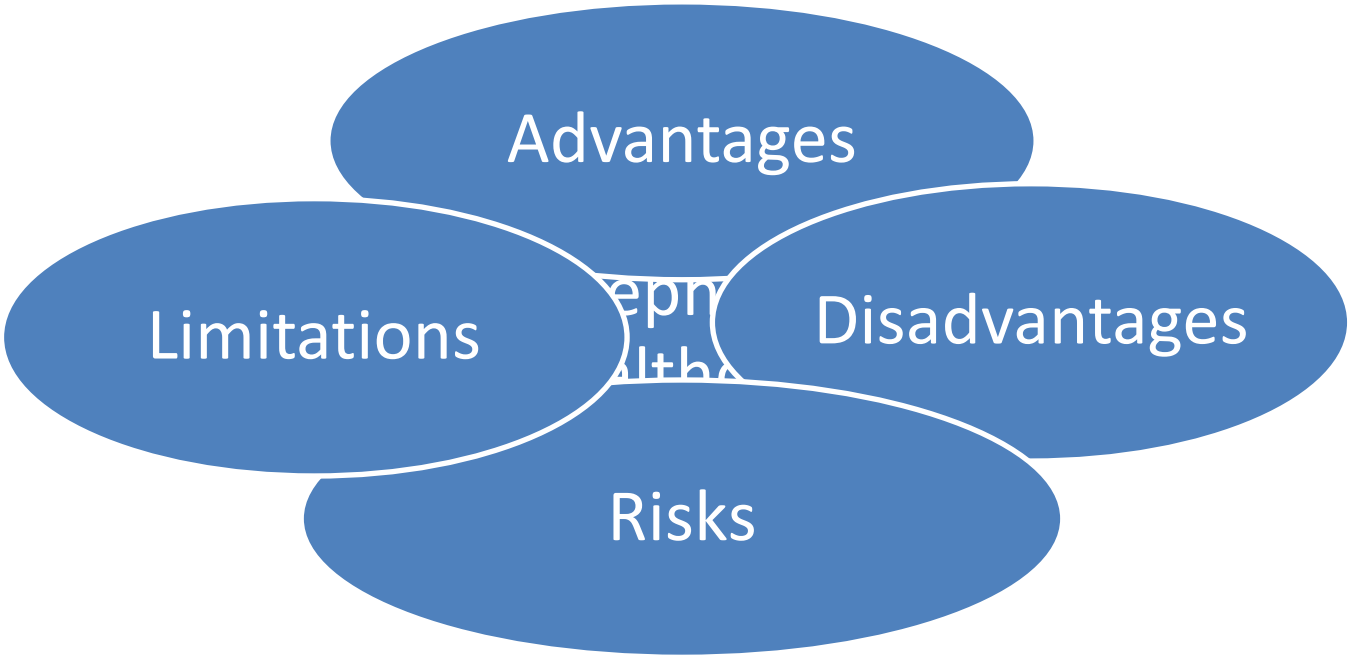
- Can the advantages and disadvantages be balanced?
- Can the rights of the patient be reconciled with the duties of the practitioner?

  * Beneficence,
  * Nonmaleficence,
  * Autonomy,
  * Justice.

Telephone healthcare



Telephone healthcare



Risks in Telephone Healthcare

The key areas where people fall down in telephone healthcare include:

- Information gathering.
- Decision making.
- Giving advice.

Risks in Telephone Healthcare

Studies in the USA in the 1970s identified deficiencies in information gathering by trainee paediatricians conducting simulated telephone consultations. These errors were generally those of omission.
(Ott et al 1974)

<u>Areas overlooked included</u>

- Medication given to the sick child,
- Allergies and immunisation
- They failed to explore how well a child with a cough was breathing
- Levels of hydration in a child with diarrhoea.

Risks in Telephone Healthcare

- Ignoring additional information offered or concerns expressed beyond the point at which the clinician made a diagnosis or a decision about what to do.
- Wellness bias.
- Premature decision making – closing an open mind.
- Remember the face to face consultation is always an option

(Perrin & Goodman 1978)(Goodman and Perrin 1978)(Yanofski et al 1992)

Use of Protocols

Coleman (1997) proposed 3 ways nurses could be protected in telephone triage – but in practice this has general application:

- Use of protocols
- Documentation of calls
- Quality assurance and audit checks

(Coleman 1997)

Software Packages

- Decision-support software packages are available that support telephone triage by prompting clinicians to give comprehensive advice on conditions that may not need a face-to-face assessment.
- Organisations offering health advice and out-of-hours providers use these packages.

Managing Risks of telephone healthcare

- No real difference to how you manage risk in your day to day practice.
- Speak to the patient; third party consultations amplify the pitfalls of telephone consultations and introduce extra dimensions relating to consent and confidentiality.
- Justify the diagnosis and management plan you make in the context of a telephone consultation.
- If there is any doubt a face-to-face consultation should be arranged.


CORONER'S
COURT

Structure of a Telephone Triage Encounter (1)

- Hello my name is…
- Collect or confirm demographics
- Speak to the patient wherever possible – check the patient is with the caller.
- Empathize and establish a rapport
- Remember the patient's perspective, social and cultural aspects.
- Take a brief medical history
- Exercise effective call control
- History of presenting complaint
- What can you see/hear……what can't you see hear…..

Structure of a Telephone Triage Encounter (2)

- Make technology your best friend
- Review of systems: what have you missed.
- Identify chief complaint
- Triage – exclude from high risk to low risk
- Reflect back what you have heard – is it right?
- Summarise what your decision will be based on.
- Make an interpretation – do not diagnose
- Negotiate a shared outcome; is the patient happy with the plan
- Check understanding
- Signpost to ongoing care – know your care pathways
- Safety netting
- Document, document, document….

QUANTUM TELEPHONE HEALTHCARE

What does it look like?

Hello, my name is Dr Kate Granger
& I'm the founder of the
#hellomynameis campaign.

