# Rural After Hours Triage Education resource

# RAHTER

A resource for all rural and remote hospitals in Australia

Developed from the SA Rural Hospital After Hours Triage Education and Training Program 2003-2005

RURAL DOCTORS WORKFORCE AGENCY Inc.

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Requests for copies and inquiries regarding this resource may be made to the Rural Doctors Workforce Agency, South Australia:

P: 08 8357 744 F: 08 8357 7088

E: ruraldoc@ruraldoc.com.au
w: www.ruraldoc.com.au

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The success of this After Hours Triage Education and Training Program was only due to the commitment and dedication of the South Australia rural GPs and hospitals involved. Thanks also to the members of the Program Advisory Committee for their guidance and expertise, Kiara Pulford, Program Coordinator at the RDWA for 18 months of the program and to Robyn Tchernomoroff and Kaye Knight from the Collaborative Health Education and Research Centre, Bendigo for their support and advice during the development of the program. The authors acknowledge Barbara Wright, Program Assistant at the RDWA, in the developement of this resource.

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FOREWORD 5

PART A - PROGRAM USERS GUIDE 7

Who is RAHTER For? 8

How to Use RAHTER 9

Section One

After Hours Triage Education And Training Program In Rural SA 11

Background 12

Who Was Involved? 12

What We Did 14

Training Program Preparation 18

Workshop Support and Coordination 20

Section Two

How To Run An After Hours Triage Training Workshop 23

Replicating the Workshops 24

Post Workshop Activities 26

Financial Considerations 28

Ongoing Training and Services 29

Useful Contacts/Resources 30

PART B - TRAINING PACKAGE FOR INDIVIDUALS AND GROUPS 33

Introduction 35

Section One

Context of Triage 37

Application of Triage 39

Nurses' Role in Triage 40

Principles of Triage 40

Why After Hours Triage? 42

Triage End-Points 45

Section Two

Patient Assessment 49

Acuity 51

The Issue of Diagnosis 51

Local Knowledge 52

Assessment 52

Techniques Used in Assessment 53

Survey 56

Primary Survey 57

Airway 57

Breathing 60

Circulation 62

Disability 64

Exposure 65

Secondary Survey 66

Consultation and Definitive Care 68

Conclusion 69

0184 Training Manual.indd 1 8/9/05 10:09:25 AM

**Section Three**

**Communication and Decision Making** **71**

Characteristics of Rural Triage 73

Decision Making Styles 76

Communication and Triage 79

**Section Four**

**After Hours Triage** **83**

Application of Triage 85

Making Triage Decisions 88

Emergency Department Triage 88

Telephone Triage 90

Multi-casualty triage 95

Triage Sort 97

Summary of Principles 98

**Section Five**

**Professional Issues** **101**

Medico-Legal Issues 103

Quality Practice 106

Documentation 107

Consumer Issues 108

Support 109

**Section Six**

**Sustainable After Hours Services** **113**

Developing an Action Plan 115

Action Plan Template 118

**RAHTER CD ROM**

RAHTER Manual

RAHTER Resources

**Activity Sheets** **119**

**References** **141**

**Figures and Tables**

Figure 1. Program Structure 13

Figure 2. Triage End-Points 46

Figure 3. Differences Between Face to Face and Telephone Triage 92

Figure 4. Triage Sieve and Sort Process 96

Table 1. Nature of Complaint 42

Table 2. Australasian Triage Scale 43

# FOREWORD

The provision of after hours primary medical services is an integral part of rural and remote general practice in South Australia (SA). The additional workload associated with the after hours service combined with a full time general practice can result in general practitioners (GPs) leaving rural communities.

The retention of nurses in our rural communities is also a concern and in an effort to find solutions that improve the attraction, recruitment and retention of both medical and other health services in the country, the Rural Doctors Workforce Agency (RDWA) has conducted a program focusing on improving after hours service provision in rural and remote SA. The **After Hours Triage Education and Training Program in Rural SA** was designed to improve the communication processes between rural GPs and nurses who manage after hours services as well as to up skill nurses in after hours triage.

The Rural After Hours Triage Education Resource (RAHTER) is the result of the program that provided training to more than 20 rural and remote communities in SA in 2004 and 2005. This Resource has been developed by both staff at the RDWA who managed the program, and also by the team of expert nurse educators who developed and implemented the nurse/GP training workshops. The RAHTER has been developed to assist rural and remote communities throughout Australia to implement training and education programs relevant to local GPs and nurses who manage the after hours primary medical service.

Supporting good models of after hours primary medical care is a recruitment and retention strategy of the RDWA and essential to addressing the long-term future of the rural and remote medical workforce of Australia. A stable and viable medical workforce will support the wider health service sector in rural areas, and will contribute to sustainable rural communities.

I encourage you and your communities, health services and GP practices to embrace this resource in an effort to support your local health services to remain viable, sustainable and of high quality.

**Dr Karen Sumner**

Medical Consultant, RDWA

(Chair, Program Advisory Committee)

# Part A
## *Program Users Guide*

**Authors**

**Jenny Fleming** Manager, Planning and Development

**Kate Hawtin** Program Coordinator

**Sandy Hammat** Program Support Officer

**Rural Doctors Workforce Agency**

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# Who is RAHTER for?

This resource has been developed from the knowledge gained and lessons learnt in implementing the After Hours Triage Education and Training Program in Rural SA. It is intended to be a practical resource for practitioners who are involved in after hours services in rural Australia (i.e. health services, nurses and rural GPs/practices). It considers the uniqueness of small rural and remote hospital settings, which are often minimally resourced and without on-site medical practitioners and dedicated emergency department nursing staff.

After hours services, while managed by rural GPs and nurses, are a community responsibility and rural communities are therefore encouraged to work with their local medical practitioners and hospitals to strive for improvements in the provision of after hours services.

This resource specifically targets nursing staff and GPs who manage the local after hours service. However hospital and clinical managers, practice managers and Divisions of General Practice staff have all participated in aspects of the training program and are also encouraged to be involved.

# How to use RAHTER

This resource includes information and material developed for the program including program objectives, workshop outlines, templates and evaluation processes. Consideration of the local setting in the development and delivery of the program has resulted in its success. For this reason, it is recommended that all potential participants of an after hours training program collectively review this document and determine which components will be relevant to the particular after hours service. Individual components of this resource may be more relevant than others, depending on whether the user is a nurse or GP or whether the training is targeting an individual or group.

**Part A:**

Program Users Guide

**Part B:**

Training Package for Individuals and Groups

**RAHTER CD ROM:**

CD ROM incorporating all workshop templates, readings and additional information that were used for the program

## Tell us what you think!

This resource is intended to share what we have learnt in implementing an after hours triage education program. While we have gained considerable knowledge and understanding of issues that can enhance after hours service provision in rural and remote SA, we would appreciate both feedback on this resource as well as any information on other programs that can enhance aspects of education and training for rural nurses and GPs managing after hours services.

Please contact us:
**Rural Doctors Workforce Agency**
57 Greenhill Rd, WAYVILLE SA 5034

P: 08 8357 7444 F: 08 8357 7088

E: triage@ruraldoc.com.au
W: www.ruraldoc.com.au

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# SECTION ONE

## *After Hours Triage Education and Training Program in Rural SA*

## Background

In 2003, the RDWA received funding from the Australian Government Department of Health and Ageing to develop and implement the After Hours Education and Training Program in Rural SA.

The program would enhance after hours primary care service provision through:

- Improving communication links between rural GPs and local hospital triage nurses
- Providing triage training for rural nurses in SA rural hospitals and GP practices
- Developing a transferable and sustainable training and collaboration model that can be applied to other areas of rural SA and Australia
- Developing strong partnerships with the State Department of Health

This section provides detailed information on how the RDWA conducted the **After Hours Education and Training Program in Rural SA.**

## Who Was Involved?

The demand for involvement in this program was extremely high and over 20 communities in rural and remote South Australia participated. The program was managed by the Rural Doctors Workforce Agency and a number of key staff were employed to oversee and implement the program. Trainers with rural experience developed and delivered key program elements and being South Australian based they assisted in building local capacity for future delivery of after hours training in South Australia. Rural Divisions of General Practice were key organisations involved in coordinating the program at the local community level. An external evaluation was conducted throughout the two-year program.

**Figure 1** describes the structure of this program and all key service partners. Working relationships were a key feature of the structure and in particular the trainers were able to work closely with the program management as well as with individual communities. This enabled the implementation of the training program to meet the broad program aims, as well as local needs. The training program was delivered locally, mostly in rural hospital training rooms. Rural Divisions of General Practice provided the necessary infrastructure and knowledge to coordinate and deliver this program locally.



