



— BELMATT —  
HEALTHCARE TRAINING

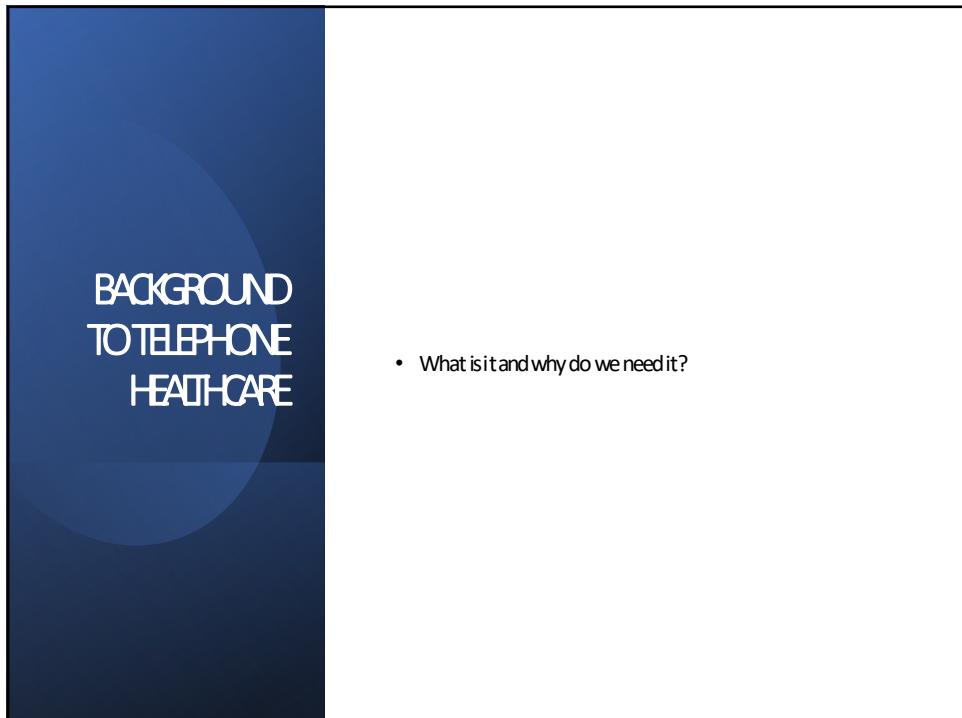
Telephone Triage and Consultation Skills

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## Programme

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

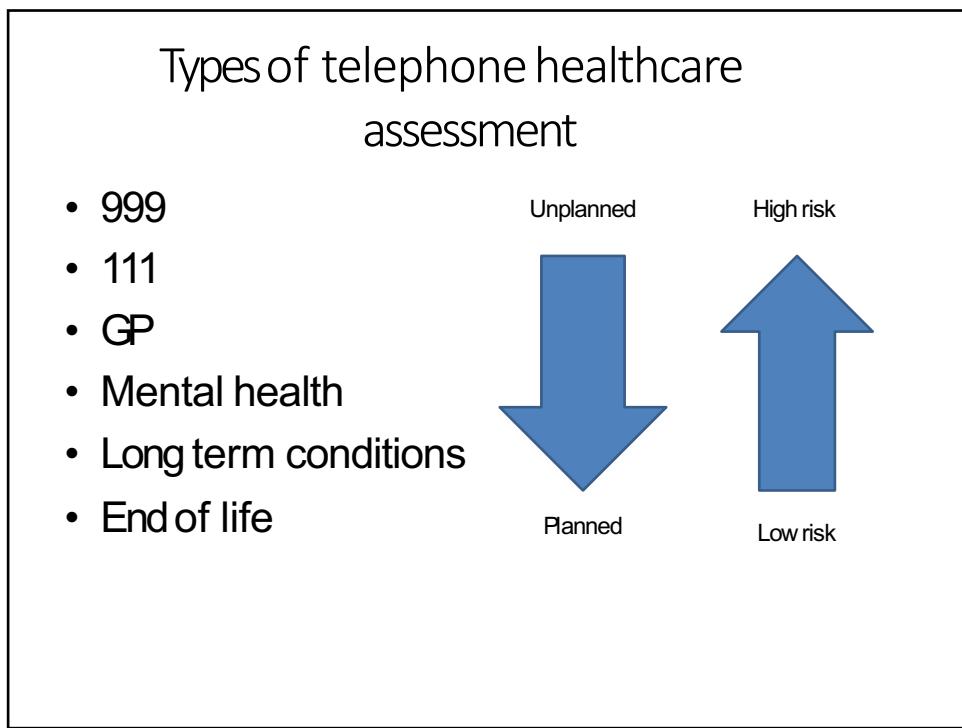
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The slide features a dark blue background with a large, semi-transparent white circle in the center. Overlaid on the circle is the text "BACKGROUND TO TELEPHONE HEALTHCARE" in white, sans-serif capital letters.

- What is it and why do we need it?

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The slide title is "Types of telephone healthcare assessment". To the left is a list of services, and to the right is a conceptual diagram.

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

The diagram consists of two large blue arrows pointing in opposite directions. The left arrow points downwards and is labeled "Unplanned" at the top and "Planned" at the bottom. The right arrow points upwards and is labeled "High risk" at the top and "Low risk" at the bottom.

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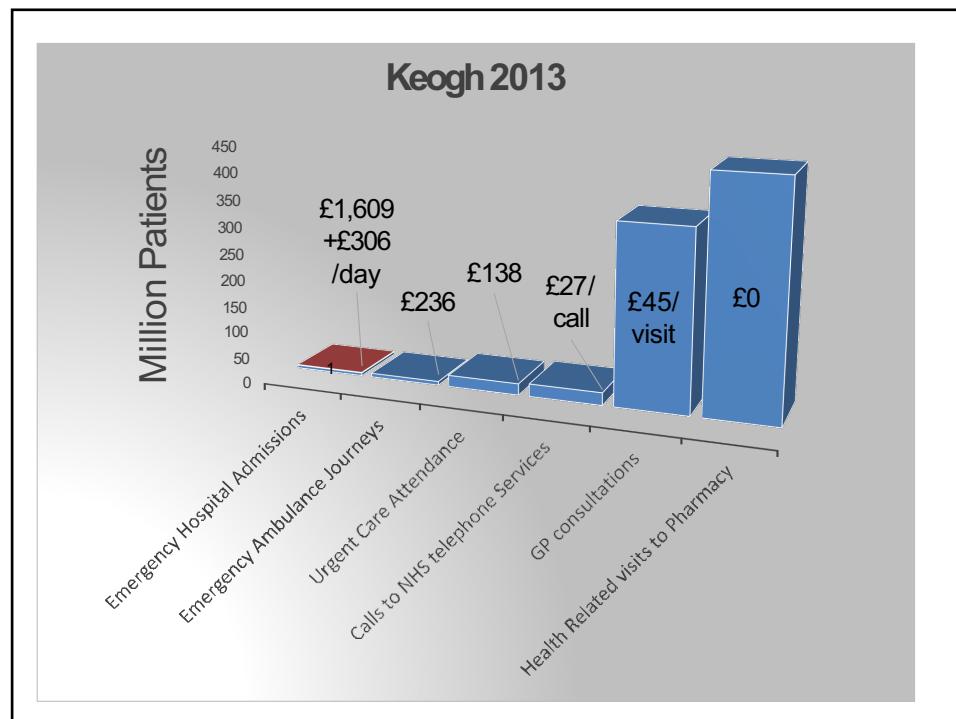
## Background to Telephone Triage

- 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.

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- 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

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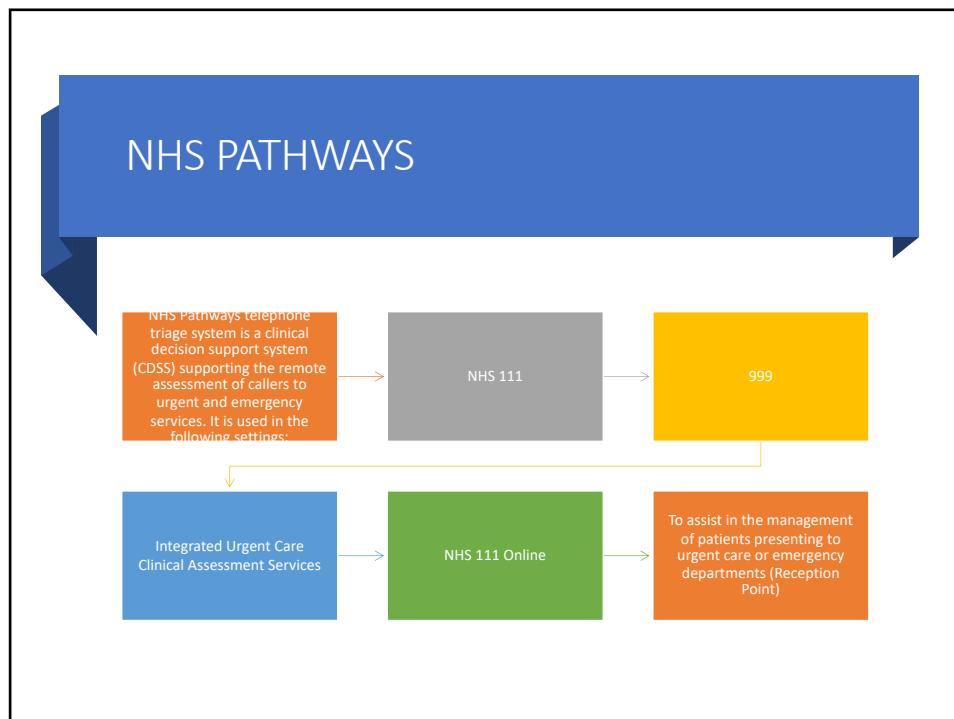
## NHS PATHWAYS