.

hello my name is…

Quantum Telephone healthcare

- Collect or confirm demographics ensuring compliance with the Data Protection Act 2018 and GDPR regulations.
- If the call has been transferred from a reception desk or a call-back is being undertaken this is crucially important.
- If the call represents an emergency, demograhic information is still essential to be able to direct the appropriate care rapidly.

Quantum Telephone healthcare

- Speak to the patient wherever possible.
- Check the patient is with the caller.

Quantum Telephone healthcare

- Empathize and establish a rapport

Quantum telephone healthcare

- Always remember the patient's perspective, particularly social and cultural context.
- Who is in the room with them……

Quantum Telephone healthcare

- Take a brief medical history

Quantum Telephone healthcare

- Verbal nods
- Effective call control

- History of Presenting Complaint

Quantum Telephone Healthcare

Quantum Telephone healthcare

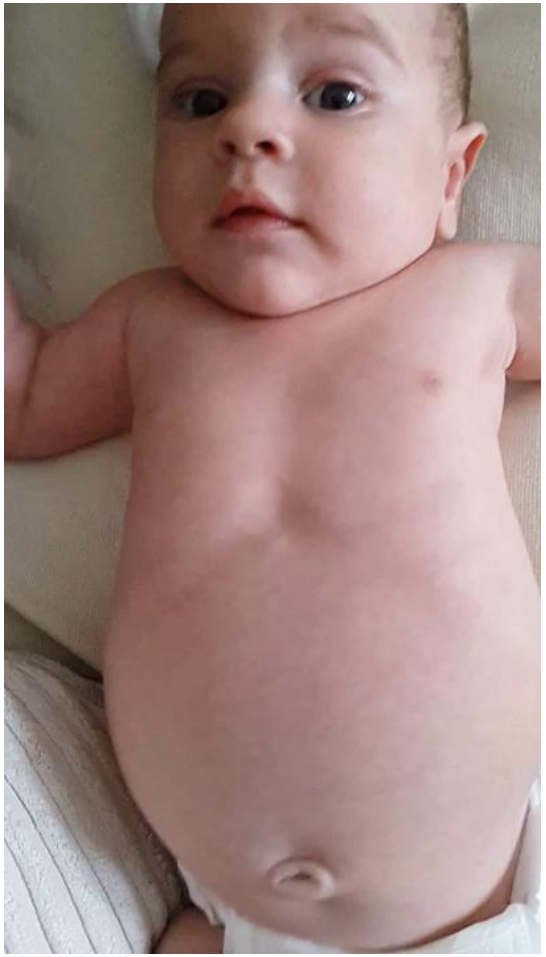
- Listen to everything…….
- What you can hear…….what you can't hear……

Quantum Telephone healthcare

- **Speech**: *content, rate, rhythm, tone, emotion*
- **Non-speech**: *cough, wheeze, background noises*

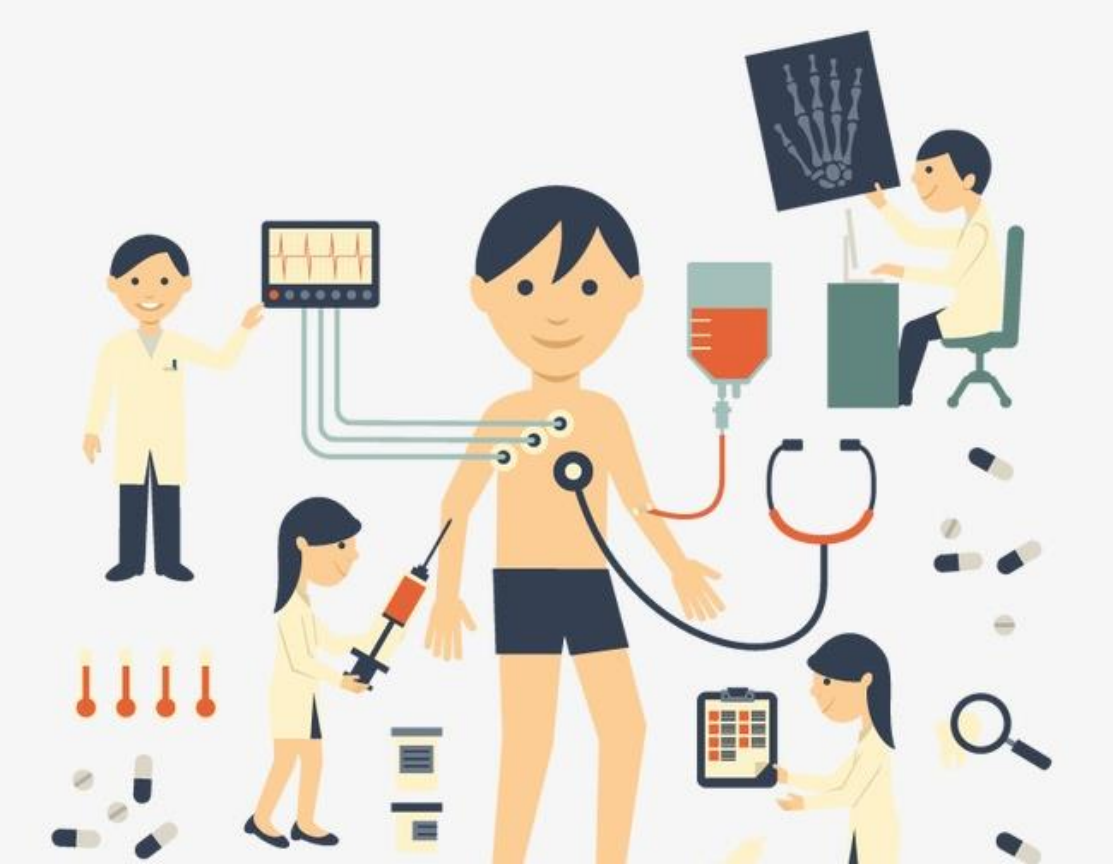
Quantum telephone healthcare

- What can't you see?
- ***Missing this could cost you your career!***
- How can you support someone in describing this?



Quantum Telephone healthcare

- Make technology your best friend.