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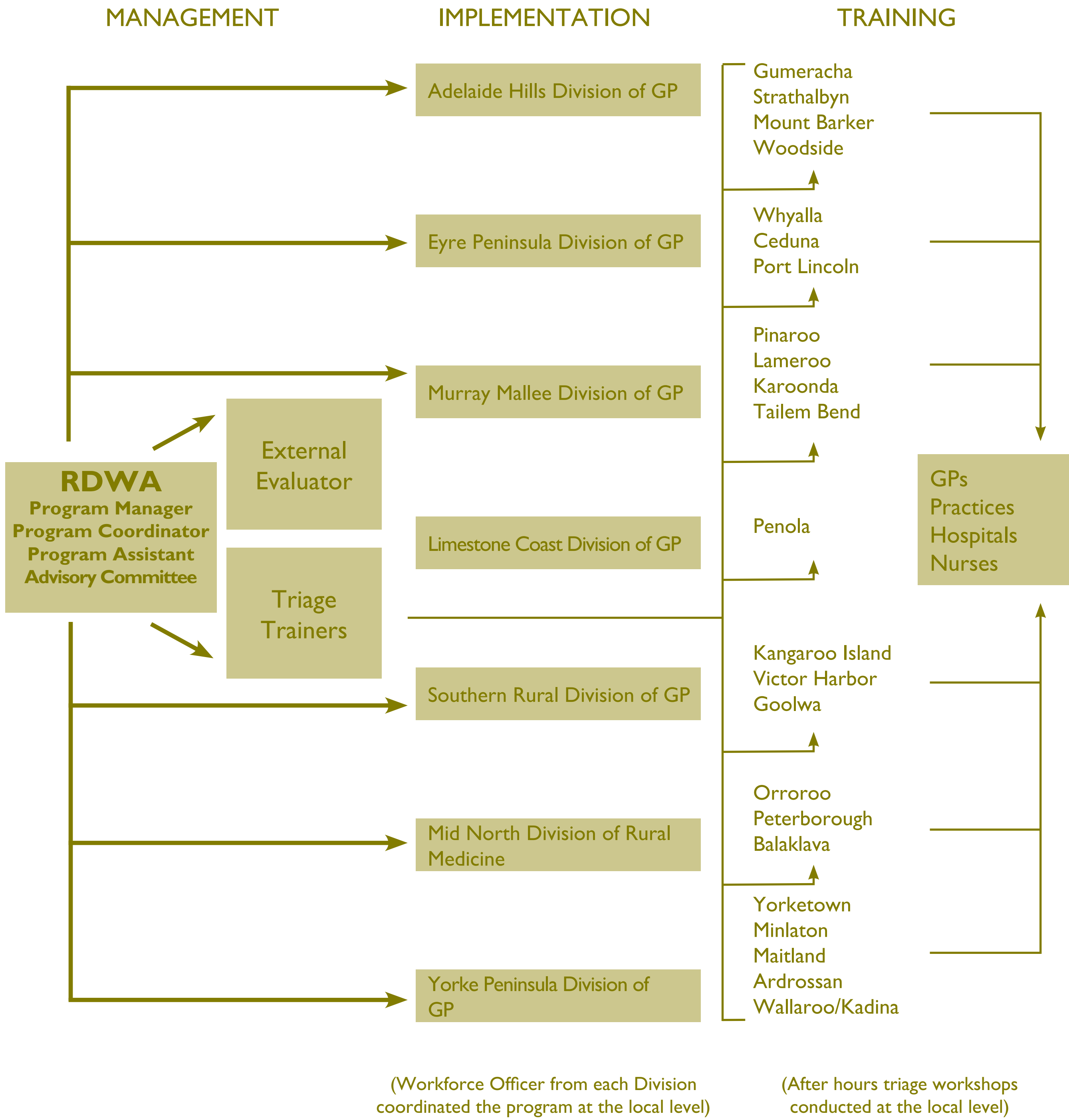
## Figure 1. Program Structure




(Workforce Officer from each Division coordinated the program at the local level)

(After hours triage workshops conducted at the local level)

# What We Did

It was important that an after hours triage training program was developed that was relevant to a range of rural hospital settings regardless of size, resource and location. For this reason a broad program outline was developed by a team of trainers who were also contracted to deliver the training program. The program outline was distributed to key members of all participating communities (GPs, nurses, hospital and Division of General Practice staff) for approval prior to the commencement of the training.

In the development of the training program a number of distinct training sessions were developed and are outlined in this section.

## A: GP/Nurse Session *(evening)*

The training program consisted of two workshops and involved both rural GPs and nurses. The GP/Nurse Session was the first activity in each of the communities and the aims were:

- To introduce the aims of the After Hours Triage Education and Training Program
- To identify any issues and concerns in relation to after hours health service provision and advice locally
- To ensure that the Nurse Workshop was focused on the local context and local issues in the area of after hours triage
- To provide an informal forum during which issues and concerns could be identified for more detailed discussion at the workshop on the following day

Topics that were considered for discussion during the GP/Nurse Session included:

- Communication issues – describing the existing communication systems, identifying problems and systems to maintain discussion on these issues
- System issues – identifying local mechanisms for reviewing decisions and the barriers or inhibitors of the current system e.g. administrative, legal, logistical and resource
- Moving forward – addressing issues discussed, developing possible solutions and committing to following up issues eg debriefing sessions

RDWA program staff, a member of the training team, Division of General Practice Workforce Coordinators and GPs and nurses in each community participated in a teleconference prior to the GP/Nurse Session. The aims of the teleconferences were to provide information about the training workshops and their objectives, build some ownership and goodwill with the GPs and nurses and develop themes and issues for discussion at the GP/Nurse Session.

## SESSION INFORMATION

Duration: 2-3 hours

Venue: Local hospital or community venue

Catering: Light-working supper

**Resources:**

✓ Power Point Presentation

✓ Lap-top/Data Projector/Screen

✓ White Board/Markers

## B: Nurse Workshop (full day)

The full day Nurse Workshop was the second activity of the program, offering a full day training and education session with rural nurses. The workshop aims were:

- To enhance Registered Nurses' knowledge and skills in assessment, communication and decision making for front line after hours health service provision
- To highlight the variety of ways in which after hours health services are provided by rural nurses and identify opportunities to develop alternative models for service provision
- To facilitate the development of sustainable frameworks for after hours health service provision through strengthened partnerships between local General Practitioners and nurses

### The content of the workshop included

- Introduction
- Context of after hours triage
- Patient assessment
- Communication and decision making
- After hours triage
- Professional issues
- Action planning, Where to from Here?

The final session of the Nurse Workshop, 'Where To From Here?' was open to GPs and hospital administrators as it was a planning process that addressed issues raised from both the GP/Nurse Session and Nurse Workshop. An action planning template was used in this session to determine possible solutions to local after hours service issues, resources, performance indicators and timeframes. For a full outline of the training program, refer to Part B of this resource, Training Package for Individuals and Groups.



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**WORKSHOP INFORMATION**

Duration: 7-8 hours

Venue: Local hospital or community venue

Catering: Morning/afternoon tea and lunch

**Resources:**

✓ Power Point Presentation

✓ Lap-top/Data Projector/Screen

## C: Follow up GP/Nurse Sessions

The training program can be conducted as a stand alone education session, however to sustain quality improvements to after hours services, ongoing planning sessions involving GPs and nurses are suggested and may focus on:

- The development of sustainable frameworks for after hours health service provision through strengthening partnerships between local General Practitioners, nurses and hospital systems
- The opportunity to review and progress local action plans

These sessions would be organised at the local level.

# Training Program Preparation

## Promotion

A generic flyer was developed by the RDWA that broadly outlined the objectives of the program. Rural Divisions of General Practice were the coordinators of this program at the local level, circulating the flyer to local general practices and hospitals prior to both workshops and also promoting the program through local media to inform rural communities. Key nursing/hospital staff were encouraged to actively promote and support program participation to nurses involved in the after hours service. Division staff individually contacted those GPs who manage after hours services, encouraging their attendance at the training program.

## Pre-reading

As no formalised after hours triage training had occurred in rural SA hospitals prior to the program, a range of pre-reading material was provided to nurse participants. This pre-reading material assisted participants to outline a range of issues relating to after hours service provision and provided an overview of the workshop content, including application of the Australasian Triage Scale.

## Pre-survey

Rural nurses who participated in the program were invited to complete a survey prior to the workshops. This survey provided trainers with 'base line' information about participant skills and knowledge in triage as well as their expectation of the workshop. These surveys were returned to the RDWA for analysis and information was then forwarded to the trainers prior to the workshops. These surveys also formed part of the program evaluation.

## Community Information

The RDWA collected a range of geographic and demographic information of each town involved in the program, in particular information relating to the hospital and medical services. This information was also provided to the trainers prior to the workshop as 'background' information that may assist them in understanding the local after hours system.

## Evaluation

Evaluation forms were distributed to all participants attending workshops, with separate evaluation forms for GPs and nurses. For a copy of the surveys used to evaluate the program see RAHTER CD ROM.



0184 Training Manual.indd 18 8/9/05 10:09:28 AM

## Registration

All participants were required to register their attendance at workshops, and Registered Nurse participants were presented with a certificate of attendance.

## Action Plans

The Nurse Workshop provided an opportunity to develop a set of actions to be undertaken to improve after hours systems and processes within the hospital setting. The workshop concluded with a 1.5 hour planning session and was a collaborative process involving local GPs, nurses, hospital administrators and Division of General Practice staff.

The Action Planning Session involved:

- Compiling local after hours issues
- Categorising issues into themes (occupational health and safety, workforce, litigation)
- Prioritising issues
- Developing solutions
- Identifying key staff and allocating tasks
- Setting time frames and reviewing plan

The action planning process resulted in a number of improvements in after hours systems across rural South Australia, including updates to hospital security, the development of formal telephone triage protocols and the updating of standing orders. For a copy of the Action Plan Template see RAHTER CD ROM.

## Workshop Support and Coordination

Key Division of General Practice staff coordinated the program locally, organising the venue, catering and equipment as well as providing technical support and recording program updates at the workshops. To support the implementation of these workshops, the RDWA developed a checklist as a guide for Division of General Practice staff.

The Divisions of General Practice coordinated the after hours triage training program (workshops) in their Division which involved

- ✓ Recruiting nurses and GPs to training workshops
- ✓ Liaising with rural hospitals, nurses and GPs regarding local needs for workshops
- ✓ Arranging the venue and catering for workshops
- ✓ Attending all training workshops and refresher sessions
- ✓ Coordinating debriefing sessions
- ✓ Program reporting
- ✓ Local program promotion and communication
- ✓ Program evaluation
- ✓ Facilitating development/refinement of triage protocols in consultation with rural nurses and GPs involved in the training program

## Attendance Incentives

To encourage maximum attendance at these workshops the Rural Doctors Workforce Agency used program funding to cover the cost to backfill Registered Nurses to attend workshops. This supported rural hospitals who found it difficult to cover attendance of a number of staff at one workshop. Rural GPs were offered a nominal amount to attend both the GP/Nurse Session and Nurse Workshop.

## Target Group

Rural GPs and hospital nurses who manage the local after hours service were targeted for this program.