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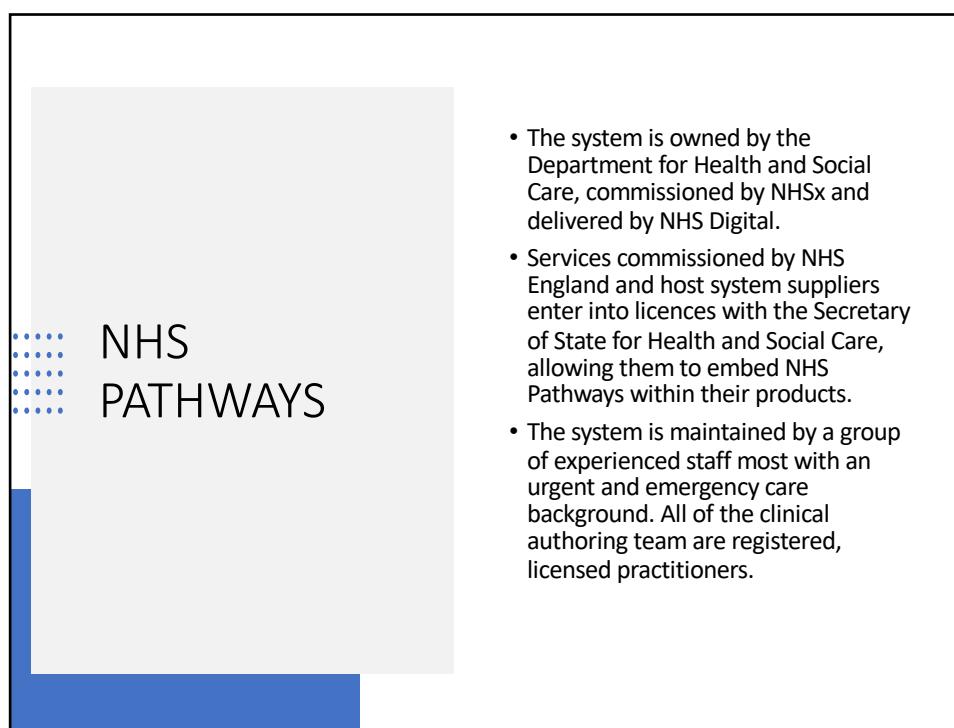
- Triage software
- Used by 111 and most 999 services now
- Reduce unnecessary emergency attendances
- Universal application
- Operates on a diagnosis of exclusion



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## How does it work



The system is an interlinked series of algorithms, or pathways, that link clinical questions and care advice, leading to clinical endpoints. Non-clinical call handlers are presented with a series of questions. Based on the answers given, the most appropriate clinical response with a specific level of care and the time frame, is reached.



Questions are asked in a clinical hierarchy, so life-threatening questions are asked early in the call, progressing through to questions about less urgent symptoms.



The NHS Pathways system is broadly divided into three modules with the system taking a symptom-based approach, rather than a diagnostic one.

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## NHSPathways

**NHS Pathways uses a medical, symptom based approach to**

**assessment of clinical problems and comprises:**

- Individual flows of linked questions which are age and gender specific.
- 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.
- Operates on a diagnosis of exclusion with a series of: “core” questions which lead to additional ‘stem’ questions if they are indicated.
- 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
- Complete documentation of all clinical conditions considered for every flow.

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NHSPathways

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.

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Module 0

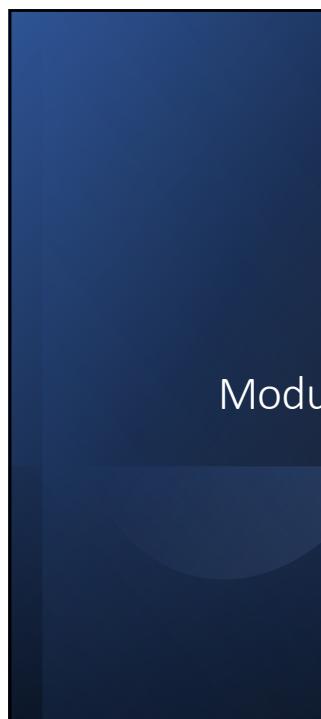
- Module 0 consists of the entry pathways into the NHS Pathways system. Emergency situations are dealt with by asking questions about:
  - consciousness
  - breathing
  - choking
  - fitting
- commonly occurring “declared” serious conditions, such as heart attack, stroke, anaphylaxis or blood sugar problems (evidence shows that for certain high profile or well understood conditions, callers often declare these and are correct in their assumptions, so the system provides a rapid means of assessing such urgent cases).
- If the answers given to the symptoms assessed in Module 0 are sufficiently serious, the questions will trigger the dispatch of an emergency ambulance. No further questions or considerations of conditions are needed at this point.
- Module 0 rules out some, but not all, life-threatening conditions. Once these have been ruled out, the call handler reaches Module 1.

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- Module 1 starts with a body map – a pictorial representation of a human body relevant to the age and gender of the patient - and contains all of the questions that may be asked by a call handler. Pathways related to that body area or body system are available and selected determined by the caller's report of the main or worst symptom. Where there is no single main or worst symptom, the non-clinical call handler should seek clinical advice.
- The system will then present various questions to the non-clinical call handler. Each answer will determine the next question asked until:
  - an end point (disposition) is reached
  - the call is ended early
  - the call is handed to a clinician
- The questions continue in a hierarchical order, and so generally the more questions asked, the less severe the symptoms.

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- Module 2 is only accessible to trained in-house clinicians.
- The module allows, if required, validation of calls that have been previously assessed by non-clinical call handlers, and for further assessment when a call becomes too complex for a non-clinical call handler to safely triage.
- This is an essential risk management tool.

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## 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.

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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.

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**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.