Review of Systems

- General
- Neurological
- ENT
- Cardiorespiratory
- Gastrointestinal
- Urological
- Obstetric and Gynaecological
- Rheumatological
- Orthopaedic
- Psychiatric

Review of Systems

- A full systems review should not be asked of every patient.
- Should be structured around the presenting complaint.
- Top to toe

- Uncovers other medical problems
- Identify symptoms that may be related to presenting symptoms
- Move from general to specific questions

36 yof: LIF pain

Gastrointestinal

Dysphagia, loss of appetite

Nausea, vomiting

Indigestion, heartburn

Abdominal pain

Change in bowel habit / appearance of stool

Urological

Storage

Infection

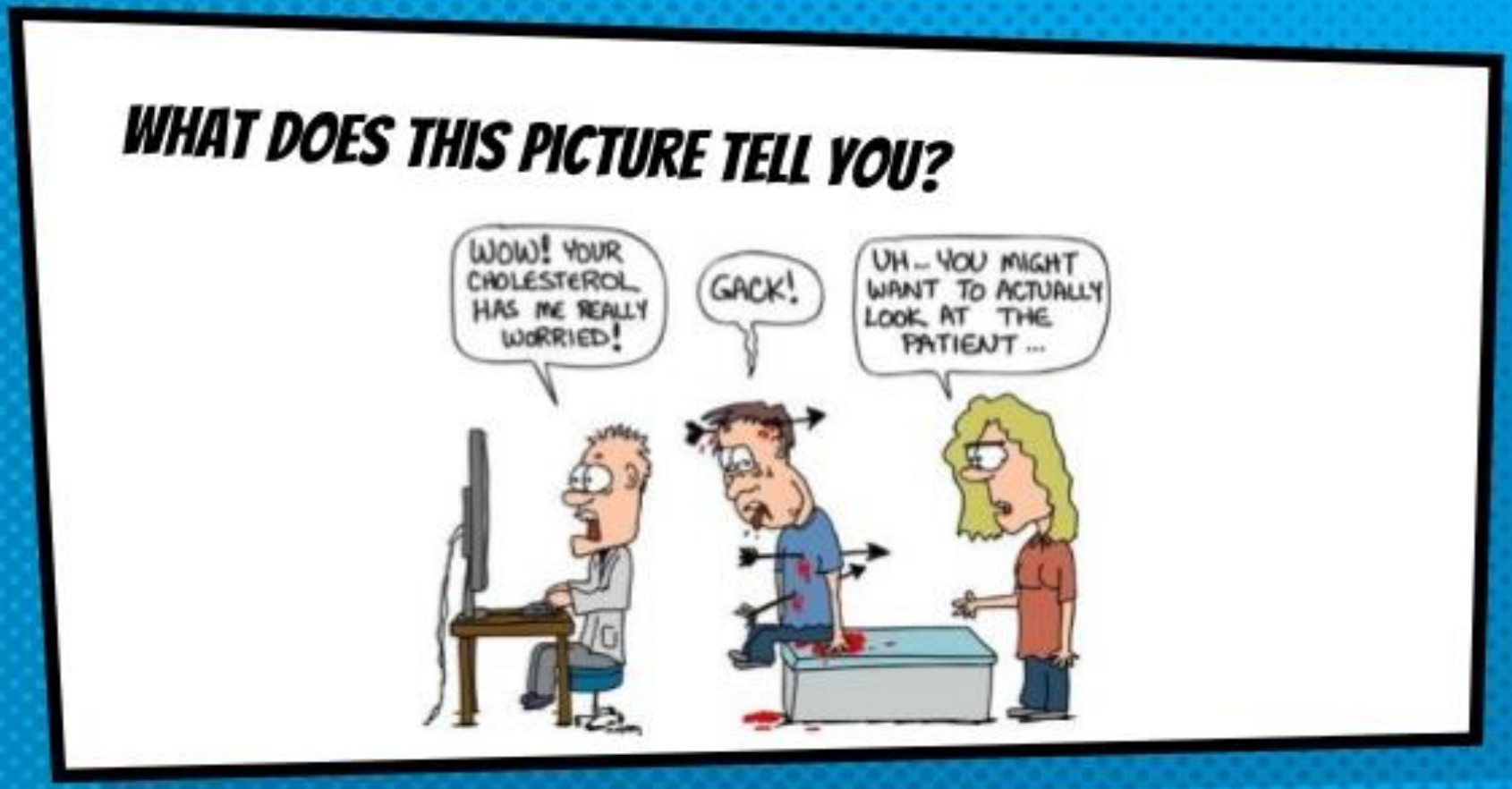
Voiding

Obstetrics & Gynae

Pain

PV Bleeding or discharge

Pregnancy



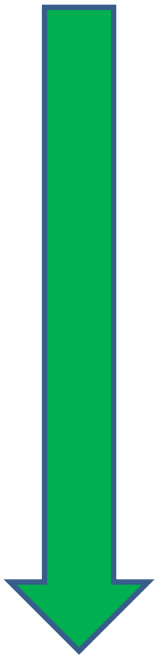
- Identify Chief Complaint

Quantum Telephone Healthcare

Triage: Ask questions to exclude

Risk

High



Low

- Life threatening emergencies requiring 999/ED
- Potential emergent or urgent conditions.
- Non-urgent, moderately sick patients.
- Persistent symptoms which are low risk for complications.
- Chronic or recurrent symptoms which are not worsening
- Mild symptoms that may be safely treated at home.