In some cases GP practice managers and nurses, hospital based enrolled nurses and administrators also attended some or all aspects of the training workshops. This proved useful, particularly in some of the issues and planning sessions.

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# SECTION TWO

## *How to Run an After Hours Triage Training Workshop*

0184 Training Manual.indd 23 8/9/05 10:09:29 AM

## Replicating the Workshops

The After Hours Triage Education and Training Program can be replicated in any rural hospital in Australia. This section provides all of the relevant material to conduct after hours triage education at the local level. For all resources to run an after hours triage training workshop, see list on page 30 and RAHTER CD ROM.

The implementation of this program is reliant on a representative willing to coordinate the following activities at the local level. This may be a member of the local hospital, GP practice or Division of General Practice.

### First Steps

| | |
|---|---|
| Consult | with all providers of the local after hours service including GPs and nurses and gain commitment to conducting education on after hours service issues |
| Consult | with other key service providers including Divisions of General Practice in developing an education program |
| Define | key components of the After Hours Triage Education and Training Program which are most relevant for individual communities, ie patient assessment, ATS and action planning |
| Liaise | with trainers* |



* Where capacity exists in a community, training may be delivered with local resources, however external trainers may need to be contracted: Refer to page 28, Financial Considerations in contracting external trainers.

0184 Training Manual.indd 24 8/9/05 10:09:29 AM

## Workshop Preparation

| | |
|---|---|
| Set | a suitable date and time for all training participants* |
| Promote | education/training session to GPs and nurses |
| Organise | venue and catering |
| Organise | training equipment |
| Refine | Training Package (Part B) to reflect local needs in conjunction with trainer |
| Print | Training Package for all participants |

## Running the Workshop

| | |
|---|---|
| Set | up the room |
| Provide | registration form for participants |
| Assist | trainer in recording program outcomes |
| Develop | local action plans |
| Distribute | and collect evaluation forms |

*Consideration must be given to the work commitments of GPs and nurses working in rural communities. As rural GPs often have patient commitments, daytime workshops can prove to be problematic, resulting in low attendance. One month's notice to both GPs and nurses of workshop date and time is recommended.

# Post Workshop Activities

A number of ongoing activities can be conducted post workshop and the development of further activities relating to the local after hours service are best discussed at the end of the workshop session as a group. Ongoing and collaborative activity between the providers of the after hours service (ie GPs, nurses and hospital administration) will ensure that a strategic approach to enhanced sustainability and quality of the local after hours service occurs.

## 1. Refresher session

Refresher 'skills' sessions that revisit original workshop material in more detail can be organised at a suitable time post workshop i.e. 2-4 months. A local resource person may be required to coordinate this activity. If appropriate, consideration may be given to link with other neighbouring hospitals to share training costs.

## 2. Debriefing

Ongoing debriefing sessions between after hours service providers can provide a useful education forum and assist in improving communication and development of local after hours systems and policies.

## 3. Action planning

Action planning is an important aspect in sustainable, quality after hours services. Revisiting action plans that were developed at the workshops at regular intervals (2-4 months) with all those involved in the after hours service is recommended. This process may be incorporated into refresher or debriefing sessions noted above.

## 4. Peer support

Rural nurses involved in the RDWA program supported the development of a peer support network that would provide an ongoing forum to discuss/review the range of issues and situations relating to their role in the local after hours service. Consideration may be given to developing a local or regional peer support network for nurses working in the after hours service.

## 5. Protocol / policy development

Protocols or policy relating to the local after hours services may not have been reviewed for some time or in some cases may not exist. While a 'template' for this may be useful, the protocols and policies also need to reflect the local needs and support the local service providers. For this reason ongoing liaison between GPs and nurses on the review or development of locally appropriate protocols and policies for the management of the after hours service is encouraged post workshop. To assist in developing local after hours protocols or policies, a number of existing resources are available. See RAHTER CD ROM.

# Financial Considerations

In order to maintain a sustainable education process the following should be considered, to adequately resource an education program for after hours triage training.

## Participant attendance

While remuneration did not prove to be a key factor in the level of attendance by GPs and nurses, some incentive for attendance should be considered. For example nurse involvement may be part of an agreed professional development activity and for GPs, flexibility in the timing of the workshops that considers both their professional and personal commitments may increase their attendance. A certificate of attendance was provided to all RNs.

## Coordination of the after hours triage education workshop

Coordination of the education workshops is crucial at the local level. Divisions of General Practice provide a key link and central contact point with all GPs in the region while hospital staff such as the Director of Nursing, Clinical Nurse Consultant or Professional Development Coordinator provide a link with all nursing staff. The ability to resource a coordinator for after hours triage education workshops should be considered.

## Trainers

If communities wish to engage with external trainers, consideration needs to be given to both time and travel costs. Costs will vary with individual trainers and in different locations. There may be cost efficiencies in engaging trainers for a full day to conduct a workshop. Two trainers conducted each workshop.

## Evaluation

The RDWA conducted an external evaluation of this program and while this may not be practical for individual communities, consideration should be given to evaluating workshop elements from a quality assessment point of view which might include:

- Changes in nurse skills, knowledge and confidence
- Views of both GP and nurse participants regarding opportunities for increased communication/interaction
- Outcomes of joint GP/nurse planning processes

## Ongoing Training and Services

After hours triage workshops conducted by the RDWA provided a general overview of a range of issues relating to the management of the after hours service. Nurses that participated highlighted a range of additional clinical areas for ongoing professional development. These included:

- Advanced life support
- Cardiac training
- Emergency management
- Additional triage training for new staff

Consideration should be given for an ongoing nurse professional development program that incorporates after hours triage education and a range of subsequent clinical areas of upskilling or development.

# Useful Contacts/Resources

The Rural Doctors Workforce Agency has conducted one of many programs that have been run in Australia to address after hours education and training for rural GPs and nurses. Others that are known to the RDWA at the time of print include:

**McGrath A.** (2002) Nurse Telephone Triage After Hours Service Delivery, West Vic Division of General Practice. See RAHTER CD ROM (Part B Section 1)

**NSW Department of Health** (2004) Triage in NSW Rural and Remote Emergency Departments with no on-site doctors. Review and recommendations of the NSW Rural Critical Care Committee.

Contact Details:
NSW Department of Health,
P: 03 9391 9000
See RAHTER CD ROM
(Part B Section 4)

**Turnball H** (2004) Central Wheatbelt Nurses Guidelines - for use by nurses when the doctor is not available.

Contact Details:
Central Wheatbelt
Division of General Practice,
P: 08 9621 1530
See RAHTER CD ROM (Part A)

The following list of resources are available on RAHTER CD ROM

**A) GP/Nurse Session**

- Nurse Survey
- GP Survey

**B) Nurse Workshop Nurse Pre Workshop Survey**

- Nurse Post Workshop Survey
- Scenarios for Pre/Post Nurse Workshop
- GP Post Workshop Survey
- Action Plan Template
- Registration of Attendance Form

**C) Follow Up GP/Nurse Sessions**

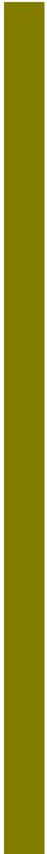
- Nurse Survey
- GP Survey

**Additional Resources**

**Department of Health** (2002) Rural Emergency Nurses Survival Kit, Government of Western Australia.

**Department of Health and Ageing** (2002) Triage Education Resource Book. Australian Government.

Contact Details:
Australian Government,
Department of Health and Ageing,
Costing and Ambulatory Classification Section
P: 02 6289 1555





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0184 Training Manual.indd 32 8/9/05 10:09:30 AM

# Part B
## *Training Package for Individuals and Groups*

**Authors**

**Professor Paul Arbon**

Chair of Acute Care Nursing, University of Canberra/Canberra Hospital

**Ms Geri Malone**

Remote and rural nursing educator/consultant, Office of Country Health, SA Department of Health

**Dr Kathryn Zeitz**

Nursing consultant, Zeitz Enterprises

0184 Training Manual.indd 34 8/9/05 10:09:30 AM

# Introduction

In 2003-05 the Rural Doctors Workforce Agency hosted a rural after hours triage training program. This was designed to support after hours health service provision in rural South Australia by strengthening partnerships between general practitioners and hospital based nurses. As a component of this a series of nurse triage training sessions were held.

This training package reviews the content of the one day nurse triage training workshop. It has been designed to provide clinicians with practical information on triage in rural settings. It can be used by individuals as an ongoing education tool and resource or by trainers to provide triage training locally. All activities are provided in the back of the RAHTER and on the RAHTER CD ROM.

## The objectives of the training package are to:

- Enhance rural nurses' knowledge and skills in assessment, triage, communication and decision making for front line after hours health service provision

- Highlight the variety of ways in which after hours health services are provided by rural nurses and opportunities to develop alternative models for service provision

- Facilitate the development of sustainable frameworks for after hours health service provision through strengthened partnerships between local General Practitioners and nurses

- Provide resources and information to support nurses in after hours decision-making

The content has been designed so it can be used as an independent learning tool by an individual or as background work to triage training programs. It provides detailed information relating to after hours rural triage practice and links to other sources of associated information. It is recommended that you work through each section in sequential order. This program was conducted over a full day, but can be modified to suit local needs. There are exercises and additional reading to support the content of this package.

We hope you find the package helpful.

0184 Training Manual.indd 36 8/9/05 10:09:30 AM

# SECTION ONE
*Context of Triage*

This section addresses the context of rural nurses working in rural and remote hospitals. The content focuses on situations where there is no medical support on site and a nursing workforce with limited specialised emergency skill base.

It has been designed to set the stage for the subsequent sections of the package and describes the purpose of triage and the importance of establishing strategies to improve the practice of after hours triage.