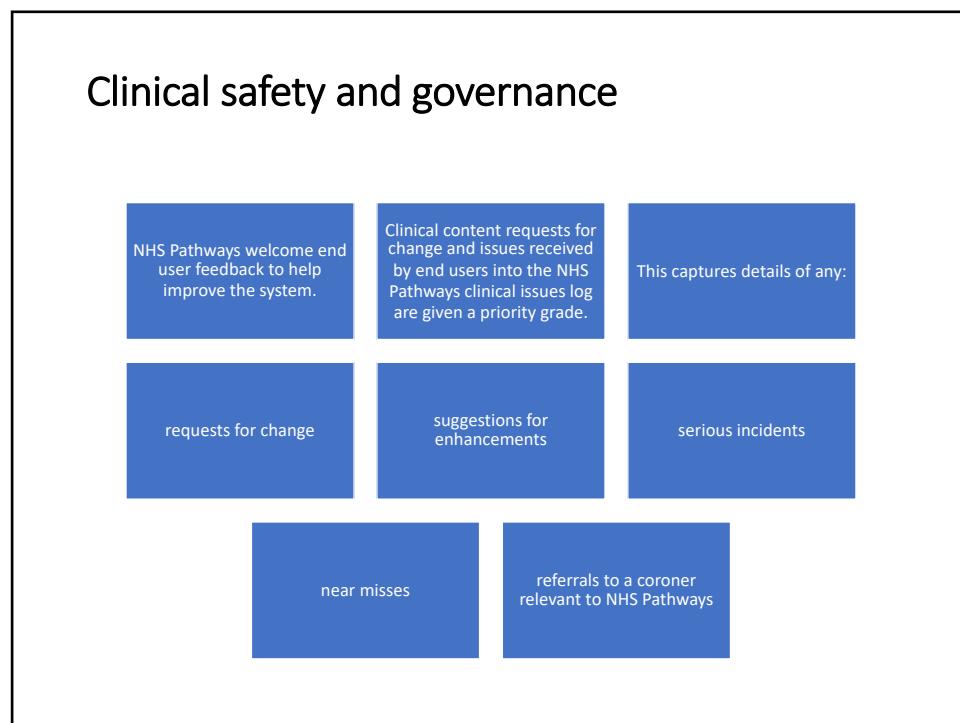
NHS111 Quality and Safety Report 2014

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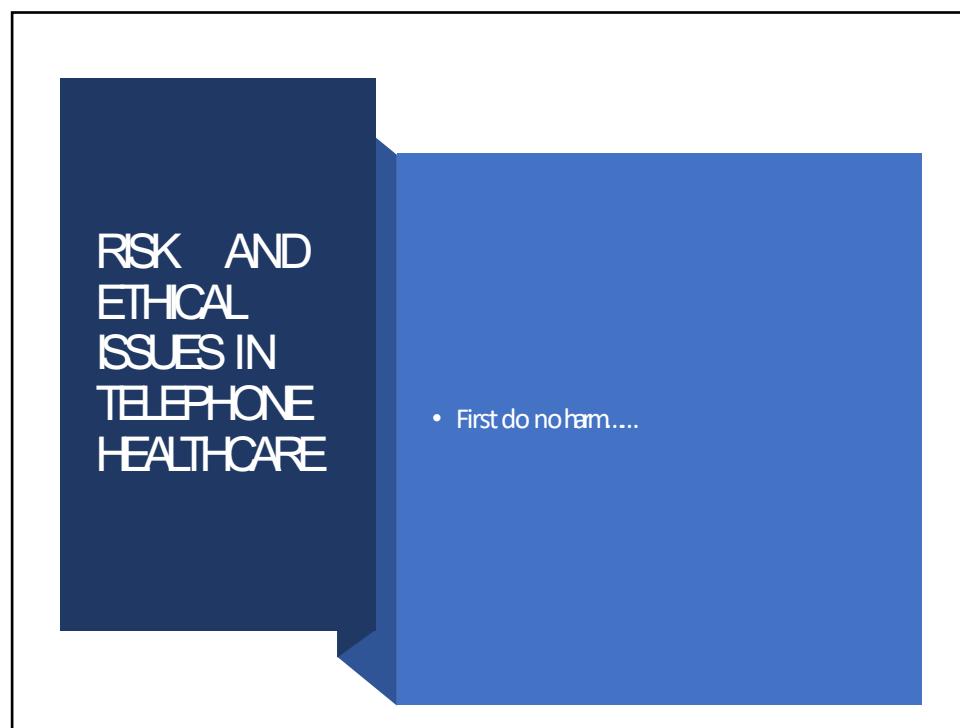
**NHS111  
Quality  
and Safety  
report  
2014**

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

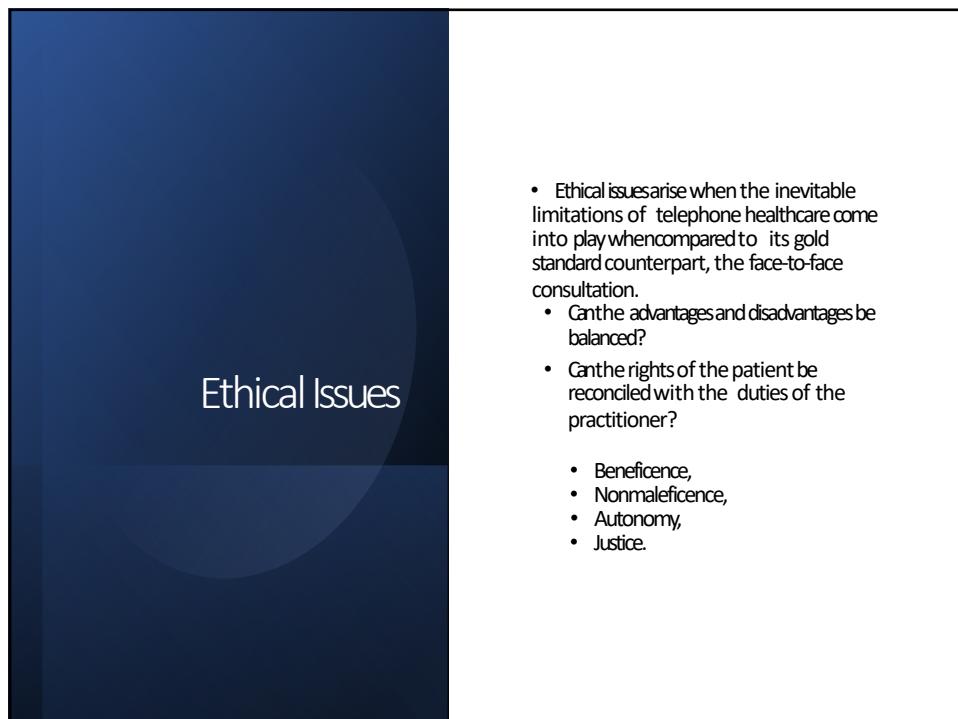
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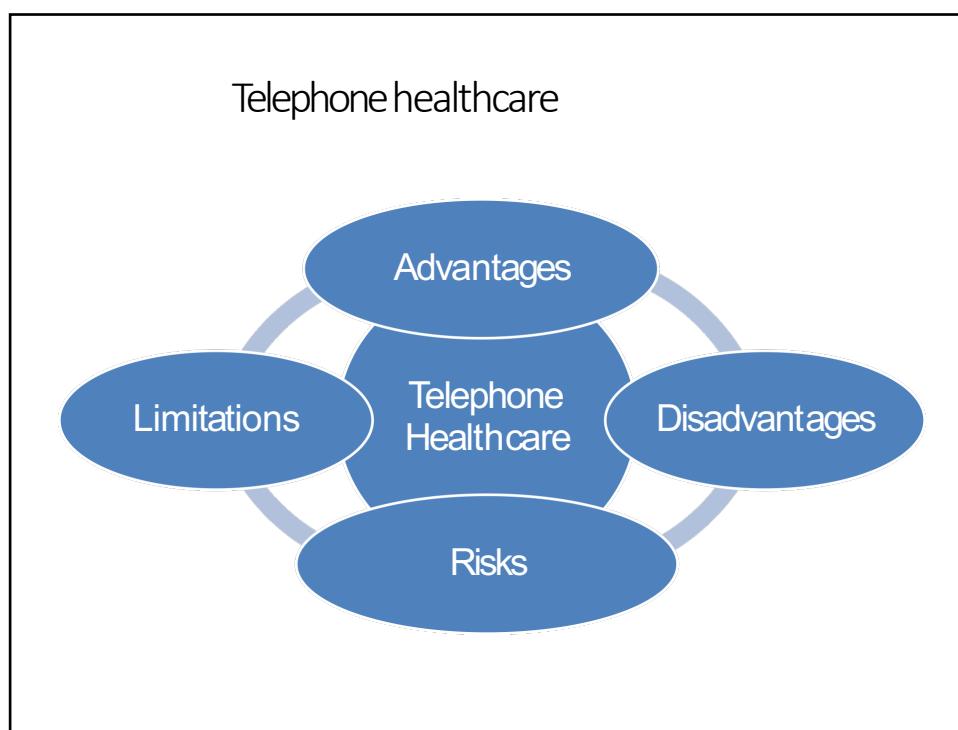
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## Risks in Telephone Healthcare

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

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

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## 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)

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**Information Governance**

- Supporting and managing the NHS Pathways clinical reference data. NHS Pathways is a clinical tool used for assessing, triaging and directing contact from the public to urgent and emergency care services such as 999, GP out-of-hours and NHS 111. It enables patients to be triaged effectively and ensures that they are directed to the most appropriate service available at the time of contact.
- Controlled by NHS Digital
- Information can be transferred to Europe ....? If this has changed
- Records kept for 8years

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## Rights of Individual

- Be informed
- Get access to it
- Rectify or change it
- Erase or remove it
- Restrict or stop processing it
- Move, copy or transfer it
- Object to it being processed or used
- Know if a decision was made by a computer rather than a person

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## 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)

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## 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.

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## 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.

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## Telephone Triage in General Practice

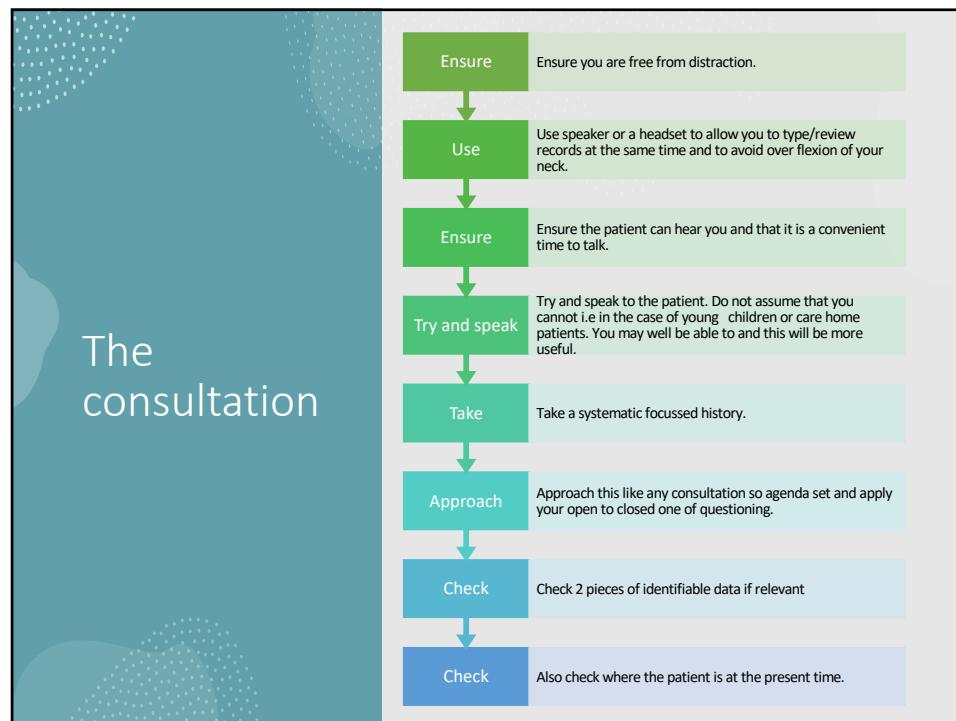
- Acute pathology e.g stroke, ACS, acute abdominal pain, sepsis.
- Breaking bad news
- Assessment suggesting serious pathology that might need to be referred need for urgent assessment
- Discussing primary care test results
- Chronic disease reviews
- Planned reviews for ongoing issues
- Medication reviews
- Discussion of hospital test results and plans
- Care home patient reviews
- Mental health assessments.
- Sick note requests
- Referral requests
- Discussion of multiple chronic symptoms
- Diabetic emergencies.