Chief Complaint: Chest Pain

- Acute coronary syndrome
- Pulmonary embolism
- Pneumothorax
- Thoracic aortic aneurysm
- Malfunctioning pacemaker
- Unstable/stable angina
- Respiratory conditions
- Gastro-intestinal conditions
- Musculoskeletal conditions and chest wall pain
- Non-specific chest pain
- Functional Chest Pain

Table 1. Causes of Chest Pain in the Primary Care Setting

Final diagnosis	Percentage of episodes		
	United States*[1]	Germany†[2,3]	Switzerland‡[4]
Musculoskeletal conditions and chest wall pain	36.2	46.6	48.7§
Gastrointestinal conditions	18.9	—	8.2
Nonspecific chest pain	16.1	—	—
Other or no diagnosis	—	—	5.3
Stable angina	10.5	11.3	11.2
Psychogenic pain	7.5	—	11.5
Respiratory condition	5.1	—	10.3
Nonischemic cardiac condition	3.8	—	3.1
Acute cardiac ischemia	1.5	3.7	1.5
Pulmonary embolism	—	—	0.3

*—Study included 399 patients in 12 family practices in Michigan.
†—Study included approximately 1,200 patients in 74 primary care practices in Germany. Data for other diagnoses have not been published.
‡—Study included 672 patients from 59 primary care practices in Switzerland.
§—Includes patients with traumatic chest pain (3.9 percent).

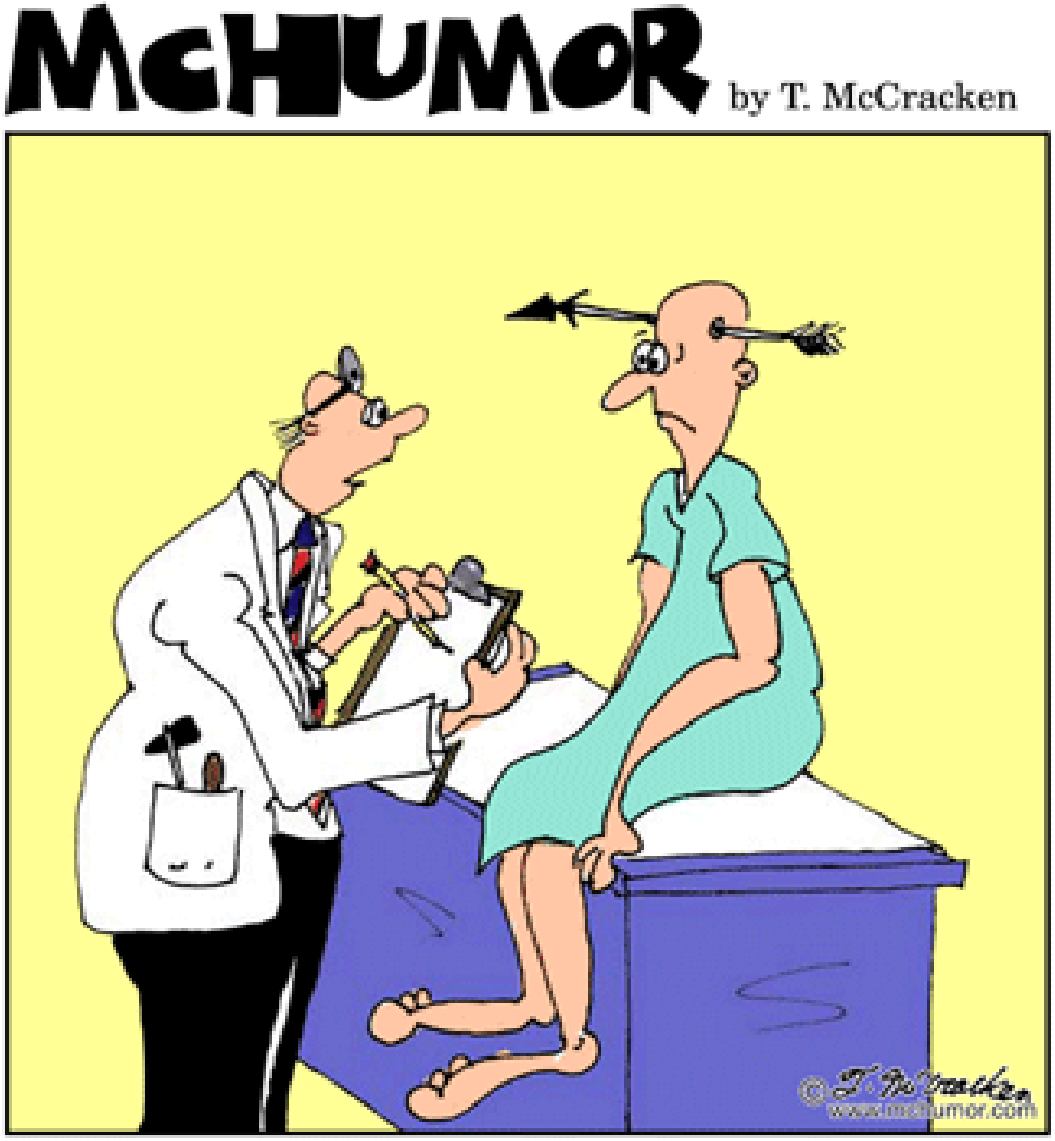
Information from references 1 through 4.

Quantum Telephone Healthcare

- Reflect back with the patient what you have heard.
- Is it right?
- Summarise what your decision will be based on.

Quantum Telephone Healthcare

- Diagnosis?
- Interpretation



"I already diagnosed myself on the Internet. I'm only here for a second opinion."