## The objectives of this section are to:

- Define after hours triage and discuss the principal issues that have led to the development of after hours triage training programs for nurses
- Overview the different types of triage and the nurse's role in triage decision making
- Introduce the triage process concept
- Describe the different contexts and methods for after hours triage
- Discuss the range of triage end-points

## Definition of Triage

Triage is a French word referring to the sorting of patients or casualties based on the degree of urgency for management or transport. Modern triage systems have evolved from early military systems in the mid 1800s.



0184 Training Manual.indd 38 8/9/05 10:09:30 AM

# Application of Triage

There are various contexts in which the principles of triage can be applied. The most obvious ones are:

## Emergency departments

Triage for the most part is practised within the emergency department setting and revolves around making decisions about the priority or urgency of care for individual patients as they present. In Australia the majority of metropolitan emergency departments utilise the Australasian Triage Scale (ATS).

## Mass casualty situations

Mass casualty triage principles are frequently applied at the scene of an accident or other emergency where there are multiple patients who are ill or injured. This triage involves a system for readily identifying the urgency of care for each patient. Currently a draft national standard (Australian) is being developed to provide a uniform national approach to the triage of mass casualties.

## Telephone triage

The strategies used in telephone triage have been evolving to assist in alleviating the after hours workload for hospitals and general practices. Models have included the establishment of call centres for patients to ring and obtain advice on an appropriate plan of action in response to an illness or injury. It is argued that call centres can reduce inappropriate presentations to major health facilities and General Practitioner call-outs.

## Nurses' Role in Triage

In many settings nurses undertake the primary role in the triage of patients. For the most part this is seen in emergency departments resulting from patients who present for care. There is evidence that nurses usually out-perform their medical and ambulance colleagues on paper-based trails of triage skill. However, it remains important for nurses to continually review their triage competence and to support less experienced nurses in developing assessment and decision-making skills and confidence in triaging.

This is even more evident in rural and remote settings where there is limited medical support.

## Principles of Triage

Triage is essentially a process that assists practitioners to determine the urgency of a patient's medical care taking into account the severity of the injury or illness and the available resources. Triage decision making is often supported by evidence-based guidelines or scales that help to determine the most appropriate priority for each patient.

The foundation of all triage is succinct, systematic and accurate assessment of patients followed by appropriate prioritisation of patient care based on the severity of the patient's injury or illness and the setting in which the triage is taking place. Important skills of triage include high-level communication skills, including listening skills, and the ability to utilise reliable decision making processes (aided by triage scales)[1].

The process of triage involves assessment, evaluation, prioritisation and management.



0184 Training Manual.indd 40 8/9/05 10:09:30 AM

## Activity One

Outline the four steps in undertaking triage.

1 ______________________________

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2 ______________________________

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4 ______________________________

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Basic steps of triage include:

- Interviewing the patient
- Problem identification
- Initiation of emergency treatment
- Prioritisation of the urgency

These steps may be carried out simultaneously

# Why After Hours Triage?

In the majority of rural South Australia, after hours medical services are provided by local GPs in the hospital premises as an extension of their general practice clinics, supported by hospital nursing staff [2]. This model involves GPs switching their phones through to their local hospital once the medical clinic is closed. When a patient calls the practice phone number after hours, the call is automatically diverted to the local hospital where a Registered Nurse takes the patients details, and assesses whether the patient requires nursing advice and reassurance, a medical appointment the next day, or advice/treatment from the doctor on call [3].

Data collected from three rural hospitals participating in the program shows that the most common times for after hours presentations occurred between midnight and 2 am. The top six presentations in these three hospitals are shown in Table 1 below.

The great majority (69%) of presentations at the three rural hospitals were given an ATS rating of 5 and a further 18% were given a rating of 4. A GP was required in about two-thirds (65.5%) of all presentations. A comparison of ATS ratings showed a significant difference for presentations depending on whether the GP was required. For presentations in which the GP was required, about 60% were given an ATS of 5 and 22% received an ATS of 4. By comparison, for presentations where the GP was not required, about 85% received an ATS of 5 and only 10% received an ATS of 4 [4].

Table One. Nature of Complaint (six most common)

| Problem | Presentation | % |
|---|---|---|
| Redressing, ROS, Review | 123 | 9.3 |
| Other musculoskelatal | 116 | 8.8 |
| Laceration, abrasion | 92 | 7.0 |
| Other ENT | 84 | 6.4 |
| Other | 77 | 5.8 |
| Vomiting/diarrhoea | 65 | 4.9 |



0184 Training Manual.indd 42 8/9/05 10:09:31 AM

Triage for the most part is applied at front line health services like emergency departments. In recent times there has been increased interest in after hours triage practice because effective triage has the potential to reduce the 'out of hours' workload on hospitals and medical practitioners. Good triage decision making ensures that patients receive timely care i.e. patients who do need immediate or urgent care are treated whilst patients who could wait until normal office hours can be assessed and their care deferred until a suitable time. The increasing strain on rural hospitals and general practitioners to deliver after hours services has drawn attention to the need to improve after hours triage.

This can be achieved through further development of triage skill among nurses and through the introduction of additional and complementary services such as telephone triage or advice lines, supported by community education. The After Hours Triage Education and Training Program has been designed to facilitate the achievement of these goals and to support the development of a more sustainable health service in local (and especially rural) communities.

There are many opportunities to improve the provision of after hours health service delivery in rural settings. Many of these opportunities are dependent on nurses' ability to triage well and good working partnerships between general practitioners and nurses in local settings.

Programs have been undertaken in various places to improve the provision of health services to communities outside ordinary office hours. In particular programs to provide formal telephone triage and advice systems have been established in Western Victoria, Western Australia and in Ontario, Canada[6]. The Western Victorian Division of General Practice has developed a dedicated telephone line staffed by a nurse to assess, advise and refer telephone enquires outside of normal consultation times. In Ontario a 24-hour nurse telephone triage service is available for rural communities. In Western Australia there is an Emergency Department based advice line and in the ACT, a territory wide health advice line is staffed by nurses.

Table 2: Australasian Triage Scale (adapted from the Triage Education Resource Book)[5]

| ATS Category | Response | Description of Category |
| --- | --- | --- |
| Category 1 | Immediate simultaneous assessment and treatment | Immediately life-threatening |
| Category 2 | Assessment and treatment within 10 minutes (assessment and treatment often simultaneous) | Imminently life-threatening<br>or<br>Important time critical treatment<br>or<br>Very severe pain |
| Category 3 | Assessment and treatment start within 30 minutes | Potentially life-threatening<br>or<br>Situational urgency<br>or<br>Severe discomfort |
| Category 4 | Assessment and treatment start within 60 minutes | Potentially serious<br>or<br>Situational urgency<br>or<br>Significant complexity or severity<br>or<br>Discomfort |
| Category 5 | Assessment and treatment start within 120 minutes | Less urgent<br>or<br>Clinico-administrative problems |

## The rationale for these emerging programs

### These programs may support the rural GP workforce by:

- Providing a marketing edge in the recruitment and retention of practitioners especially in smaller rural locations
- Contributing to a risk management strategy through improved access to early advice and reduction in extended working hours and call-ins for general practitioners and nurses
- Assisting in fatigue reduction and improved quality of work-life for practitioners
- Facilitating improved communication between GPs and nurses through joint planning and after hours service delivery

### Providing support for nursing staff by:

- Reducing inappropriate presentations to hospital
- Recognising the extended role of advanced practice nurses and validating previously informal practices
- Improving triage practice and patient outcomes through formalised systems
- Facilitating better communication between hospitals and general practices

### Improving the service provided to the community by:

- Ensuring a reliable source of professional advice and information supported by evidence-based clinical guidelines
- Providing a portal for help that is convenient and readily accessible. This may overcome reluctance to seek advice from health services that are perceived to be overloaded
- Supporting patient participation in the development of after hours services and planning
- Conducting community education programs



0184 Training Manual.indd 44 8/9/05 10:09:31 AM

## Triage End-Points

There are many different models of after hours care delivery for rural health services. A range of factors influence the models that are selected and applied in different parts of the country. These include the type of general practice (for example, private clinic, multiple practices servicing one hospital) and the type of hospital service. A common model for after hours service provision has GP calls diverted to the hospital after hours and the hospital supported by an on call system/roster of local GPs.

Other models are emerging. For example, a medical practitioner may not be available after hours and the rural hospital nurse may triage and assess patients, consult with an external service provider and call in assistance if required.

Nurses managing after hours health services have a number of choices (referral points) when determining the appropriate level and timing of care.

### Activity Two

List four different sources of information and support that rural nurses could seek out to assist in their clinical decision-making.

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4 ______________________________

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Triage end-points are described in the following diagram and are equally applicable whether the presentation is by telephone or in person to the emergency area of the hospital.

## Figure 2: Triage End-Points

The focus of this program is to provide participants with guiding principles and skills to apply the processes of triage in a variety of settings. There is currently a range of acceptable protocols, standards and guidelines developed to assist in the decision-making of triage. Some of these will be discussed as examples but it is important for each health setting to determine the appropriate guidelines and standards for triage that are to be followed based on local setting, skill-mix and knowledge.

## Readings to support this section

See RAHTER CD ROM

**Fatovich, D, Jacobs, J, McCance, J, Sidney, K and White, R** (1998) Emergency Department Telephone Advice. Medical Journal of Australia **169**: 143-146

**South Australian Emergency Nurses Association (SAENA)** Position Statement: Triage in Rural and Remote Hospitals (Revised 2003)

## Additional Information

**McGrath A** (2002) Nurse Telephone Triage After Hours Service Delivery, Western Victoria Division of General Practice. See RAHTER CD ROM (Part B Section 1)

0184 Training Manual.indd 48 8/9/05 10:09:32 AM

# SECTION TWO
## *Patient Assessment*

Effective patient assessment underpins good triage decision making. Nurses undertaking triage functions must be able to assess a patient's injury or illness efficiently and thoroughly so that triage priority can be determined.

