Telephone Triage

Description

Since the 1970’s there has been an almost 400% increase in ED visits while the US population has increased by approximately 10% per decade. Telephone triage, telephone advice counseling (Sabin) or telehealth nursing, as it is sometimes called today, became a popular method used by managed care and other private physician and health maintenance organization (HMO) groups in the 1970’s to provide an entry into the healthcare system for an increasingly large number of patients.1,2

Today these formal commercial telephone triage programs function with specific physician-approved policies, protocols, staff education, patient documentation requirements, and quality improvement programs in order to function safely.2,4-5 The chief advantage of telephone triage systems to the patient is timely access to a healthcare professional.6 Successful systems of telephone triage have also been reported to make a positive difference in the appropriate use of the emergency department, patient satisfaction, and nurse/provider satisfaction.7,8 By reducing unnecessary visits to a physician’s office or an emergency department, the use of telephone triage may save time, patient costs and emotional trauma.4,9 Although the goal of telephone triage is to provide the right level of care with the right provider at the right location at the right time there are challenges with the system.6

Identified concerns include: nurses, in spite of these protocols and decision-tree algorithms, may employ their own clinical judgment;10 legal liability issues may put not only the nurse, but the physician and facility at risk of a lawsuit;7 the inability to review the medical record or past medical history of the caller;10 language barriers;10 incomplete documentation issues;10 lack of patient compliance and evaluating the appropriateness of decision-making algorithms.6 When nurses were surveyed, they cited challenges assessing patients without visual cues and the demands of being the gatekeeper for large numbers of patients without a corresponding supply of available services.11

The Netherlands recently implemented a large scale, country-wide research intervention using the same five-level urgency markers for both physical and telephone triage in a primary care setting. Compliance to triage was good; safety was acceptable, however, as in other cases, further research is recommended to validate tool performance, compliance, decision-making and continued competence.1,5,6,9

ENA Position

It is the position of the Emergency Nurses Association that:

1. Emergency nurses do not give advice or clinical management recommendations over the telephone.

2. Formal commercial telephone triage nurses require specialized education; follow pre-established and physician-approved policies and protocols, complete patient documentation, and participate in quality improvement programs for safe and quality patient care.

3. Further research is recommended to determine if commercial telephone triage programs improve the use of available health services within the community.

Background

In 2010, the American College of Emergency Physicians (ACEP) and the Emergency Nurses Association (ENA) Joint Five-Level Triage Task Force approved a joint position statement stating “the quality of patient care benefits from implementing a standardized emergency department triage scale and acuity categorization process.”12 They went on to support the use of a reliable, valid five level triage scale such as the Emergency Severity Index (ESI).” Telephone triage is not addressed as a function of that process.
The Emergency Nursing Scope and Standards of Practice, Standard 1a Triage, approved and endorsed by both the ENA and American Nurses Association (ANA), states, “the emergency registered nurse triages each health care consumer utilizing age, developmentally appropriate and culturally sensitive practices to care, prioritize and optimize health care consumer flow, expediting those health care consumers who require immediate care.” Telephone triage is not included within the scope of emergency nursing practice.

Giving advice over the phone outside of a formal telephone triage system can put the nurse, physician, and facility at risk. In a policy statement approved in 2013, ACEP recommends that “emergency department personnel not attempt medical assessment or management by telephone.” They further explain that callers with a mental health or limb- or life-threatening emergency are an exception and recommended they be instructed to access emergency medical services. As for patients recently discharged from the ED, ACEP recommends they be managed according to pre-determined protocols. Emergency nurses are advised not to give advice or clinical management recommendations over the telephone. However, if patients call with questions regarding ED discharge instructions and the chart is readily available, follow facility policy if clarifying instructions and notify the concerned patient to return to the emergency department, since the nurse may be liable for miscommunication. Instruct patients to dial 911 in cases of a mental health, life or limb threatening emergency after determining if they need assistance to make the call. And as always, observe common courtesy and handle these matters in a respectful, caring manner.

Resources


References


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