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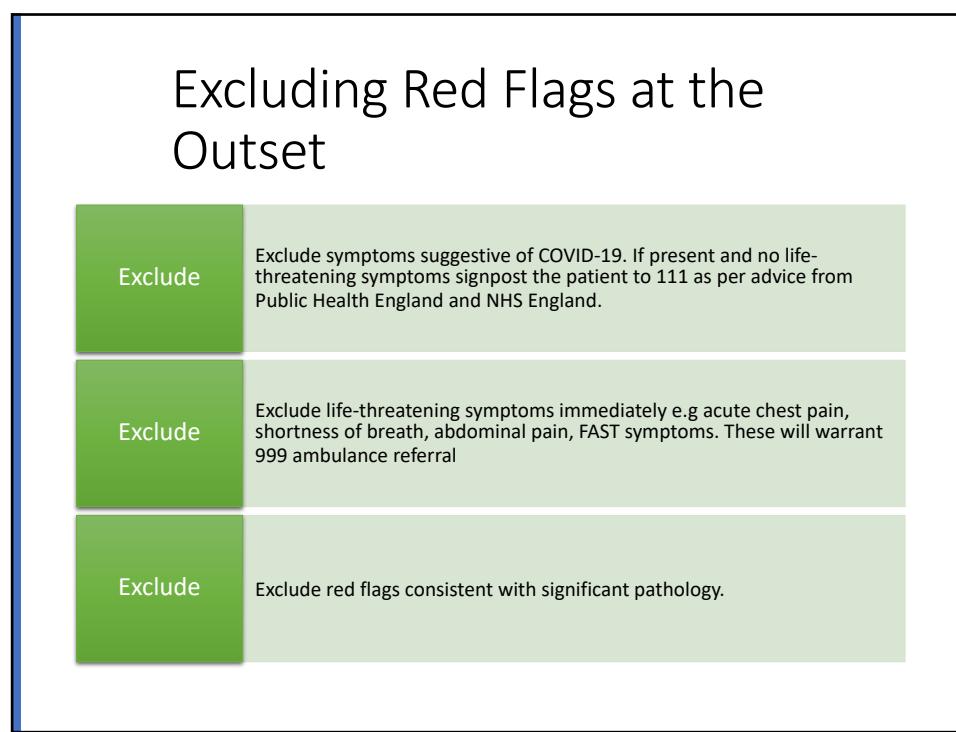
## Pre-consultation

- Ensure your pre-consultation preparation has been appropriate.
- Do you know the patient? If so, this is likely to make the consultation more efficient.
- Review the problem list.
- Review the last few consultations. Have they been telephone consultations? If so, your threshold for face-to-face consulting maybe lower.
- Review any relevant hospital letters, recent walk in centre contacts, out of hours contacts.
- Review any recent test results
- Review the medication list.
- Do reception notes contain any useful information e.g 'low mood'm ongoing urinary symptoms, etc?

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## The Examination

How does the patient sound? Are they in pain? Is there any obvious shortness of breath?

- Do they have a BP machine? Can they check their own pulse? Can they check their BM?
- Can parents/guardians of children count a breathing rate? Can they identify recession?
- Some patient may even have a pulse oximeter?
- If this is a third-party consult e.g from a paramedic, can you document a full set of observations including a blood sugar and ECG findings.
- Can the patient email any skin lesions to you via a generic surgery email inbox?

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## Disposition

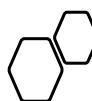
- You may wish to convert your telephone call into a video call (if you have appropriate software). This is helpful for observing children, rashes, possible cellulitis, for mental health consultations, or anything you feel having direct observation of the patient would be helpful.
- You may need to see the patient directly - ensure you use the appropriate PPE. This is currently not the preferred option, but there are situations where this may arise, for example a gynaecological exam, abdominal palpation, child assessment. If you do this, establish if they have any symptoms of COVID-19.
- If so, they will need to be referred to the appropriate service/place in your local area, for example the 'hot hub' if you have one in your area. If they don't, they should be asked to advise the practice/place they need to attend if they develop symptoms before their appointment.

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## Disposition

- If the disposition is telephone advice then consider what resources you could provide to the patient e.g PIL via SMS, or links to websites about joint exercises, mental health resources. Careful safety netting will be important at the end of any telephone consultation. Patients should be reassured that they can call back at any point if they still have concerns.
- The outcome of your consult may involve referral to another healthcare professional e.g. dentist, social worker, district nurse, care navigation team.

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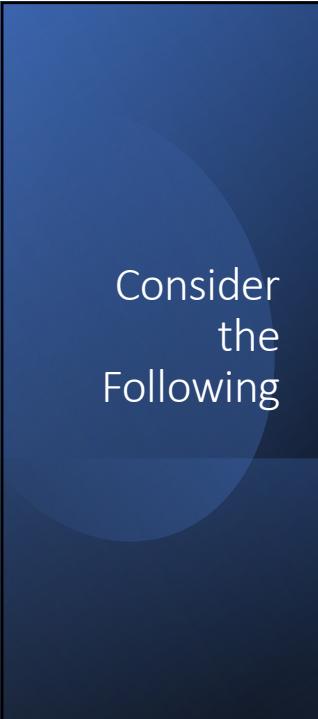
## Remote Prescribing

Remote prescribing

This will increase over the next few months and remote prescribing can pose its own problems.

Common drugs that you may start prescribing remotely may include, the contraceptive pill, antibiotics, HRT and mental health medication.

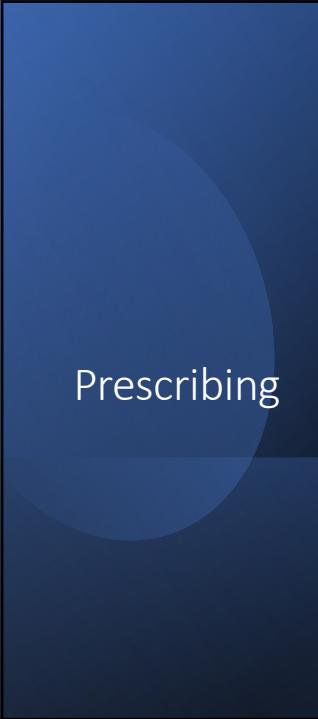
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## Consider the Following

- The indication for the drug e.g. antibiotic. Do you have enough evidence to justify a prescription or would video call help? do you need some preliminary investigations e.g. a CRP, a urine dipstick, a blood sugar?
- If it is something the patient has had before, can you justify prescribing it again e.g steroid cream? pain relief?
- Ensure the patient is counselled for any new prescription
- Are there any non-pharmacological options e.g self help, websites, books, online resources
- If a drug is initiated, how do you plan to follow this up?
- If you do not plan to follow up the case then have you provided a careful safety net?
- Does the patient know what you are prescribing and why?

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## Prescribing

- Does the patient require a dosette? If so how will you set this up?
- If they are self isolating/shielding, how will they get the drug?
- Does the patient know where you will send the drug if using electronic prescribing services (EPS)
- Does the patient know what to do if they develop a problem with the drug prescribed?
- If for a medication review, are all appropriate checks up-to-date and if not, are they needed urgently i.e DMARD drugs or could they wait an extra few months assuming all has been stable e.g BP meds
- Set an appropriate timeframe for the next medication review.
- If a patient is stable, could you consider a 12-month prescription e.g of a contraceptive pill instead of six months?

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## Documentation

Ensure it is clear that your consultation has been via telephone and document that there is a current coronavirus pandemic in your notes. If it has been via video link, document this and document that the patient has consented to this.

- Ensure your plan is clear and why you have decided to prescribe remotely. Clearly document the safety net you provide and follow up advice.
- Any examination should also be documented e.g speaking comfortably in sentences or any values provided by a patient, carer or paramedic.

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



# **hello** my name is...

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## 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 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....

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- ABCD
- Exclude red flags

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Pc –Abdo Pain

HPC -Socrates/opqrstu

- O – onset injury yesterday at school around 12h00
- Palliative – took paracetemol and ibuprofen – short term relief
- Q –sharp pain with no associated symptoms. No urinary symptoms.
- R- No radiation
- Site/Severity –Lt side stabbing pain
- PMH – medical – JAMTHREADSCA
- Surgical – no surgery or operations
- Accident s-
- Gynae Gravida – npregnancies Parity – how many live births

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- Immunisations –why haven't they had imms
- Medication – contraceptive pill
- Allergies - Penicillin

- Social History – who lives at home with partner. Works in an office.