The role of rural nurses in hospitals where there are no on-site medical staff and where nurses are not specifically trained in or work solely in the emergency department is unique and challenging. In particular, rural nurses in these settings require ongoing knowledge development and skills maintenance. An important requirement for nurses in these situations is the development of high level assessment skills for first line management of emergency patients presenting to their health units. Assessment is the foundation of triage and effective triage results in better patient outcomes.

The objectives of this section are to overview first line patient assessment including:

- Explain the role of patient assessment in appropriately determining patient acuity
- Describe the process of undertaking a systematic patient assessment
- Describe patient assessment using a primary and secondary survey approach
- Identify key points in the consultation process

Patient assessment is a fundamental first step in appropriately allocating a priority for action in any emergency care situation. Good patient assessment not only allows appropriate triage by identifying the acuity of the presentation, but it also enables the initiation of appropriate emergency treatment(s) and forms a baseline for ongoing assessment of patients. Superficial or incomplete patient assessment is the most common cause of inappropriate intervention, errors in management and poor outcomes of care.

# Acuity

The aim of patient assessment in the triage context is to identify the patient's current condition and the urgency with which intervention/treatment is required. In performing triage the aim is not diagnosis but rather the assessment of current patient signs and symptoms to provide the basis for determining priorities for patient management and for establishing the urgency of interventions.

# The Issue of Diagnosis

Traditionally, nurses have been taught to look for abnormal findings (signs and symptoms) as a component of their patient assessment. Nurses identify abnormalities from the basis of their knowledge of normal anatomy and physiology (often using a systems based approach). Consequently, nursing assessment frequently identifies what is abnormal but does not determine a definitive medical diagnosis.

Medical students are taught to take this additional step and determine a differential diagnosis through what is known as diagnostic reasoning. Nurses in rural and remote practice are often required to provide a provisional diagnosis on the basis of presenting signs and symptoms. This assists when nurses are required to describe the patient's presentation and in particular when calling in medical assistance after hours. Nursing triage is therefore aimed at determining the severity or acuity of the patient's problem by identifying and assessing abnormalities (signs and symptoms) and where possible putting forward a provisional diagnosis or principal presenting problem.

## Local Knowledge

In determining patient priority the context of the patient should be considered in making rural triage decisions. Nurses in rural settings responding to telephone triage enquiries need to have a good understanding of their community and the range of social determinants of health and apply this in their triage work. However local knowledge may also have a negative effect if triage nurses make assumptions about the situation of their patients without carefully assessing the situation on each occasion. Nurses should always be careful and not assume that they know what has happened to their patients or their situation.

## Assessment

A holistic approach should be used in patient assessment including the use of knowledge and skills in

- ✓ Interviewing
- ✓ History taking
- ✓ Physical examination
- ✓ Psychosocial assessment

The extent to which nurses have been taught these competencies varies considerably and often assessment skills have been 'learnt on the job'.

### Activity Three

List techniques that you use in undertaking a physical assessment

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0184 Training Manual.indd 52 8/9/05 10:09:32 AM

## Techniques Used in Assessment

In addition to the use of professional knowledge and communication skills nurses need to be able to perform several specific assessment techniques and should be familiar with:

1. Inspection – process of observing, includes observation of behaviour and appearance
2. Auscultation – the process of listening for abnormalities and also includes listening to what the patient is saying
3. Palpation – the process of feeling for abnormal signs
4. Percussion – the process of feeling and listening associated with assessment of body cavities of air filled spaces

## Elements of Patient Assesment

There are three key elements to patient assessment which are

- ✓ Scene
- ✓ Story
- ✓ Survey - primary and secondary survey

## Scene - Danger

Whether the patient assessment occurs at the scene of an accident or on the doorstep of the hospital, consideration must always be given to the dangers that you place yourself in and dangers to the patient(s). Assessing the surrounding environment first is important, protecting yourself and the patient.

## Activity Four

In undertaking a patient assessment, what risks should you be alert for?

Be alert for:

- Potential and actual dangers to yourself, your patient and the community
- What is happening around you
- Be aware that the patient themselves may be the source of danger to you, others and themselves
- The patient may still be in danger of further injury

Ensure your safety first, then others around you, and finally the patient. Self-protection includes a broad range of strategies ranging from avoiding exposure to blood borne diseases through to avoiding the risk of explosion from volatile gases. Where a situation is not considered safe always seek assistance.



0184 Training Manual.indd 54 8/9/05 10:09:32 AM

One system to manage risks uses the acronym SAFE:

**S** Shout for help
**A** Approach with care
**F** Free from danger
**E** Ensure a safe exit

## Story

The collection of a history from the patient, relatives, carers or friends can be undertaken simultaneously with the survey. The extent of the history is dependant upon the acuity of the situation and the condition of the patient. Often it is only possible to collect a minimal history until the situation allows for further exploration.

It is suggested that the minimal history collected should include what happened and when, and what might affect the patient's treatment or recovery. The acronym AMPLE reminds us of what might affect treatment or recovery:

**A** Allergies
**M** Medications
**P** Past illnesses
**L** Last meal
**E** Events leading to this presentation

# Survey

A Primary and Secondary survey approach is recommended (based on the A.B.C.D.E action plan - see page 57). This approach was initially developed for the management of trauma patients but applies equally to patients with medical problems (urgent or non urgent).

The length of time it takes to complete a patient assessment will vary depending upon the condition of the patient, the complexity of the situation and the experience of the practitioner. On some occasions, usually in the less urgent scenarios, the primary assessment may only take a few seconds. For example, upon greeting a patient, if they are able to answer your initial questions clearly in sentences without any notable shortness of breath then you can rule out immediate threat to life. This example contrasts with the presentation of an unconscious patient who is unable to provide those verbal cues or the critically ill presentation in which you may never get past primary assessment and resuscitation.

However it is important to be aware that as soon as you greet a patient you have commenced the primary survey.

## Primary and Secondary Survey

The aim of the primary survey is to

- ✓ Identify and treat life-threatening problems based on an A.B.C.D.E action plan
- ✓ Commence resuscitation if required
- ✓ Focus on management of patient problems and not diagnosis

The aim of the secondary survey is to

- ✓ Identify patient problems not apparent during the primary survey
- ✓ Complete head to toe surveillance
- ✓ Collect a detailed patient history

An effective strategy needs to have a plan of action

- ✓ Treat A.B.C.D.E in that order
- ✓ Treat and repeat frequently
- ✓ Consider options for definitive treatment, subject to locally agreed arrangements

## Primary Survey

Primary survey combines assessment with simple life saving interventions to treat life-threatening problems as they present themselves.

The A.B.C.D.E action plan involves the assessment of:

**A** Airway
**B** Breathing
**C** Circulation
**D** Disability
**E** Exposure

## Airway (with cervical spine control)

Airway obstruction is among the common causes of death in emergency situations. Care of the airway takes precedence over all other patient interventions. Common causes of obstruction include:

- The tongue falling against the posterior pharyngeal wall
- Blood, vomitus
- Inhaled matter or localised trauma
- Swelling

## Activity Five

What cues are used to assess adequacy of the airway?

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Assessing the airway includes:

- Signs of agitation
- Airway noise (gurgling, stridor, silent)
- Air movement at the mouth
- Cyanosis (late sign)

## Managing the Airway

- POSITION, position, position – positioning of the patient and/or airway is the most important strategy to maintain an open airway during the emergency phase of care. The patient may be managed initially in a stable side or lateral position and/or alternately their airway may be positioned appropriately by jaw thrust/chin lift manoeuvres
- LOOK – foreign objects and other occlusions have been missed when practitioners fail to inspect the upper airway adequately
- OPEN the airway – positioning, jaw thrust or chin lift
- CLEAR the airway – finger sweep and suction. Lateral position with extension of the head/neck where advisable
- SECURE the airway – oropharyngeal or nasopharyngeal airway. More advanced approaches include laryngeal mask, endo-tracheal tube, cricothyrotomy
- MONITOR the airway – never leave a patient with a potentially compromised airway alone even with an artificial airway device in situ. Unconscious patients with no advanced airway support should always be on their side
- CERVICAL SPINE – always be alert for the potential problem of cervical spine injury. There is the possibility that excessive movement of the cervical spine will convert a fracture/dislocation without neurological damage to a fracture/dislocation with neurological impairment. Avoid hyperextension or hyperflexion of the patient's head and neck

**Remember that a secure airway is more important than a secure cervical spine.**

## Breathing (with oxygen)

Once an airway is secured with care of the cervical spine, attention is turned to breathing.

Breathing can be compromised by problems effecting the mechanics of ventilation or gas exchange within the lungs such as:

- Neurological – head injury/drugs/alcohol
- Trauma – fractured rib/ pneumothorax and/or haemothorax
- Medical – asthma/ chest infection/ pulmonary oedema

### Activity Six

What are the signs indicating effective ventilation?

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0184 Training Manual.indd 60 8/9/05 10:09:33 AM

Assessment of breathing includes:

- Look for air movement at the mouth
- Check respiratory rate, depth and rhythm (know the normal parameters for age groups)
- Check for chest (and/or abdominal) movement
- Check for use of auxiliary muscles of respiration

  Listen for crepitus
- Assess colour (pallor or cyanosis)

Treatment of breathing difficulty includes:

- Always use high flow oxygen in emergency care of dyspnoea
- Position the patient to assist respiration (eg. semi-recumbant)
- Assist ventilation if inadequate
- Medical interv entions such as chest drain for pneumo/haemothorax or nebulised medication for asthma
- Apply occlusive dressing for open pneumothorax
- Consideration of analgesia for rib fracture

### Oxygen Therapy

High concentration oxygen (40% or greater) should be administered to all ill or injured patients who have difficulty breathing (or the potential for compromised respiration or tissue oxygenation) via a secure fitting facemask and where available one with an attached reservoir. The flow rate is adjusted to ensure the reservoir remains inflated during inspiration (10 - 15L/minute).

Pulse oximetry can be used as an adjunct to identify adequate oxygenation, although early changes in ventilatory function are often missed if high concentration oxygen is being given. As with any piece of monitoring equipment remember the pitfalls.