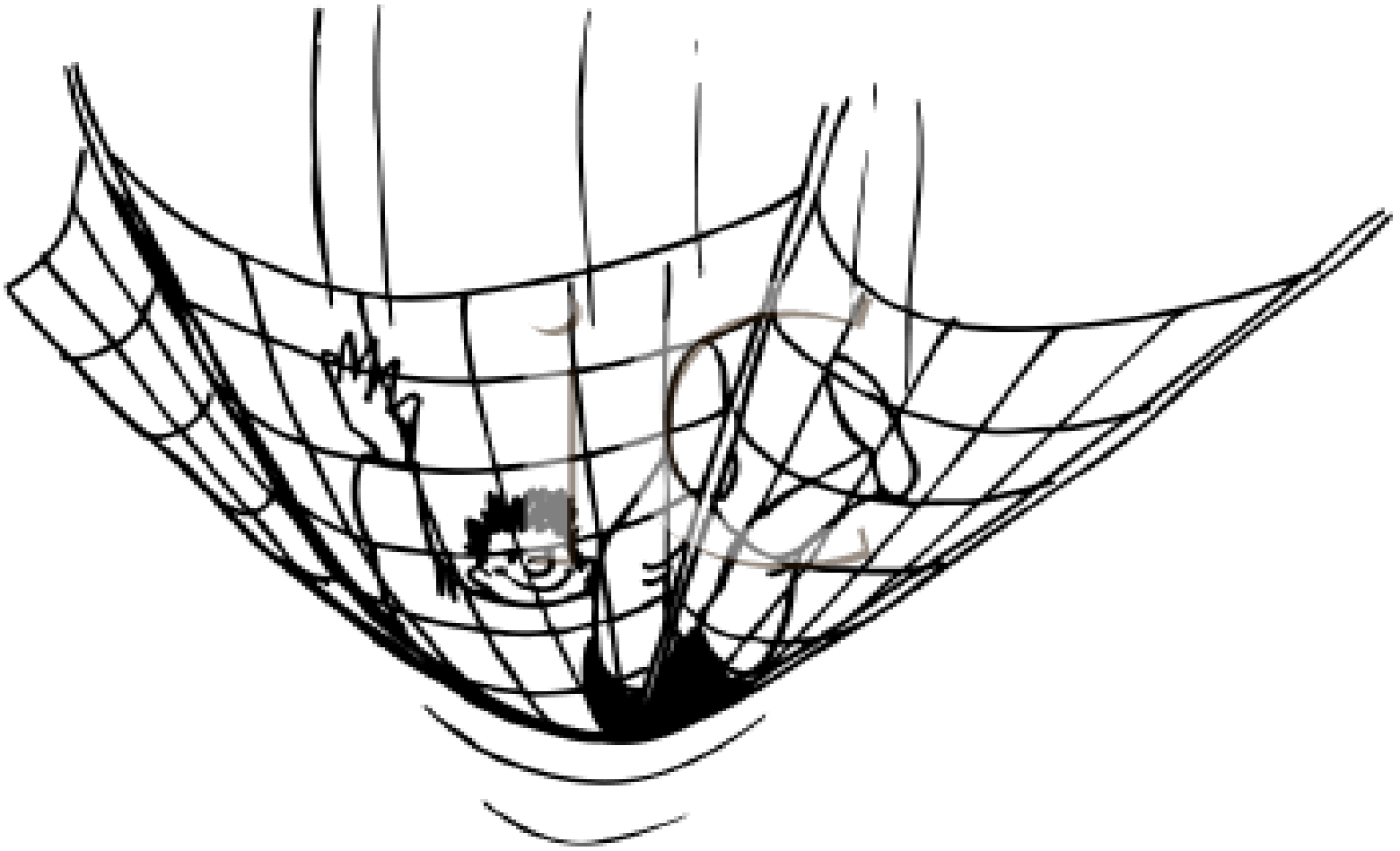
Quantum Telephone Healthcare

- Negotiate a shared outcome.
- Is the patient happy with the plan?
- Does the patient even understand the plan?

Quantum Telephone Healthcare

- Signposting: when you have enough information to make a decision.
  (Do you have enough information to make a decision?)
- Know your care pathways

Quantum Telephone Healthcare



Safety Netting

- Be specific: 'If x happens, call back immediately.'
- Provide a broad timescale for when symptoms should have resolved; define action to be taken if it doesn’t.
- Consider booking a follow up appointment there and then.
- Refer patients to written information, patient leaflets, recognised and appropriate helplines and organisations which may be accessed to reinforce or support verbal advice.
- Ensure patients know how to access further advice (eg 111/OOH).
- Make sure the patient knows the call is not a: ‘once and for all’ decision.
- Bear in mind the need to re-assess if symptoms are not settling, or if there is no response to the treatment you have given. Include: ‘red flags’ where these are appropriate and be prepared to reconsider an earlier impression.
- Document the specific advice given.


SNAP
Your career
The SAFETY NET...

Quantum Telephone Healthcare

"DOCTORS ARE WARNED TO TAKE METICULOUS NOTES OF ALL CONVERSATIONS WITH PATIENTS WHO REFUSE TO ACCEPT TREATMENT ADVICE"

- Comprehensive, contemporaneous note keeping is essential.

Record Keeping S.O.A.P

Subjective	Statements of symptoms and complaints, ideally in the patient's own words.	Presenting Complaint History of Presenting complaint
Objective	Findings	What you have heard - Speech and non-speech. Patients medical history Previous medical assessments / tests
Assessment	of subjective and objective findings	Clinical decision making – putting ALL the facts together to reach a conclusion
Plan	of treatment	Documenting a care plan including recommendations, instructions, medications, further consultations and worsening care advice.

Information Governance: recording phone calls

- Electronic sound files form part of the patient's records
- Recordings must be made, stored and disclosed under the provisions of the relevant legislation
- Patients must be informed the call is being recorded.
- Patients have a right to be provided with copies of information that is held about them and this would include recordings of telephone consultations. (Data Protection Act (1998),
- Secret recordings of calls from patients are not permitted. (GMC: Making and Using Visual and Audio Recordings of Patients (paragraph 56.11))

Information Governance: recording phone calls

Recording may protect the clinician – but not always.

- Sessional GP working in the out-of-hours setting
- Prescribed Penicillin
- Patient penicillinallergic
- Anaphylactic response
- Claim ensued.

Information Governance: recording phone calls

- No paper record of allergy status noted
- GP adamant his usual practice was to check therefore the patient must have withheld this.
- Triage telephone recordings reviewed, from which it was clear that the patient (without any prompting) volunteered that they were allergic to Penicillin

Lest we forget.....

TELEPHONE HEALTHCARE QUALITY CONTROL

Auditing……

Improves patient safety

Improves patient care

Permits feedback and reflection

Identifies development needs

Identifies good practice

Why audit calls?

