Radiology Nursing and the Telephone: Risk Reduction

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Objectives

- Discuss the role of the telephone in the provision of care in the radiology setting
- Identify the standards of nursing practice that direct the provision of care over the telephone
- Describe risks associated with the practice of nursing over the telephone
- Discuss strategies to reduce risk in the delivery of care over the telephone

The role of the nurse and the telephone

- Patient Education/Preparation
  - Pre-procedure
  - Procedure Follow-up
    - Advice
    - Lab results
    - Referrals

Telephone Nursing

- All care and services within the scope of nursing practice that are delivered over the telephone. Greenberg et al, 2003

Two Types of “Nurse Calls”

Triage

- Symptom based
- Time sensitive assessment
- Urgency
- Access to care

Non-Triage

- Usually not time sensitive
- Patient education/management
- Compliance with plan of care

Telephone Triage

- A component of telephone nursing practice that focuses on assessment, prioritization, and referral to the appropriate level of care.
- …involves identifying the nature and urgency of client health care needs and determining appropriate disposition. Greenberg et al, 2003

Standards

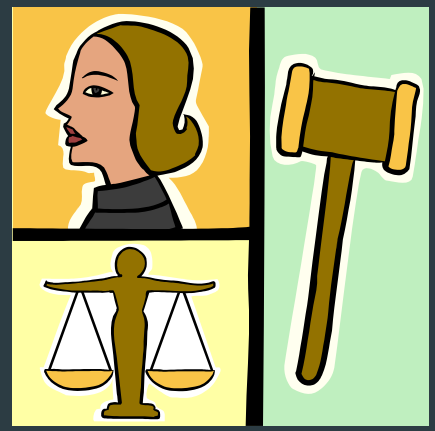
- Basic Nursing
  - Nursing process
- Legal/regulatory
  - Boards of Nursing
- Professional
  - AAACN
- Accreditation
  - TJC, NCQA, AAAHC (PCMH, ACO)
- Organizational Policy
  - Training, Documentation, Decision Support Tools

Desired Outcomes

- **SAFE PATIENT CARE**
- Patient is prepared
- Patient is empowered and educated
- Patient is heard and understood
- Patients needs are met
- Care is individualized

Reducing the risk

- Adhere to Standards
- Nursing Process
- Aware of High Risk Callers
- Documentation



Nursing Process

- Assess
  - Data collection
- Diagnose
  - Conclusion
- Outcomes
  - What do you hope to accomplish?
- Plan
  - What needs to be done (collaboratively)
- Intervene
  - How will it be done
- Evaluate
  - How will you know if your patient ***doesn't*** get better?

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Physical Exam by "Proxy"

- **Audible to Nurse**
  - Respirations & respiratory findings (cough, wheeze)
  - Neurological (level of consciousness, confusion, slurred speech)
  - Affect (report; don't interpret)
  - Background noises (crying or fussing baby, environmental clues)
- **Measurable by Patient**
  - Vital signs (Temperature, pulse, respirations, blood pressure)
  - Blood glucose
  - Weight
- **Observable by Patient (Using Eyes, Hands, Nose)**
  - Signs of dehydration (mucous membranes, output)
  - Bilateral comparison
  - Use landmarks
  - Size comparison (foods or sporting goods)

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Common Pitfalls to Avoid

- Accepting patient/care giver “self-diagnosis”
- Jumping to conclusion
- Failure to speak to the patient
- Functioning outside of scope
- Failure to utilize critical thinking
- Fatigue and haste
- Failure to LISTEN and THINK
- Being multitasked and/or distracted
- Failure to anticipate worst possible
- Failure to err on the side of caution
- Failure to adequately assess
- Knowledge deficit
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High Risk Patients/Callers

- Extremes of age
- Comorbidities such as diabetes, post-op, or immunosuppression
- Repeat callers (repeat calls for same problem)
- Frequent flyers
- Patients with multiple complaints or poor historians

Documentation

- Document ALL calls
- Document to paint a picture
- Document all pertinent findings
- Signatures per policy and file promptly

Swedish Malpractice Claims: What Went Wrong

- Failure to listen to the caller
- Communication failure
  - Nothing communicated
  - Wrong thing communicated
- Failure to confirm understanding
- Asking closed-ended questions; Open ended questions yield more complete picture

Ernesater (2012)

Swedish Malpractice Claims: What Went Wrong

- Asking too few questions
- Failure to speak to the patient (missing nonverbals)
- Failure to reevaluate repeat callers (take a fresh look)
- Failure to explore reason for concern
- Failure to explore reason for request

Ernesater (2012)

Swedish Malpractice Claims: What Went Wrong

RECOMMENDATIONS:

- Specific training in communication skills
- QA: Take a systems approach rather than focusing on individual nurse (identify contributing elements)
- Revise DSTs to utilize open ended questions

Ernesater (2012)

Inaccurate Decision Making

- Inadequate information gathering
- History disregarded by triage nurses
- Protocols should be used as checklist to highlight rare but serious reasons for call
- RNs made decision early in call and “mind snapped shut”, overlooking subsequent critical information
- “Wellness bias”
- Suggest further research to assess role of clinical judgment vs strict adherence to DSTs

Belman (2002)

Strategies to reduce risk

- Use the nursing process on every call
- Use clinical judgment!
- Always speak to the patient
- If in doubt, err on the side of caution
- If the caller's concerned (or if you are concerned), the patient should be seen
- Avoid jumping to conclusions
- Patients who call repeatedly (eg 2 times in 24 hours) should probably be seen.
- Documentation tool must encourage systematic assessment and thorough documentation

Strategies to reduce risk

- Document extensively
- Verify caller understanding, intent to comply and comfort with plan
- Know & function within your scope of practice
- Communicate with your team and collaborate when indicated but
- Remember you maintain accountability for your clinical decisions and (usually) patient outcomes
- Use extreme caution when multitasked, rushed, or fatigued

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THANK YOU, ARIN!

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