Be aware of your oxygen supply which may be limited.

## Circulation (with bleeding control)

The adequacy of circulation can be affected by injury or illness which compromises the mechanics of cardiac function and the circulatory system or which results in a loss of circulatory fluid volume. Ultimately these problems will lead to shock or cardiac arrest.

### Definition of Shock

Loss of circulatory control resulting in insufficient organ perfusion and tissue oxygenation.

### Types of shock:

- Hypovolaemic
- Cardiogenic: Myocardial contusion, acute myocardial infarction, arrhythmia
- Distributive: Sepsis, Anaphylaxis, neurogenic shock
- Obstructive: massive pulmonary emboli, tension pneumothorax, cardiac tamponade

## Activity Seven

What are the normal pulse ranges for:

Infants (up to 1 year old):

______________________________

Child up to 5 years old:

______________________________

Older child 6 - 12 years:

______________________________

Adults/Adolescents:

______________________________

### Assessing circulation includes

- ✓ Mental state – restlessness, level of consciousness
- ✓ Pulse rate and rhythm – know normal parameters and effects of medications, age, fitness level
- ✓ Peripheral perfusion – assess capillary return
- ✓ Blood pressure

The presence of pulses can assist in estimating the blood pressure. Where a radial pulse is palpated it implies systolic blood pressure is > 90mmHg. If there is no radial pulse detected, but a femoral pulse is detected, blood pressure is thought to be > 80mmHg. If only a carotid pulse can be felt, blood pressure is most likely >70mmHg.

Remember that blood pressure is a poor indicator of circulatory status as more than a 30% reduction of blood volume needs to occur before the systolic blood pressure will fall.

## Treating circulation includes

✓ Arrest visible bleeding

✓ Fluid replacement
- Appropriate fluid
- Blood is the best replacement for blood loss
- Warmed fluids
- Do not overload (elderly)
- Use of burns replacement formulas

✓ Monitor effectiveness
- Urine output
- Mental state

# Disability

Disability in this context refers to the assessment of the neurological response of the patient. The AVPU scale (see below) is a quick assessment tool that should be used during the primary survey phase. The assessment of pupil size and reactivity is a useful adjunct.

**A** Alert – appears to respond normally

**V** Verbal – responding to verbal stimuli

**P** Pain – responding to a painful stimulus

**U** Unresponsive

Pupils:

- size - dilated /constricted
- response - brisk /sluggish

Glasgow Coma Scale is a standard tool for assessment of neurological status and can be used in the secondary survey stage. The importance of assessing neurological status early is that it provides a baseline for ongoing assessment and changes in neurological status.



0184 Training Manual.indd 64 8/9/05 10:09:34 AM

### Assessment of Disability (including c-spine)

Spinal injury is easily overlooked particularly where there are distracting injuries or the patient is unconscious.

- Be aware of signs of spinal shock
- Check if history of incident provides information about mechanism of injury, which will assist in your assessment
- Medical 'clearance' of the c-spine cannot be made if the patient is:
    - GCS < 15
    - Intubated
    - Affected by drugs or alcohol
    - Has painful distracting injuries

### Treatment of Disability (including c-spine)

- Be aware of the possibility of neurological injury
- Know the mechanism of injury
- Apply a rigid collar
- Immobilize c-spine during transfers
- Lateral x-ray as part of 'trauma series'
- Don't forget ABC

## Exposure

The goal is to ensure that a thorough examination of the patient occurs and that the effects of exposure are reduced. Clothes must be removed in order to make a full examination; ideally this should be staged. Where there is trauma present the whole body including the back must be sighted to exclude life-threatening injuries to the back. Remember every patient has a front, a back, two sides and a bottom. Remember to manage exposure to the elements and keep the patient warm or cool.

### Summary of Primary Survey

Three important points

- ✓ Management of the severely ill is time critical
- ✓ An organised systematic approach must be used
- ✓ Firstly identify and treat immediate life threats (ABC)

# Secondary Survey

Principles of secondary survey

- Only commence after primary is complete
- As you commence always recheck the A.B.C.D.E
- The secondary survey can be applied to the trauma or medical patient whether urgent or non urgent
- Can lead to a provisional diagnosis
- The secondary survey completes the physical assessment

## Additional measures

- This may be a good time to perform and document a full set of vital signs. Attach documentation to monitoring equipment available if not already done so
- Consider the value of initiating pain management; should be considered early
- Complete a full history
- Consider other investigations such as BSL
- Give comfort measures
- Consider need for insertion of urinary catheter, nasogastric tubes etc

## Activity Eight

What assessment skills do you use for undertaking the secondary survey?

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____________________________________

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____________________________________

## Head to toe examination

A systematic assessment involves starting at the head and moving down the body using the following techniques:

**Look**

For bruising/bleeding/deformity

**Listen**

For chest and heart sounds/bowel sounds

**Feel**

For crepitus/surgical emphysema/ deformity/pain

**Don't forget the patient's back

### Summary of Secondary Survey

Three important points

- ✓ Secondary survey is secondary
- ✓ It is a dynamic and ongoing process
- ✓ ABC remains the priority throughout emergency care of the patient

## Consultation and Definitive Care

After the assessment, which may be undertaken by the nurse as the primary responder or as a member of the team with a medical practitioner or ambulance personnel, a decision needs to be made. Where to from here? What is the definitive management of this patient?

This decision may be made early in the assessment process when it is obvious that the patient will need to be managed in a tertiary level unit and transferred under the care of a retrieval team. In this situation it is advisable to make contact early to facilitate the speed of the response and to access advice about stabilisation and management.

If the patient can be safely managed in the health unit the decision on definitive treatment may be more straightforward.

Regardless, the nurse will need to consult with the local medical practitioner regarding the ongoing management of the patient or may be required to consult with a retrieval service in a metropolitan location.

### To ensure that this is done in a concise manner the following principles apply:

- Be prepared
- Document your findings and have them in front of you
- Refer to documentation in a systematic way
- Use primary and secondary survey approach to ensure you have been thorough and not missed any area
- Be decisive/clear about your findings
- Be confident but always ask questions and clarify
- Do not make assumptions

# Conclusion

Sometimes the assessment of the patient is very easy and takes very little time. It may be tempting to adopt a non-systematic approach and take the patient as they present, without a thorough assessment. This approach frequently results in errors or omissions.

It is more often the case that assessment is complex and difficult decisions must be made in a complex and time critical situation.

Remember that the physical examination is only part of the assessment. To complete the picture a story/history from the patient and/or other sources is required. The history should include information about this presentation and also past medical history or other circumstances that will affect care.

Patient assessment relies not only on a level of knowledge and skill in the management of the emergency presentation but also highly attuned communication skills and a level of confidence.

Readings to support this section
See RAHTER CD ROM

Zimmermann Polly Gerber (2002) Guiding Principles at Triage: Advice for New Nurses. Journal of Emergency Nursing. **28**:1 24-33

0184 Training Manual.indd 70 8/9/05 10:09:35 AM

# SECTION THREE
## *Communication and Decision Making*

Effective communication underpins effective triage practice ensuring that adequate information is obtained to inform decision-making and ensuring that all members of the health team have the information that they require. Clinical decision-making can be limited when communication barriers are not well understood and/or challenged and this is especially so in rural and remote health settings. This section considers the establishment of effective communication, especially in rural emergency situations and the factors that can impact on clinical decision-making when there is no on-site medical support.

## The objectives of this section are to:

- Identify appropriate communication strategies for after hours services
- Consider issues affecting communication and decision-making for nurses in this context including barriers to good communication
- Relate ethical issues to the decision-making process
- Discuss factors in enhancing good communication in emergency situations
- Discuss the unique issues of after hours triage in rural hospitals

## Characteristics of Rural Triage

Communication and decision-making in clinical situations is frequently challenging. In rural settings features of the rural environment, community and local hospital services can exacerbate these challenges.

Several of the common features that have been identified as influencing communication in rural triage are described below.

Knowing the community – Nurses need to be careful to obtain detailed and clear information concerning their patients and the history of the incident/injury because it is easy to make assumptions when you know the community and individual community members well

Caring for relatives and friends – In rural locations nurses are more likely to be placed in the challenging situation of caring for relatives and friends known to them

Lack of anonymity – Nurses are not only likely to know members of the community for whom they are caring but will also be known to the community. Clinical decisions must be dispassionate and made without fear or favour even though nurses may be challenged by patients, their family or others in the community about their decisions or more generally about hospital policies and access to care

Broad range of knowledge and skills needed – Rural nurses dealing with emergency and other after hours care are required to have a broad range of knowledge and skill. In metropolitan emergency departments staff are able to use the multidisciplinary team to provide the mix of skill and knowledge that may be required to ensure that each client is assessed and cared for adequately. At least initially, rural nurses frequently need to assess clients and initiate immediate care without any support. Rural nurses generally cite assessing and providing care for paediatric, obstetric and mental health patients as most difficult

Being on your own and isolated from support services – In rural locations advanced support services including pathology, imaging and critical care are not immediately available

Lack of other options for care – Rural hospitals may have limited options for referral of patients and limited access to other support services

'Wait' is often not a problem – Unlike metropolitan emergency departments wait for care is generally not a problem in rural hospitals. At times there may be a period in which nurses need to provide immediate care while awaiting the arrival of a medical practitioner

Initial emergency care is often an anxiety issue – Rural nurses often describe their concern about providing emergency care and at times doubt their ability to manage these patients on their own

Triaging to whom and where? – Rural nurses require a good understanding of 'triage end-points' available locally and/or through other communication mediums

May not be in a hospital setting – Occasionally nurses are required to triage patients outside of the hospital setting and in contexts which are unfamiliar to them. Telephone triage also alters the context of the patient during the triage process

Decisions may carry significant ramifications – Nurses need to clearly understand their duty of care and work within established policy and procedure that provides a framework to protect practitioners and patients. Frequently this framework is poorly articulated or fragmentary

Adapted from Collaborative Health Education and Research Centre (CHERC) [7]

## Activity Nine

Issues that can influence good communication.