How can calls be audited

- Listening to calls – either live or recorded
- Reviewing documentation (but not only documentation)
- Should follow its own agreed protocol – audit tools
- Undertaken by trained auditors
- Should be SMART

SMART Auditing

- Specific
- Measurable
- Achievable
- Realistic
- Timely

MEDICINES MANAGEMENT IN TELEPHONE HEALTHCARE

Prescribing by telephone (1)

GMC states:

- *“Before you prescribe for a patient via telephone, video-link or online, you must satisfy yourself that you can make an adequate assessment, establish a dialogue and obtain the patient’s consent…”*
- *“you must prescribe only when you have adequate knowledge of the patient’s health, and are satisfied that the medicines serve the patient’s needs.”*

Prescribing by telephone (2)

- Ensure the patient is content and understands the proposed management plan
- The regular medications (including over-the-counter medications) taken by the patient and any drug sensitivities should be known or elicited by the clinician
- The rationale for treatment should be explained together with its risks, benefits and burdens
- Adequate provision for follow-up in the event of no improvement, worsening symptoms or side effects should be made

Prescribing by telephone (3)

- The patient or a carer should be in a position to attend a pharmacy, surgery or out-of-hours centre to obtain the prescribed item
- The drug prescribed should be efficacious, cost-effective, prescribed at appropriate dose and in the appropriate quantity
- For infections for which there is equivocal evidence for the effectiveness of antibiotics, the prescriber should consider the option of issuing a “delayed” prescription that can be redeemed by the patient at a future date should symptoms not improve spontaneously
- Controlled drugs should not usually be prescribed on the basis of a telephone consultation alone.

Repeat Prescriptions

NHS Urgent Medicine Supply Advanced Service (NUMSAS)

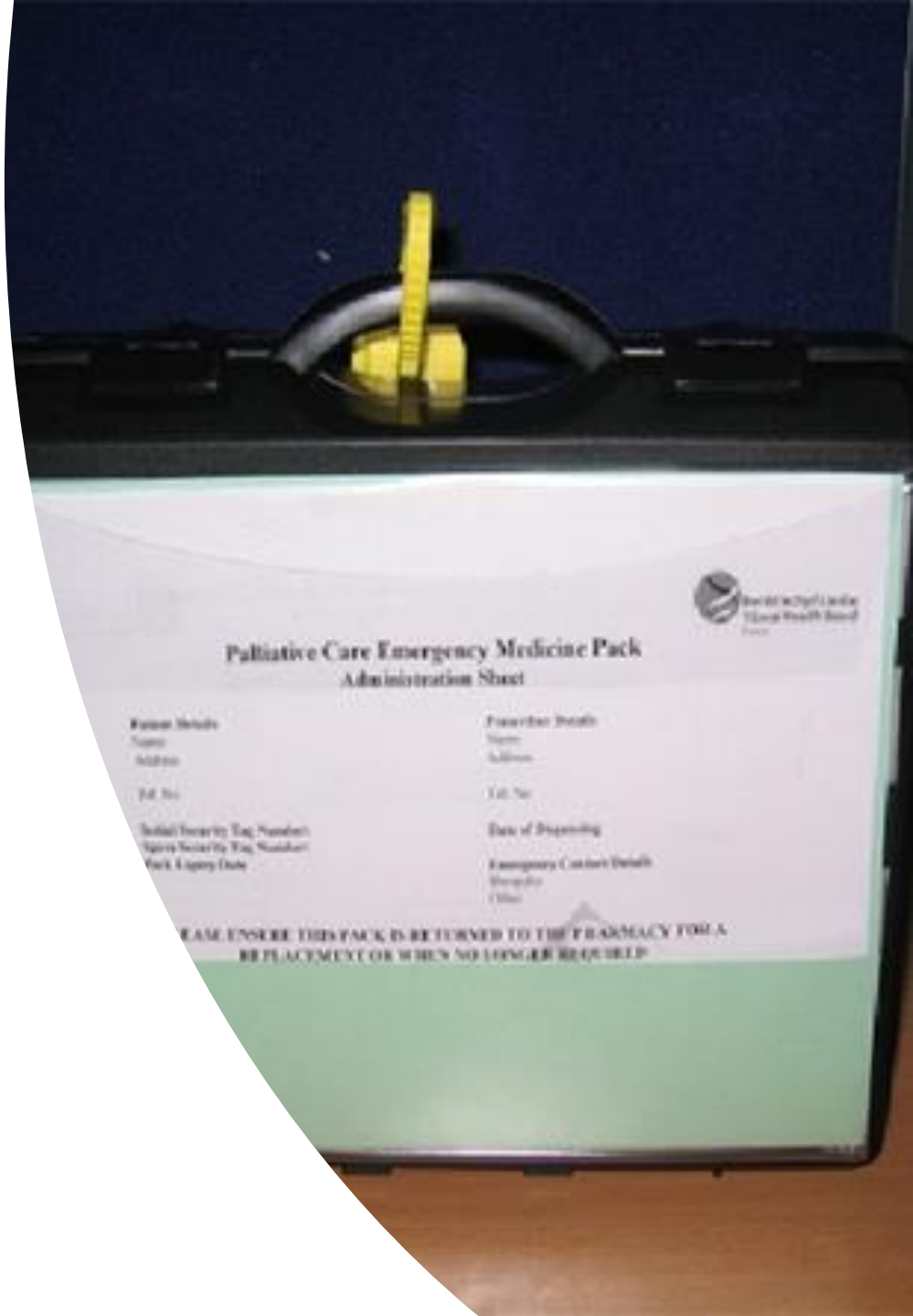
Pharmacy Urgent Repeat Medicines Service (PURMS)

- Permits emergency supply of medicines for patients referred by NHS 111 only
- Reduces burden on urgent and emergency care providers.
- Includes prescription only and other medicines usually obtained on prescription from their.
- Made under emergency supply provisions only when deemed necessary by the pharmacist
- Does not apply to patients requesting emergency supplies from the pharmacy directly.