Family history –

Systems Overview – cvs – aneurysm – left side tearing pain radiating to the back

Respiratory – chest infection/pneumonia

- Abdo – appendicitis, cholecystitis, liver disease, bowel obstruction
- GU –STIs cystitis, pyelonephritis
- Psychiatric – anxiety psychosomatic
- HEENT – infection
- Gynae - coils, endometriosis, ovarian cysts, polyps

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## Structure of a Telephone Triage Encounter (2)

- Make technology your bestfriend
- Review of systems: what have youmissed.
- Identify chiefcomplaint
- Triage—exclude from high risk to lowrisk
- Reflect back what you have heard—is it right?
- Summarise what your decision will be basedon.
- Make an interpretation –do not diagnose
- Negotiate a shared outcome; is the patient happy withthe plan
- Checkunderstanding
- Signpost to ongoing care—know your carepathways
- Safety netting
- Document, document, document...

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## Stages of Decision Making

### Obtain consent at the outset Information gathering

- Listen – actively hearing what the patient doesn't say

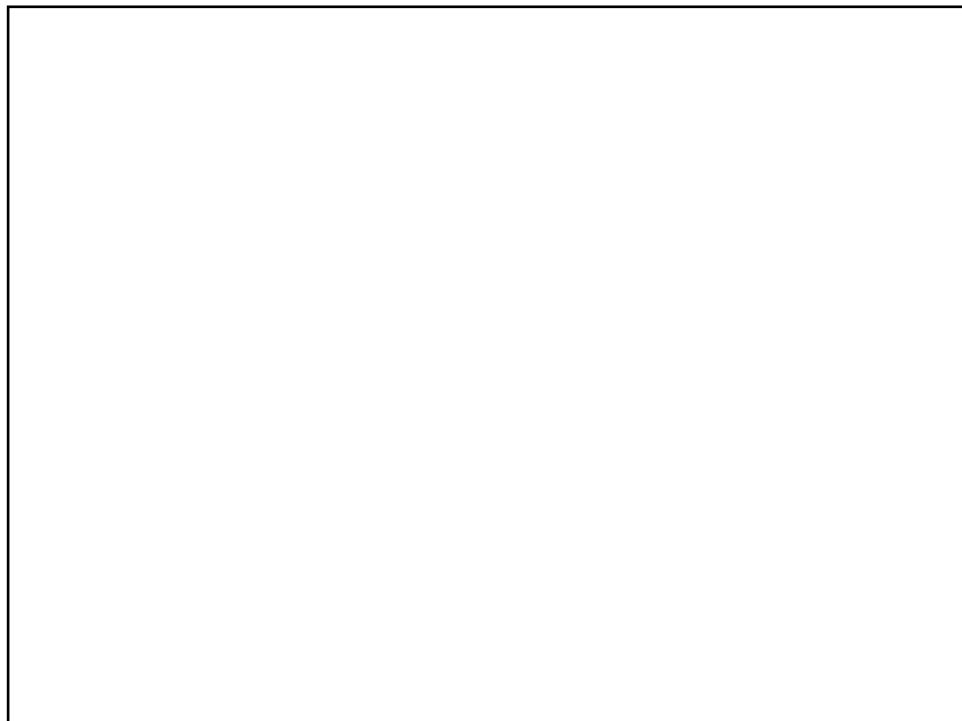
### Understand

- Interpreting the main reason for the call amongst all the information the caller may give you

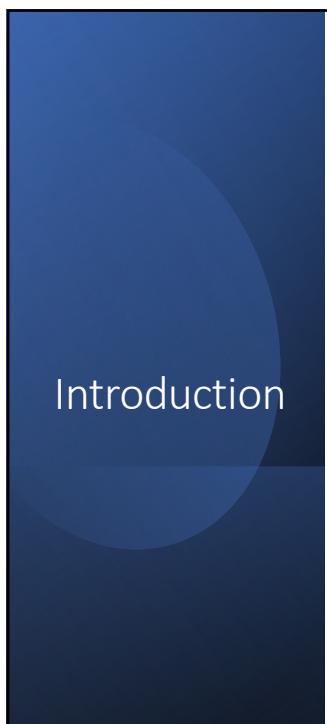
### Agree

- Reflecting back to the caller the main concern and agreeing the next course of action

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- Always introduce yourself by name and ideally mention your organisation. If the caller is not the patient, establish/confirm the identity of the caller and relationship to the patient (and consider any implications for confidentiality).
- Try to speak directly to the patient if possible/appropriate. A first-hand history tends to be more reliable although there are clearly situations when an additional history from a third party will be valuable.
- Always empathise as few patients, no matter how offhand they seem, take the decision to call lightly. An initially prickly, demanding manner may be fuelled by anxiety, so empathise when you take the call, e.g.: "I hear (x) has a nasty sore throat, tell me all about it".
- Clinicians should remember that if it is the second call for the same patient within a short time frame, it will often require an even more careful and thorough triage as statistically, it is more likely to indicate a more significant clinical problem which requires a face to face consultation

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## Establishing why they have called

It is always important to be sure you have established the “caller’s agenda”. Sometimes the caller/patient’s ideas, concerns and feelings become evident without more direct questioning. Sometimes you will have to ask, e.g. “Tell me, have you any worries about what might be going to happen” or “have you had any bad experiences with these sort of symptoms before?”. Then, the fear of the throat closing up, the eardrum perforating or meningitis developing will be out in the open.

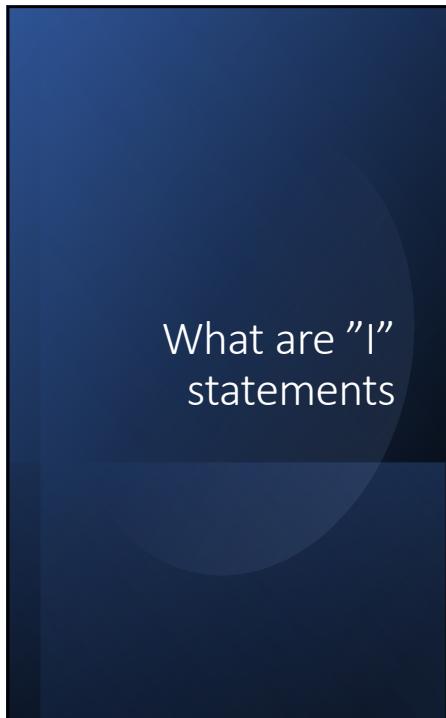
Always try to maintain respect for the other person and avoid labelling “Typical behaviour – they’re all the same”. Without respect, negotiation is impossible.

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## Gathering Information

- It is important to engender the confidence of the caller by making it clear that you are interested in what they are saying. It is equally important to avoid any unnecessary questions that might be regarded as an invasion of privacy or make the conversation sound like a police interrogation! Try to deal with issues one at a time.
- While it is important that you are in charge of the call it is vital that the caller is not made to feel in a vulnerable position. Avoid poorly timed questions and try hard to avoid repetition as this diminishes the confidence of the caller. Deliver questions/information in a clear manner, without ‘waffling or padding’ or ‘beating about the bush’.
- 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?
- Sometimes you can help the caller who is anxious or angry with the use of “I” Statements. Using ‘I’ Statements allows a person to ‘own’ their thoughts feelings and opinions rather than using ‘you’ statements, which may implicitly blame the other person.

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**What are "I" statements**

**I' Statements may be used:**

- Anytime you want to share your feelings in a frank, unthreatening, undemanding way
- If both parties have issues to resolve
- If the caller uses 'you' or blaming statements a lot. Remember your 'rights' must not be violated

**I Phrases can make repeated or sensitive questions or statements less threatening.**

- "I am wondering..."
- "I get the feeling that..."
- "I have a sense of..."

**'I' Statements can be used to diffuse hostility:**

- "I understand that you are angry"
- "I am sorry that...." Can be an expression of sympathy only and does not have to imply that anything was your fault
- 'I' Statements that disclose your feelings in a professional manner and create empathy:
- "I am concerned that"
- Having drawn together the information we need to assess the situation a management plan can be devised.

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## SIGNPOSTING

- Important to establish rapport with caller
- Introduce yourself to the caller and advise them on the direction the call will take:

**'I am going to ask you some questions in order that we come to the most appropriate outcome.'**

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## Initial Assessment

- **Establish who is on the phone:** patient , relative, third party, i.e. mum/dad, carer, sibling. Is the caller the patient. Try and confirm patient address at the outset.
- **NEVER ASSUME**



- **Rule out Immediate Life Threatening conditions:**  
Reason for call, ABC's, Consider safety of patient, do you need to use language line, type talk etc.