Make a list of the factors that might affect your ability to communicate with others or to get the information that you need. You can be as specific as you like and could consider features of your work place that affect good communication or the way that the response to emergencies is organised or managed in your location.

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Nurses should consider issues that might influence their understanding of the patient's situation or change their assessment of patient acuity such as:

- Stereotyping people or problems
- Second guessing the caller
- Failing to identify hidden agendas
- Collecting inadequate data or allowing inadequate talk time
- Being an expert on everything
- Absorbing patient anxiety
- Inadequate documentation

Adapted from Collaborative Health Education and Research Centre (CHERC)[8]

These factors can result from the assumptions that we make about patients or their situation either because we think we know them, we take things for granted or because we become too absorbed in the situation and have difficulty making a dispassionate assessment.

# Decision Making Styles

It is useful to consider how we make decisions and while we should not rely too heavily on generalisations about decision-making styles, nurses will utilise different styles in different social or work situations and contexts.

## Decision making styles:

- Impulsive – don't look before you leap
- Fatalistic – it's in the cards
- Compliant – anything you say Sir!
- Delaying – I'll cross that bridge later
- Agonising – I don't know what to do
- Planning – weighing the facts
- Intuitive – it feels right
- Paralysis – can't face it
- Deviant – going to do it my way

You may recognise some of these styles in your colleagues but it is much more difficult to recognise your own style or styles. This is because we usually adopt different approaches depending on the situation. For example, if you have children, you might be aware of the number of occasions in which you adopt a fatalistic or delaying approach when deciding to answer their questions! In the workplace it is often the situation that determines our approach. In emergencies we need to try to be proactive and adopt styles that support planning, early decision making and review/evaluation of our decisions.

## Activity Ten

It is Sunday evening and the mother of a sick child telephones you. The child has been wheezing for the last couple of hours and has had a cold for two or three days. The child does not have a history of asthma or any other respiratory disease. The only GP in your community is away for the weekend though their calls have been referred to a colleague some 90 minutes from your hospital. Do you:

- Reassure the parent and ask them to make an appointment for Monday
- Ask them to call or attend the GP practice (90 minutes)
- Ask them to bring the child in to see you
- Call an ambulance

Write a short statement explaining the option you chose.

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0184 Training Manual.indd 77 8/9/05 10:09:35 AM

## Making a decision

Strategies to assist people to work through a problem and reach a decision have been described. These tend to follow a process similar to the 'nursing process'

Step 1. What is the question/decision? – clarify the reason for attendance/call

Step 2. Gather the information you need – primary and secondary assessment

Step 3. Identify the alternatives/choices – what actions/referrals/ treatment(s)

Step 4. Weigh the evidence – document and consider

Step 5. Make a choice among the alternatives

Step 6. Do it!

Step 7. Review and evaluate – feedback loop

## Activity Eleven

Read the scenario in activity ten, page 77 again and using the decision-making process described in the 7 steps on the left, would you come to the same decision? Can you see how this closed circle from clarifying the decision - through making a decision and action - and back through evaluating the outcome and then considering the next step can work?

While we are not normally conscious that we make decisions like this it is useful to think about what you are doing in this way, particularly when you are uncertain about what to do.

Of course in emergencies we are often faced with decisions that are not easy or straightforward.



0184 Training Manual.indd 78 8/9/05 10:09:36 AM

## Communication and Triage

Errors in health care occur because of technological failure occasionally and because of communication failure often. In health, as in other industries, clinical (accident) review committees and quality and safety committees are increasingly interested in the so-called 'human factors'. The majority of clinical incidents occur because of breakdown in human communication rather than technological failures. Nurses need to consider several of the important issues that underlie this problem.

Healthcare work is characterised by a hierarchical arrangement and this is apparent particularly within the nursing workforce and between medicine and nursing. Communication in hierarchies often breaks down because junior staff or staff who feel that they have less expertise (as often occurs between nurses and medical staff) fail to assert their opinion or to reiterate their concerns. Senior staff (both nurses and medical practitioners) must ensure that their approach to others is open and receptive; that they listen and do not simply discard the comments of other practitioners no matter how urgent the situation. In addition, staff should be careful to avoid filtering information that they pass on from one practitioner to another – taking care that their own assumptions or preconceived ideas do not have a detrimental effect.

Generally, no single individual can be held solely accountable for an accident or error. The so-called 'Swiss Cheese model' applies whereby a missed observation or failure to intervene/comment is not picked up by the next practitioner and then by another and so on resulting in an error where under normal circumstances someone would have picked up on the problem. Poor documentation systems and communication hierarchies are the most common causes of such errors.

**It is argued that the term 'accident' should not be used because this suggests that the incident was, at least to some extent, unavoidable.**

Accidents occur because of the breakdown (or occasionally absence of) good communication and/or systems (including documentation) that would otherwise have ensured that an error was recognised early and the clinical incident avoided.

The airline industry provides the most graphic examples of accidents that have resulted from a breakdown in communication. Within the airline industry systematic training programs are now mandatory to ensure that staff in all forms of employment (at all levels) understand their responsibility to communicate and to listen to others. It is interesting to note however that there is considerably less risk in traveling by air than there is in being admitted to a hospital! Nurses and other health care practitioners need to carefully consider communication issues, and this is particularly true in the 'boiler-house' context of emergency care, and review their own style and approach.

Within the rural hospital environment nurses understand the importance of detailed documentation of telephone and face-to-face triage and the use of hand-over algorithms (cheat sheets) when calling General Practitioners. Effective communication in the emergency situation is the foundation for good decision-making and good patient outcomes. In each situation different factors will disrupt effective communication and nurses should review their own situation. At times the relationship with local medical practitioners and their style of communication will be an issue; at times inadequate documentation of telephone enquiries will be an issue and so on.

**Strategies should be developed to address local issues and prevent communication breakdown.**

One strategy utilised in rural hospitals is the clinical review. Randomly selected triage cases can be reviewed by a multi-disciplinary group which considers the management of the client on this occasion, the steps in their care, the processes and documentation used and so on. These reviews need not (and probably should not) focus on those cases where there was a poor outcome, as this tends to shift the focus from improvement of the systems of care to audit and blame.



0184 Training Manual.indd 80 8/9/05 10:09:36 AM

## Activity Twelve

Discuss with peers how you would set up a clinical/peer review process to consider cases and help each other to learn and improve your service.

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## Readings to support this section

See RAHTER CD ROM

**Nurses Board of Western Australia** Scope of Nursing Practice Decision Making Framework - supporting those who care

**Queensland Nursing Council** (October 1998) Scope of Nursing Practice Decision Making Framework

# SECTION FOUR
## *After Hours Triage*

0184 Training Manual.indd 83 8/9/05 10:09:37 AM

The principles that underpin good triage practice apply at any time and in any setting. This section considers the application of triage principles to the performance of triage after hours and in the context of rural hospital practice.

## The objectives of this section are to:

- Overview the process of triage in rural hospital settings and telephone triage
- Describe the Australasian Triage Scale and demonstrate its application
- Discuss the unique issues of after hours triage in rural hospitals
- Identify the differences between the process of triage and the end-points when the triage occurs during normal working hours and after hours
- Identify specific issues/challenges and limiting factors of telephone triage
- Discuss circumstances that are challenging to the triage situation
- Discuss the role of protocols in after hours triage
- Discuss unique aspects of triage where multiple casualties are present
- Demonstrate the use of the Triage Sieve



0184 Training Manual.indd 84 8/9/05 10:09:37 AM

# Application of Triage

As discussed in the introductory section there are three main settings where triage skills are required in rural health services. This section overviews the three types of triage: direct triage, telephone triage and multi-casualty triage.

In all triage applications the goal of triage is the identification of the primary problem and acuity of the problem rather than a specific diagnosis.

Generally rural nurses will be responsible for emergency department triage or face-to-face triage when patients present directly to the hospital seeking care. In addition rural nurses will frequently be required to triage patients who telephone the hospital seeking advice ie telephone triage. In both of these instances the focus is on providing the best available care to a single patient in a timely fashion.

As for most nurses, rural nurses may be called upon infrequently to perform triage in multi-casualty situations. This form of triage differs from the more routine triage described above as it requires more careful consideration of the resources available and the competing needs of several patients. This section will consider triage methods (including multi-casualty triage) available to nurses.

## Activity Thirteen

What is the goal of triage?

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________



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## How to triage?

The cornerstone of triage is assessment. Collection of thorough primary and secondary survey information will allow prioritisation of each patient presenting for care.

## Activity Fourteen

Review Section Two Patient Assessment and consider which patient information provides the most useful assessment of patient acuity, and therefore priority. Make a list and explain why you have chosen each.



0184 Training Manual.indd 86 8/9/05 10:09:37 AM

The purpose of triage is to provide a system to prioritise care. Priorities may be set to determine the reasonable time frame in which medical care should commence without foreseeable risk of harm to the patient (review the Australasian Triage Scale categories and timeframes) or to determine the priority for care amongst a group of seriously injured patients as in multi-casualty incidents. In both cases the fundamental ethical principles applied are beneficence (doing the greatest good for the majority of patients) and non-maleficence (doing no harm).

**In reality triage is an inexact process and practitioners must make the best decisions that they can on the information that they have available to them.**

This is the reason that we emphasise the importance of rapid and skilled assessment of patients. Triage is a continuous process and patients should be re-assessed and re-triaged regularly. Practitioners should understand that triage involves making rapid decisions in very complex situations and should be open to re-evaluating their decisions each time the patient is re-assessed and altering triage priority. Furthermore, practitioners should avoid being too critical of their triage decisions after the fact. In these emergency situations quick and decisive action is required, and while we might criticise decisions at a later date it is best to rely on regular patient review as a form of safety net for each patient.