End of life care: Anticipatory Prescribing

Just in case boxes include:

- A brief carer leaflet
- A leaflet detailing use of lorazepam tablets
- A summary of symptom control guidelines in a sealed envelope identifying it as for HCP use only.
- Paramedics are able to administer drugs in JIC box



TELEPHONE HEALTHCARE IN ACTION

Some real cases…..

NHS Pathways – Back Pain

Some real calls.. . Fire is on…

CLINICAL DECISION MAKING

History taking and red flags in telephone healthcare

Clinical Decision Making

Clinical decision making is a balance of experience, awareness, knowledge and information gathering, using appropriate assessment tools, your colleagues and evidence-based practice to guide you.

Good decisions = safe care.

Core Skills of Clinical Decision Making

- **Pattern recognition**: learning from experience.
- **Critical Thinking:** removing emotion from reasoning, being 'sceptical', clarifying goals, examining assumptions, being open-minded, recognising personal attitudes and bias, able to evaluate evidence.
- **Communication Skills:** active listening to everything, facilitating a patient-centred approach that embraces self-management; information provision - the ability to provide information in a comprehensible way to allow patients/clients, their carers and family to be involved in the decision making process.

Core Skills of Clinical Decision Making

Evidence-based approaches: using available evidence and best practice guidelines in decision making.

Team work: using the evidence to enlist help, support and advice from colleagues and the wider multi-disciplinary team.

Sharing: learning and getting feedback from colleagues on decision making.

Reflection: using feedback and outcomes to reflect in order to enhance practice delivery in the future

History Taking

The difference between life and death

History taking: A reminder

We take a history to……

- Elicit the nature of the problem
- Reach a diagnosis (????)
- Explore the patient's own beliefs and agree the problem
- To find out the patient's expectation
- Agree a management plan and ensure 'partnership in care'

History taking in telephone healthcare

- Presenting complaint
- History of presenting complaint
- Past medical history
- Mental health
- Medication
- Family history
- Social history
- Sexual history
- Occupational history
- Review of Systems
- Third party information
- Summary

Adapted from Douglas et al 2005

History taking in telephone healthcare

Presenting complaint / HPC

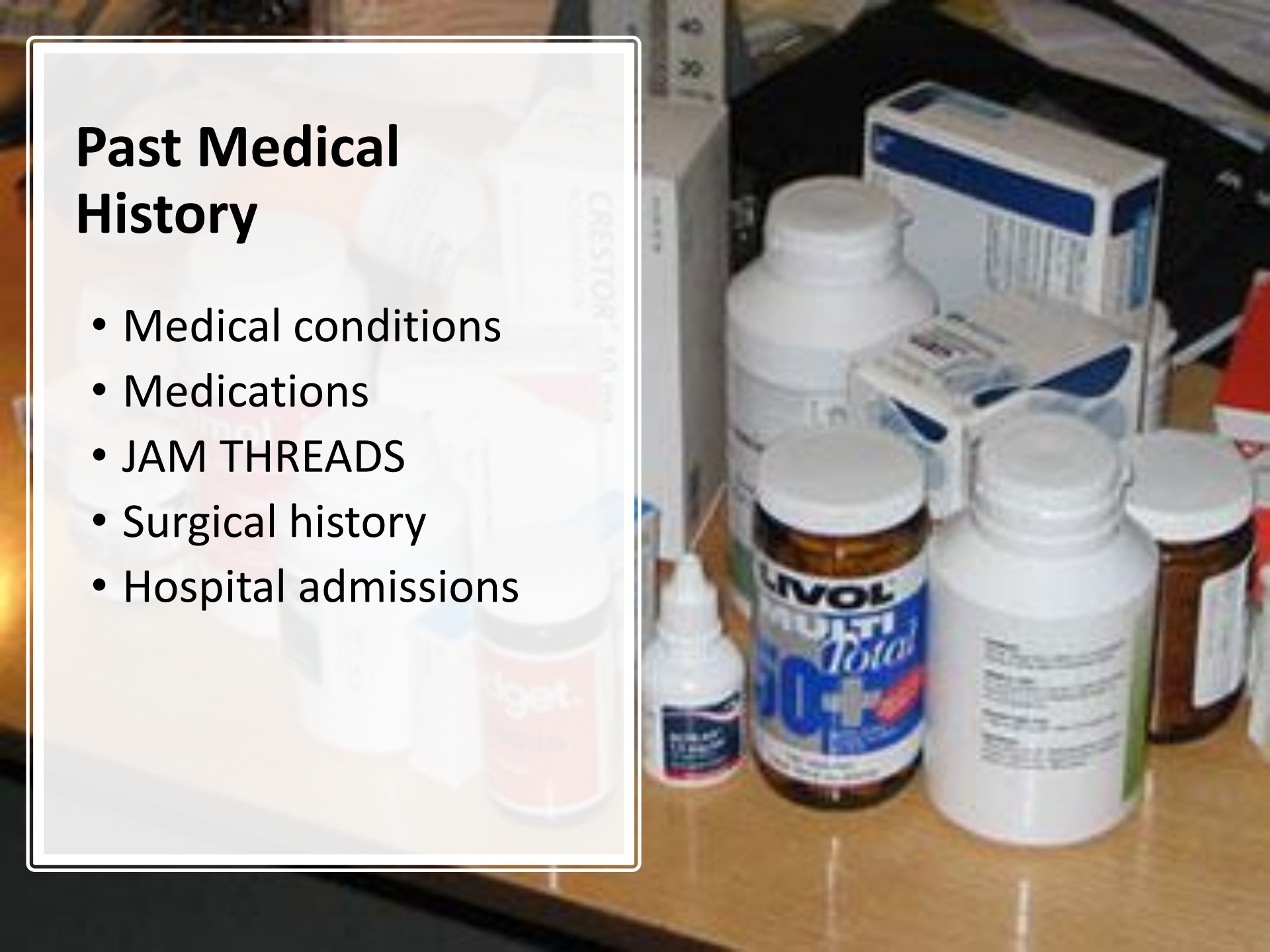
- Make sure you've really got the problem
- Focus on the symptoms not the diagnosis
- Explore cardinal symptoms
- Explore pathognomonic symptoms