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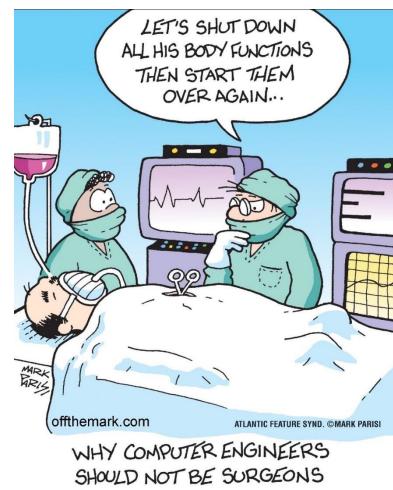
## Initial Assessment

- **Consider all verbal cues**
- Speech pattern, speed, volume, articulation of words
- **Establish reason for call**
  - What has made you call tonight? What has changed?
  - What is your norm?
  - Is this different than your normal pain, breathing rate etc
- **Questioning:**
  - Do not use leading questions, it is important to listen to what the caller/patient is telling you
  - Always ask to speak to the patient if it is possible
  - What have you taken?
  - Have they seen the GP or health visitor?
  - Check if the child is on the child protection register

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## 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, demographic information is still essential to be able to direct the appropriate care rapidly.



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## Quantum Telephone healthcare

© Cartoonbank.com

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



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Quantum Telephone healthcare

- Empathize and establish a rapport

sending virtual hug  
Loading...  
[Progress Bar]

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Quantum telephone healthcare

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

## Cultural Differences When Communicating

Why didn't he shake my hand?  
What now?  
Should I give him my card?  
She's a bit close!

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- Can they self help?
- Have they been to the pharmacy
- School nurse or local GP
- Health visitor

## Signposting



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## Time stratification

If the caller requires to be seen face to face how quickly is this required:

- 999?
- Home visit 1hr, 2 hr, 4hr?
- GP practice today, tomorrow, next week?



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## Medical Structured History Taking

- Presenting Complaint
- History of presenting complaint
- PMH/Allergies/Medication
- Social and Family History
- Other Information

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## Quantum Telephone healthcare

- Take a brief medical history



"You do have an extensive medical history, don't you, Mr. Simmons?!"

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Quantum Telephone healthcare

- Verbal nods
- Effective call control

"Just shut up and take the lollipop."

www.shutterstock.com · 100107767

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Reflection

Reflect information gathered back to caller /patient to ensure that you have picked up information prior to making a final decision.

Clarify points to ensure you have recorded them correctly.

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- History of Presenting Complaint

## Quantum Telephone Healthcare

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### Quantum Telephone healthcare

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



"I'm sorry, but the doctor can't see you right now."

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## Quantum Telephone healthcare

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



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## Quantum telephone healthcare

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



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## Quantum Telephone healthcare

- Make technology your best friend.



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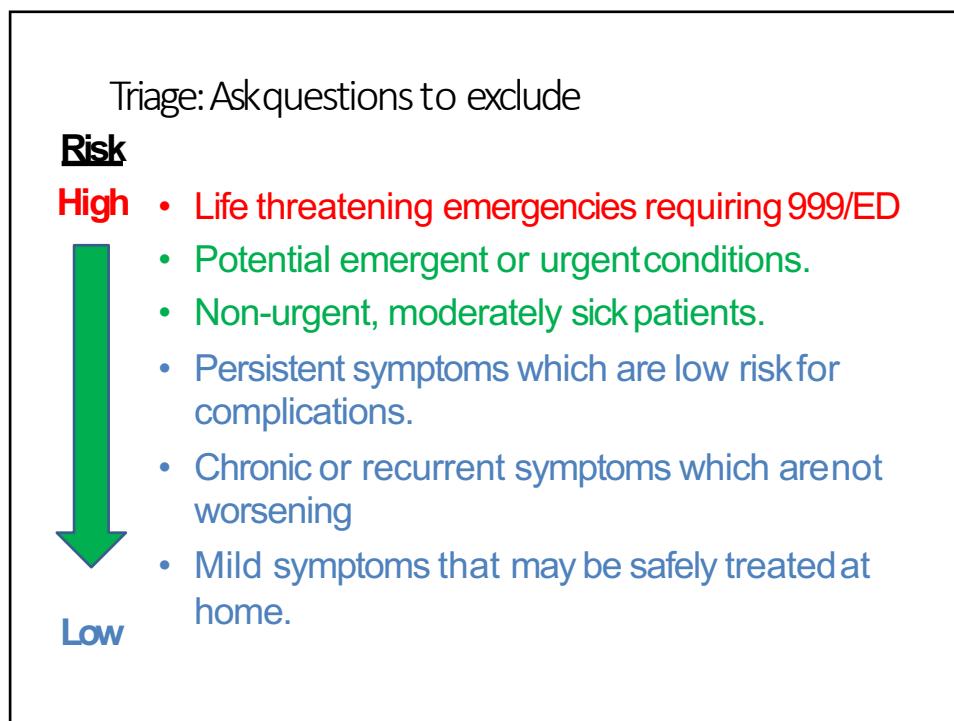
### WHAT DOES THIS PICTURE TELL YOU?



- Identify Chief Complaint

Quantum  
Telephone  
Healthcare

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## 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.



The NHS wants patients to make more decisions about their treatment...so here's your blood tests and prescription pad, I'll be back later.

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## 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.

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## 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

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## History Taking

The difference  
between life  
and death



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## History taking: A reminder

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

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## 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

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## History taking in telephone healthcare

### Presenting complaint / HPC

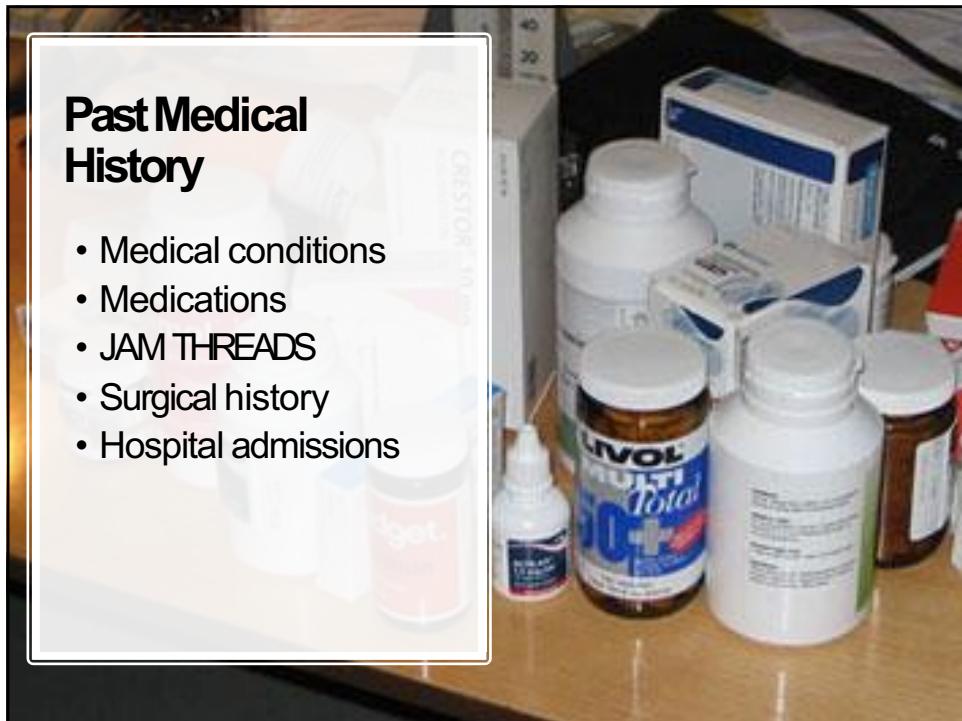
- Make sure you've really got the problem
- Focus on the symptoms not the diagnosis
- Explore cardinal symptoms
- Explore pathognomonic symptoms

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### 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

86



87

A slide with a dark blue header bar. The word 'JAM THREADS' is written in white capital letters on the left side of the bar. The main content area is white and contains a bulleted list of medical conditions. The list includes: Jaundice, Anaemia and other haematological conditions, Myocardial Infarction, Thyroid/Tuberculosis, Hyper/hypotension, heart disease, Rheumatic fever, rheumatoid arthritis, Epilepsy, Asthma and COPD, Diabetes, and Stroke/seizures.

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**Samosa Diet**

<b>Sexual History</b>	<ul style="list-style-type: none"> <li>• Relationship status? Contraception? When was the first day of your last menstrual cycle? Pregnancies? eg: P2G1</li> </ul>
<b>Allergies</b>	<ul style="list-style-type: none"> <li>• Drugs, environment food, dressings, type of reaction?</li> </ul>
<b>Medication</b>	<ul style="list-style-type: none"> <li>• Prescribed, OTC, Herbal, Supplement, Recreational</li> </ul>
<b>Occupation</b>	<ul style="list-style-type: none"> <li>• Current and previous, environmental exposure</li> </ul>
<b>Smoking</b>	<ul style="list-style-type: none"> <li>• Current or ex-smoker, pack year history, ready to quit?</li> </ul>
<b>Alcohol</b>	<ul style="list-style-type: none"> <li>• Number of units per week – consider CAGE questionnaire?</li> </ul>
<b>Diet</b>	<ul style="list-style-type: none"> <li>• Health Diet, types of food, amount</li> </ul>
<b>Immunisations</b>	<ul style="list-style-type: none"> <li>• Up to date? Tetanus, Influenza, Pneumococcal, Hep B?</li> </ul>
<b>Exercise</b>	<ul style="list-style-type: none"> <li>• What type of exercise? How often? For how long?</li> </ul>
<b>Travel</b>	<ul style="list-style-type: none"> <li>• Recent travel? When? Where?</li> </ul>



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**CAGE Questionnaire for Detecting Alcoholism**

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

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## 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.

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## 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

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**Review of Systems**

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

93

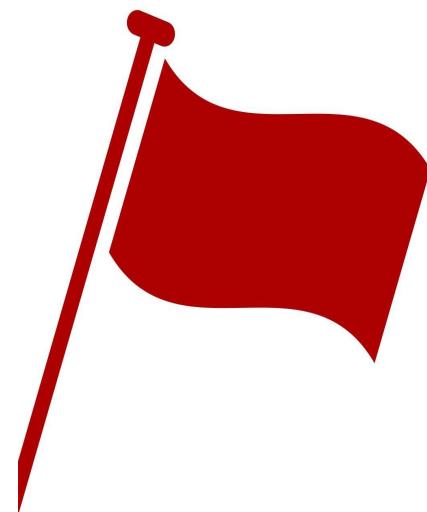
**Review of Systems**

- 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

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## Red Flags

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



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## Quantum Telephone Healthcare

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



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Quantum Telephone Healthcare

- Diagnosis?
- Interpretation

**McHUMOR** by T. McCracken

"Off hand, I'd say you're suffering from an arrow through your head, but just to play it safe, I'm ordering a bunch of tests."

97

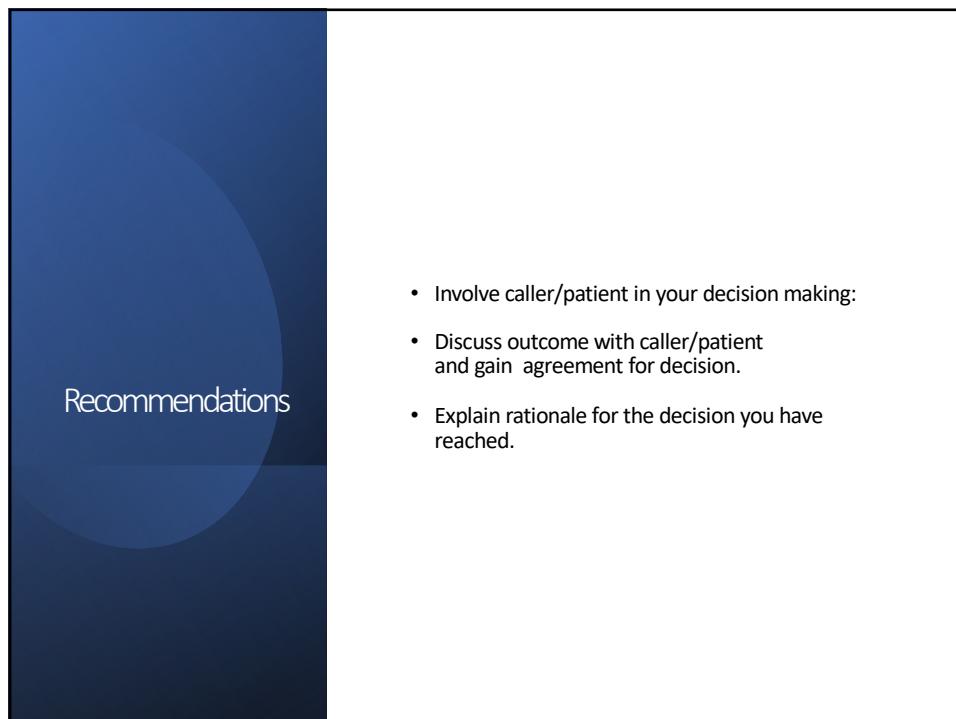
"I already diagnosed myself on the Internet.  
I'm only here for a second opinion."

GLASBERGEN

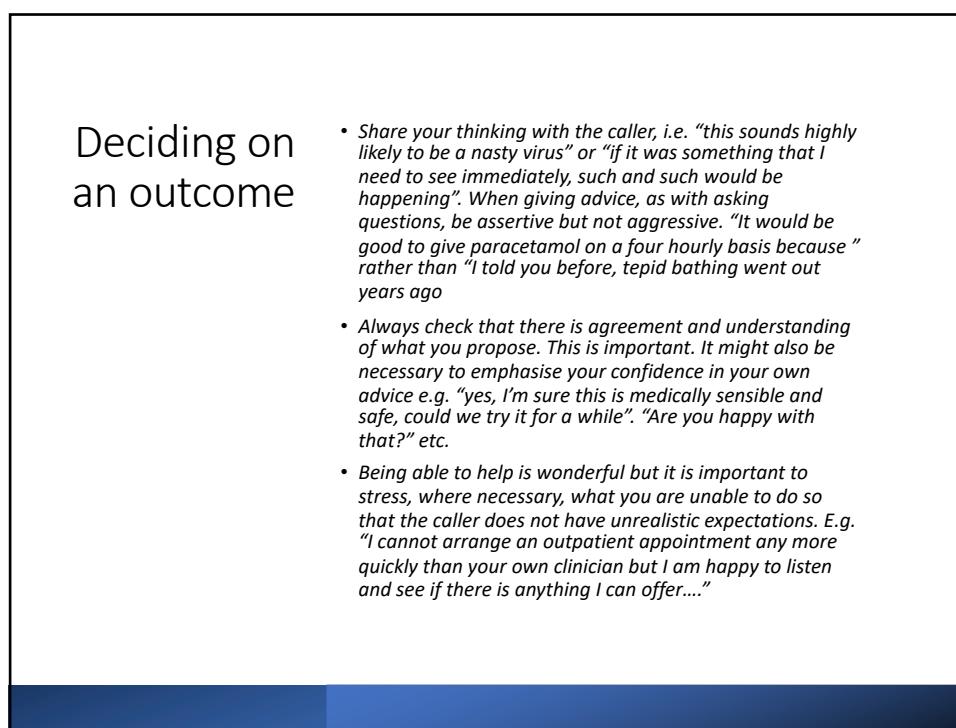
Quantum Telephone Healthcare

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

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## 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



101

## Social Circumstances/Barriers

### Consider social circumstances:

- Ability to attend own GP/Out of hours clinic
- Patient transport
- Single parent with other children in the house
- In house on own
- Is the child in school or nursery



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## A consultation with others is needed (999 Ambulance, Nurse referral, social services)

- It is important that the caller fully understands why this course of action is being taken and that they agree decision.
- If the agenda is agreed the clinician will have reassured the patient that the best action is being taken.
- If not, the patient may be made even more anxious and refuse the ambulance when it arrives.

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## Outcome: Face to face consultation

This may be either at a centre or at home. Well established models exist for establishing the venue for a face to face consultation. This is an area where assertive negotiation may be required to establish a genuine win/win relationship with the caller. Be prepared to work together towards a compromise without neglecting yourself or your beliefs (a win-win situation).

"If we can meet at the Primary Care Centre I will be able to see you more quickly". Think positively and do not presume a negative outcome will occur. "I don't suppose you can bring him in, you see I'm very busy" is less likely to engender the response you are seeking. Such statements tend to be self-fulfilling!

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- Short
- Concise
- Relevant presenting symptoms/ Any comments on social situation
- Any red flags

## Clinical Summary

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## Concluding a call

- During the course of the call you have identified the key elements to enable you or a colleague to resolve the caller's situation. In terminating the call it is important that the outcome of the call is agreed between both parties. In this way the caller will feel confident that an appropriate outcome will be achieved and will not have unrealistic expectations. This might be expressed as:
- "Just to recap, we've agreed that you will try to use the calpol on a four hourly basis and check his temperature each hour. If it is settling you will take him to the Health Visitor tomorrow but if not, you will ring back and I will see him at the Primary Care Centre before 11 o'clock. Are you happy with those arrangements
- Always prepare a safety net and give the caller permission to ring back if things get significantly worse, e.g. "please do feel free to call if he gets worse". Give concrete examples of worrying signs and symptoms. Explain what to do if your plan is not working, including when and how to seek help.
- Give clear, specific, follow up instructions e.g. "If the pain/temperature has not settled in an hour please call back"
- If necessary, re-check patient understanding and acceptance of your plan.

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## Management Plan

- Clear management plan to develop patient confidence
- Ensure there is shared understanding
- The aggressive and usually anxious patient can make life a misery if badly handled. Even these calls can lead to a rewarding consultation if appropriately completed.
- A confident assertive clinician delivering good advice makes everyone feel better!
- With clear understanding of the patients' agenda and assertive triage, comes less stress, fewer complaints and a more pleasant working environment for everyone

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## Also consider

- Consent
- Information Governance
- Data Protection and GDR
- Ethical Considerations
- What are the Common Pitfalls during a telephone consultation

108

## DO NOT THINK YOU ARE ALL ALONE!



109

## Resources available to support Telephone Triage

- Self/previous experience
- Caller/patient
- Peers
- Partners – Out of hours, A&E
- Pharmacists
- Call Structure Framework
- Toxbase
- Quality Assured Websites
- Books – BNF, OTC etc
- Safeguarding Leads



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## Visualisation

### Can be a really useful tool

- We cannot see or touch the patient but we can aid our decision by enlisting an aide or assistant. The patient or caller can become an extension of our senses, by involving them in their own or the patient's care we make our assessment inclusive.
- They can tell us if a particular area is hot or cold, clammy, red, blue or swollen or if a rash blanches or not. Their input can fundamentally effect the decision we reach.
- However it can sometime be difficult for the patient to tell us exactly where the problem is.