Mnemonics – a tool not a rule

- O –Onset, are Other people sick
- P -Provocative and palliative actions
- Q – Quality and quantity of the pain/symptom
- R – Region, radiation, recurrence
- S - Severity
- T - Timing/temporal/treatment
- U – Understanding / Impact / What do ‘u’ think is wrong?
- V – Values / goals of care

Past Medical History

- Medical conditions
- Medications
- JAM THREADS
- Surgical history
- Hospital admissions



JAM THREADS

- **J**aundice
- **A**naemia and other haematological conditions
- **M**yocardial Infarction

- **T**hyroid/Tuberculosis
- **H**yper/hypotension, heart disease
- **R**heumatic fever, rheumatoid arthritis
- **E**pilepsy
- **A**sthma and COPD
- **D**iabetes
- **S**troke/seizures

Samosa Diet

Sexual History	• Relationship status? Contraception? When was the first day of your last menstrual cycle? Pregnancies? eg: P2G1
Allergies	• Drugs, environment food, dressings, type of reaction?
Medication	• Prescribed, OTC, Herbal, Supplement, Recreational
Occupation	• Current and previous, environmental exposure
Smoking	• Current or ex-smoker, pack year history, ready to quit?
Alcohol	• Number of units per week – consider CAGE questionnaire?
Diet	• Health Diet, types of food, amount
Immunisations	• Up to date? Tetanus, Influenza, Pneumococcal, Hep B?
Exercise	• What type of exercise? How often? For how long?
Travel	• Recent travel? When? Where?

CAGE Questionnaire for Detecting Alcoholism

Question	Yes	No
C: Have you ever felt you should **C**ut down on your drinking?	1	0
A: Have people **A**nnoyed you by criticizing your drinking?	1	0
G: Have you ever felt **G**uilty about your drinking?	1	0
E: Have you ever had a drink first thing in the morning (**E**ye opener)?	1	0

A total score of 0 or 1 suggests low risk of problem drinking
A total score of 2 or 3 indicates high suspicion for alcoholism
A total score of 4 is virtually diagnostic for alcoholism

CIWA Scale (CIWA-Ar)

The Clinical Institute Withdrawal Assessment for Alcohol, revised scale

- Patients frequently under-report alcohol use and physicians often overlook alcohol problems in patients (Kitchens 1994) It is estimated that 1 of every 5 patients admitted to a hospital abuses alcohol. (Schuckit 2001)
- Unrecognized alcohol withdrawal can lead to potentially life-threatening consequences including seizures and delirium tremens
- Efficient, objective means of assessing alcohol withdrawal that can then be utilized in treatment protocols.

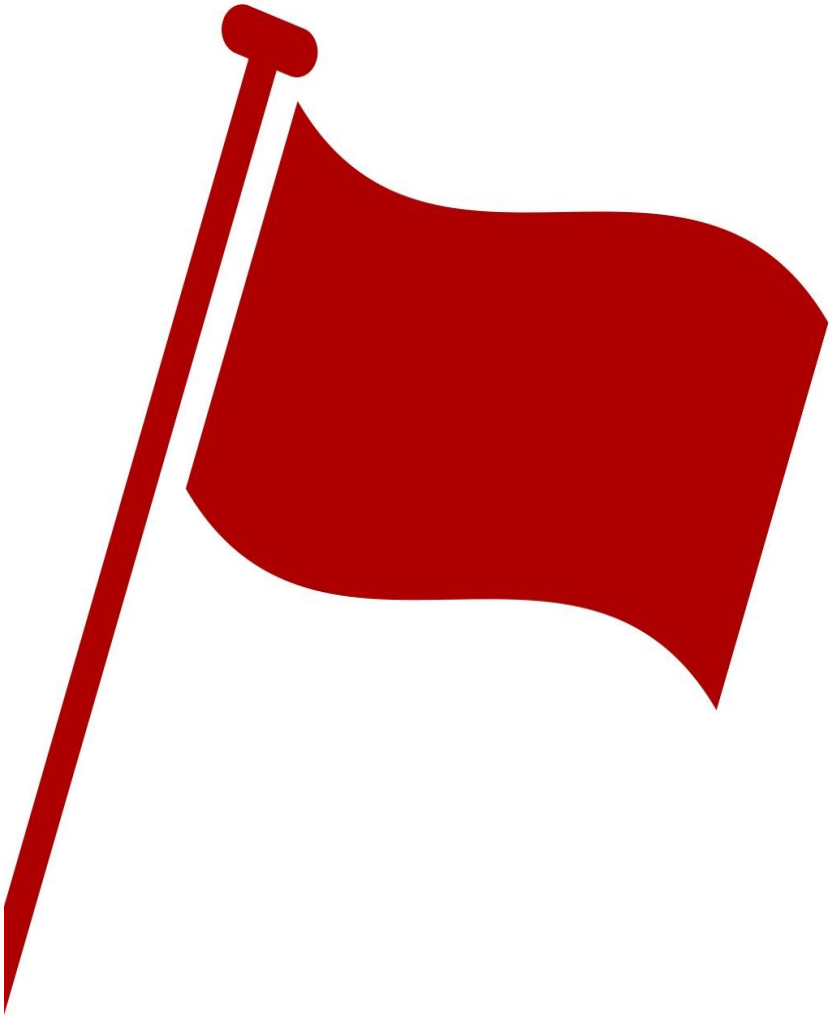
Clinical Opiate Withdrawal Scale (COWS)

COWS allows rapid assessment of levels of opiate withdrawal and assists in determining appropriate treatment.

Combines subjective with objective criteria to limit feigned responses (Wesson 2003) but of course over the telephone those objective criteria are difficult to assess

Red Flags

- http://www.gponline.com/education/medical-red-flags



Have you heard enough?

- Consider whether enough information has been gathered to allow a safe assessment of the problem and a safe management decision and crucially, have all conditions requiring more urgent action been reasonably excluded?

Some real calls – 34 yof – Chest pain

34 yof……chest pain……

34 yof – CHEST STILL HURTS!!!