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## Take a Few Minutes

Group 1

In groups, consider the pitfalls to taking a good history

Group 2

Reflect on why a structured triage is important Group 3

What are red flags and give examples?  
Group 4

What is a red herring?

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## Red Flags



**A Red Flag** is any piece of information that informs your thinking on the severity or clinical urgency of the patient's situation or symptoms.

It is the recognition of these 'out of the ordinary elements' or conversely 'classic signs' which alerts you to recognise a potentially serious situation and act accordingly.

This can occur at any time or in any part of the consultation period and may relate to something that is happening now or happened previously

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## Potential Red Flags



-  Past Medical History
-  The patient's recent ongoing contacts around this particular ongoing episode of care
-  Background conversation or noise
-  An unusual or out of the ordinary symptom or clinical feature

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**Red Herrings**

- Any information that might trigger a response from you, which may not necessarily be correct.
- The derivation arises originally from the use of cured or '**Red**' herrings being dragged along the ground when training hunting dogs-if the dogs followed this scent they lost the scent of their quarry-hence leading to its use to mean a false trail or clue.
- This was then applied to the work of crime fiction writers, such as Agatha Christie etc where irrelevant details are included in the plot to divert you from seeing what is really going on in the situation.

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**Quantum Telephone Healthcare**



- Comprehensive, contemporaneous note keeping is essential.

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

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## 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))

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## 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 penicillin allergic
- Anaphylactic response
- Claim ensued.



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## Information Governance: recording phone calls

- No paper record of allergy status noted
- GPadamant 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



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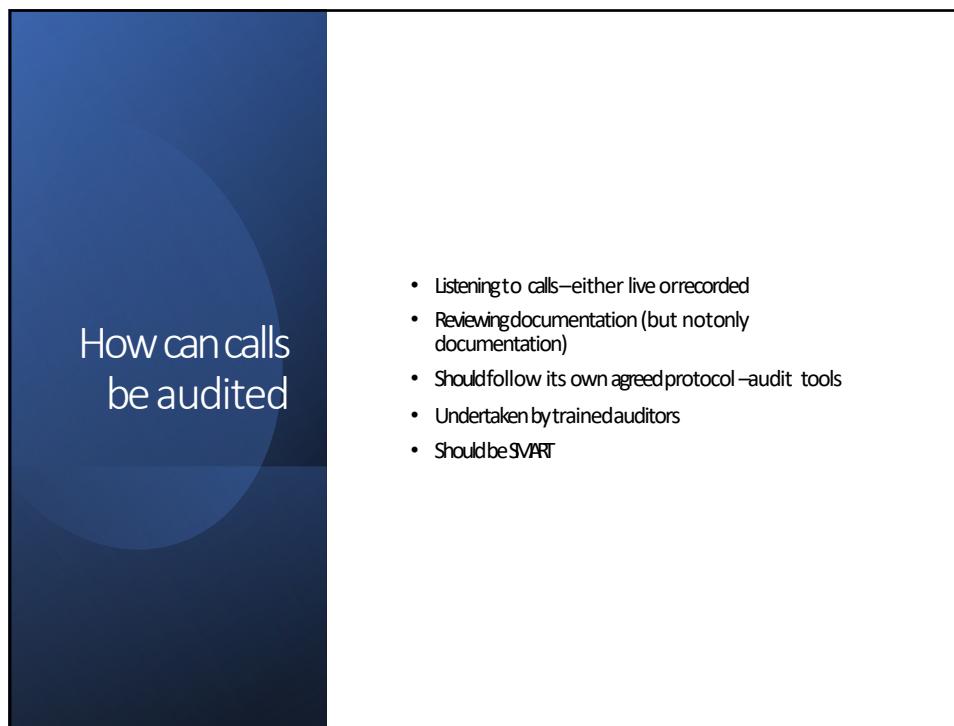
## TELEPHONE HEALTHCARE QUALITY CONTROL

- Auditing....

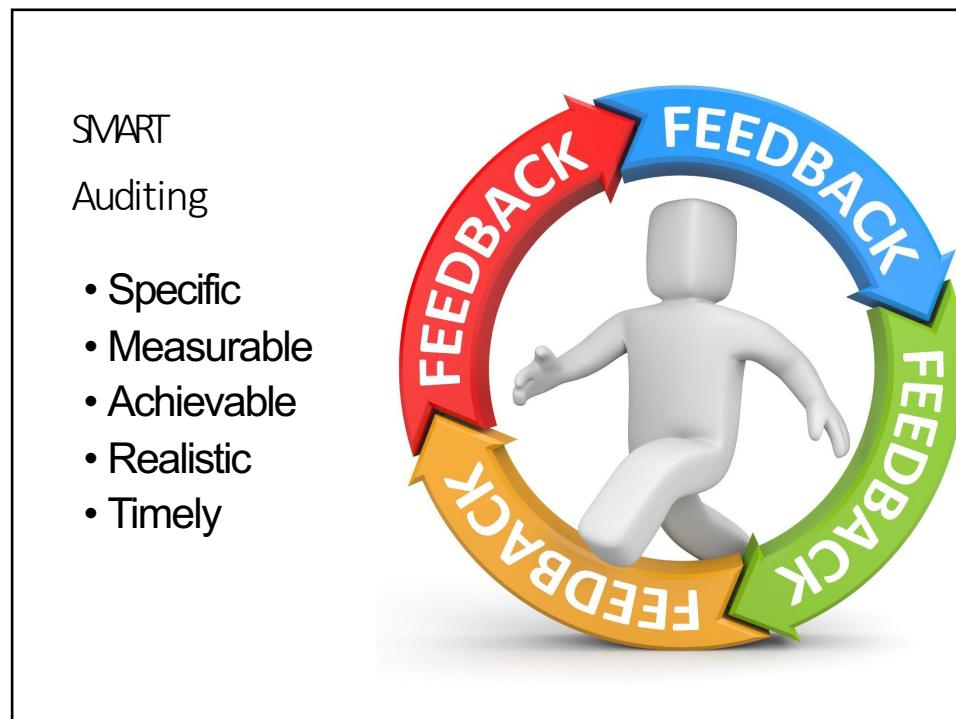
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121



122



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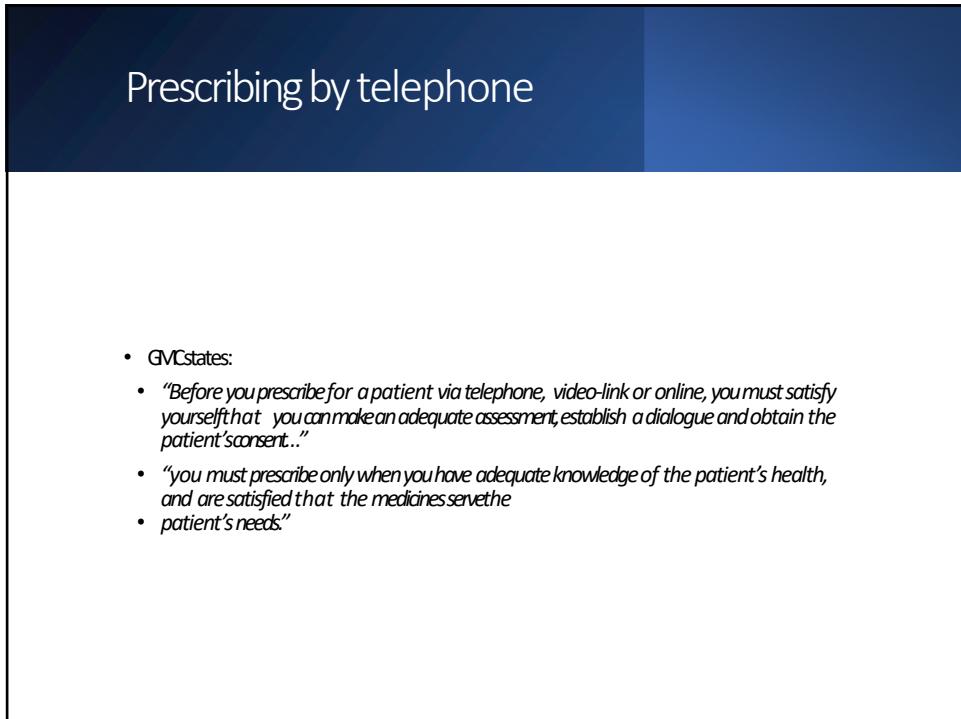


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## MEDICINES MANAGEMENT IN TELEPHONE HEALTHCARE

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### Prescribing by telephone

- GVC 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."

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## Prescribing by telephone

- 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

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## Prescribing by telephone

- 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.

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## 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.

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## 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 JICbox



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## **TELEPHONE HEALTHCARE IN ACTION**

Some real cases.....

131

NHSPathways—Back Pain



132

Somereal calls... Fire is on...



133

- 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?

134

Some real calls – 34 yof – Chest pain



135

34 yof.....chest pain....



136

34 yof – CHESSTILLHURTS!!!



137