## Broad steps in the triage process include

- ✓ Interviewing the patient
- ✓ Problem identification
- ✓ Initiation of emergency treatment for life-threatening problems
- ✓ Prioritisation of the urgency

It is important to note that these may be carried out in rapid succession[8]

## Making Triage Decisions

Whilst assessment is the cornerstone of triage, decision-making is the key to achieving the best outcome. These decisions are based on four premises

- Need to be based on the current condition of the patient
- Need to consider the potential for deterioration or de-compensation (using history and clinical findings)
- Provide a "needs based" assessment from triage findings
- Need to provide the complete picture as the basis for the accurate identification of the patient's problems.

Adapted from Collaborative Health Education and Research Centre (CHERC)[10]

Having discussed the underlying principles of triage, it is important to also consider the differences in the following three types of triage

1. Emergency Department Triage
2. Telephone Triage
3. Multi-casualty Triage

## Emergency Department Triage

A National Triage Scale (NTS) was developed in 1993/94 by the Australian College of Emergency Medicine (ACEM). It was designed to provide more consistency in the allocation of treatment priorities for emergency departments across Australia. The scale was based upon benchmarked criteria including the response time to see a medical practitioner.

This scale generated some debate regarding the difficulty in applying the scale to rural and remote emergency departments where there are no on-site medical practitioners and the benchmarks associated with metropolitan emergency departments are less relevant. The Australasian Triage Scale (2000) was developed in response to some of these criticisms and is more rural friendly. The major change was the emphasis on time until treatment was initiated (rather than time until seen by a medical practitioner ).

For further information refer to the reading, Guidelines for Implementation of the Australasian Triage Scale in Emergency Departments[11]. See RAHTER CD ROM.



0184 Training Manual.indd 88 8/9/05 10:09:37 AM

## Activity Fifteen

List three steps in triaging a patient who presents to an emergency department in a rural hospital.

1 ______________________________

2 ______________________________

3 ______________________________

The recommended processes for rural nurses undertaking triage in an emergency department are:

1. All patients presenting to an emergency department for assistance should be assessed on arrival by an experienced RN with training in the application of triage principles

2. The patient should be allocated a priority based on the Australasian Triage Scale (ATS) and the code recorded. The triage nurse applies the ATS score in answer to the question 'This patient should wait for assessment and treatment no longer than'

3. The triage nurse should ensure continuous re-assessment of patients and re-evaluation of the current triage priority accordingly

The ATS guidelines outline clinical signs and symptoms matched with urgency criteria. There is agreement nationally that the times specified for initiation of treatment, based on the condition of the patient are appropriate. The ATS provides a useful tool to ensure consistent decisions are made when the opportunity to practice the application of triage is not consistent across nursing or medical staff. The scale provides an opportunity to benchmark individual triage practice as well as hospital performance and workload against national benchmarks.

There are a number of challenges in undertaking triage in the rural setting. Nurses are working in emergency departments on an 'as required' basis and may not have the exposure/experience or opportunity to maintain a variety of emergency nursing skills including triage decision-making. Due to lower numbers of presentations nurses do not continuously triage, which in turn creates difficulties in maintaining skills and familiarity with using the ATS. Medical back-up varies and most settings do not have a medical practitioner on site. The availability of the medical practitioner after hours is variable.

A series of recommendations has been made in relation to the application of the ATS in rural/remote sites[12].

- Use of Australasian Triage Scale – the waiting time measure should be used as 'time to nurse intervention/beginning' of patient treatment process
- Simplified guidelines for category allocation should be implemented
- Local arrangements between medical staff and nurses need to be determined and documented

In the rural setting it is important to document the time of nursing intervention as well as the time of medical intervention. These parameters and the assigned triage category provide useful information for future planning and funding of after hours triage/ emergency care services in rural locations.

## Telephone Triage

Telephone triage systems are designed to provide ready access to advice for patients, and frequently result in a triage decision and referral to a hospital emergency department or other health care service provider.

The early telephone triage systems began in the 1980s and these systems are rapidly becoming a primary source of care[13]. Their popularity is based on the perception and conclusion that they reduce costs of presentations for emergency care and clinic visits[14]. Telephone triage has been described by Briggs (1997)[15] as a "Systematic process that screens a caller's symptoms for urgency and advises the caller when to seek medical attention based on the severity of the problem described. The process also helps to direct callers to the most appropriate health care setting or advises home care."

Telephone triage systems differ from health advice lines in that callers to telephone triage services usually have a specific problem that requires an intervention whereas advice lines are generally community based, providing information on general health issues. The aim of triage in this setting is not diagnosis but rather to determine the acuity of the patient, the appropriate level and location of care and waiting time.

In Ontario[16] a review of a tele-triage was undertaken reviewing 28,000 call records and surveying 5475 households who had used the service. The majority of calls were made between 4pm and 8pm and possessed the following attributes:

- 90% of callers had symptoms
- 7% of callers were looking for information
- 3% called because they had symptoms and wanted information
- 89% of callers were women
- Most of the patients were aged between 0-16 years
- Rural residents under-utilised the service

These findings are supported by a survey in Western Australia (Fatovich et al 1998)[17] of 1682 calls to an emergency department. It was found that Sunday was the busiest day with 58% of calls occurring between 4pm and midnight. Forty nine percent related to children under 14 and 55% of patients calling were female. Spontaneous illness accounted for 72% of the calls with fever in children, pain and shortness of breath the most common complaints. These findings are somewhat consistent with a study of after hours hospital presentation data of 3 hospitals involved in the program (see Table 1 Page 42). The majority of presentations occurred between midnight and 2am, however the number of presentations were equal between male and female patients.

Rural hospitals generally provide a point of telephone contact for patients and their staff must make triage decisions for patients who telephone and speak to the duty nurse.

## Goals of telephone triage

The goals of telephone triage services are to facilitate:

- Decision making of the caller and determine the health services that are required
- Access to timely care providing referral/ scheduling advice
- Management of symptoms and self care practices and provide ongoing communication
- Health behaviour changes through health information provision
- Effective outcomes (Larsen Darn 2002[18], Van Dinter 2000[19])

In order to determine the urgency of a telephone triage call, the nurse must understand and be able to apply the principles of assessment, appreciate the complexity of the telephone communication and decision making processes inherent in conducting triage via the telephone and apply strategies to manage this process - adapted from (CHERC)[20].

**Figure 3: Differences Between Face to Face and Telephone Triage**

| Telephone | Face to Face |
|---|---|
| Time is required | Quick - within minutes |
| Only one sense is available | All senses are available for you |
| Patient's appearance is a mental image | Patient's appearance is tangible |
| Normal processes of assessment have limited application | Assessing urgency using normal assessment processes |
| The scene must be established through verbal communication- rapport developed, roles and relationships defined | The scene is set - roles and relationships are clear, the environment establishes the process |
| Decision made relates to disposition - when to seek further assistance | Decision made relates to waiting time to be seen |
| Once contact with service is made, patient role is inherently active | Once contact with service is made, patient role is inherently passive |
| Environment creates anxiety | Environment creates reassurance |
| Opportunity for reassessment is limited | Opportunity for reassessment is instant |
| To be a good listener | To be a good "spotter" |
| Assessment is based on what the caller tells us | Assessment is based on a selection of cues |

Adapted from (CHERC) [21]

## The process of telephone triage

Grossman (2002)[22] describes six main steps in undertaking telephone triage:

Step 1. Introduction of self and opening communication channels

Step 2. Performing the assessment via interview

Step 3. Making the triage decision

Step 4. Offering advice according to protocol or established guidelines for care

Step 5. Incorporating follow up plans when concluding the call

Step 6. Documenting the call

It is important to note that these steps are in the context of formalised triage systems that are often computerised and protocol driven. For more detail on Grossman's Telephone Triage Process please see RAHTER CD ROM.

## Guiding principles/protocols

Protocols are valuable in telephone triage to structure the call, keep information requests objective, help problem solve, provide support and help reconstruct the call. However, a protocol alone will not be able to account for all the possibilities that exist within a crisis situation[23].

Guiding principles do need to be developed and whether they include protocols, guidelines or standing orders it is important that the systems are developed in a partnership between general practitioners and nurses and that they are practical and reviewed, updated and archived appropriately.

## Telephone triage risks

There are a number of risks inherent in the telephone triage process. Awareness of these risks will assist practitioners to avoid the possible pitfalls of assessing and advising patients at a distance without the benefit of direct physical assessment. Clearly the most obvious challenge is the inability of the nurse to physically assess the patient. Other unique rural challenges are the medical practitioners' availability and the physical distance for patients to access health care services. Nurses need to have a good understanding of their local community.

## Activity Sixteen

Identify four additional risks associated with undertaking telephone triage.

1 ______________________________

2 ______________________________

3 ______________________________

4 ______________________________

## In general risks include:

- Making the wrong assessment. Being prejudiced, biased or stereotyping an individual or a condition
- Obtaining an incomplete history
- Making an incomplete assessment by not collecting comprehensive information or by 'second guessing' the caller
- Trying to be an expert on everything
- Caller mistrust based on past experiences or fear, failure to identify hidden agendas and absorbing patient anxiety
- Caller misunderstanding – use of technical terminology
- Poor and inadequate documentation
- Assuming that these are informal consultations and duty of care does not apply

(Based on Grossman[24] and CHERC[25])

### Avoiding perils and pitfalls

✓ Follow principles of assessment and triage

✓ Document with care and retain records

✓ Initiate follow-up contact particularly if uncertain

## Multi-casualty Triage

Where the casualties outnumber medical first responder personnel, triage principles should be applied. The goal of triage in a Mass Casualty Incident (MCI) is to achieve the greatest good for the greatest number of patients. General principles of triage apply. The principles of a primary survey are applied to assign priorities to patients and focus on assessment rather than making a diagnosis. Ensure you have knowledge about the process and coding for multi-casualty triage recommended in your state/territory because currently different systems operate across Australia.

### Principles of multi-casualty triage

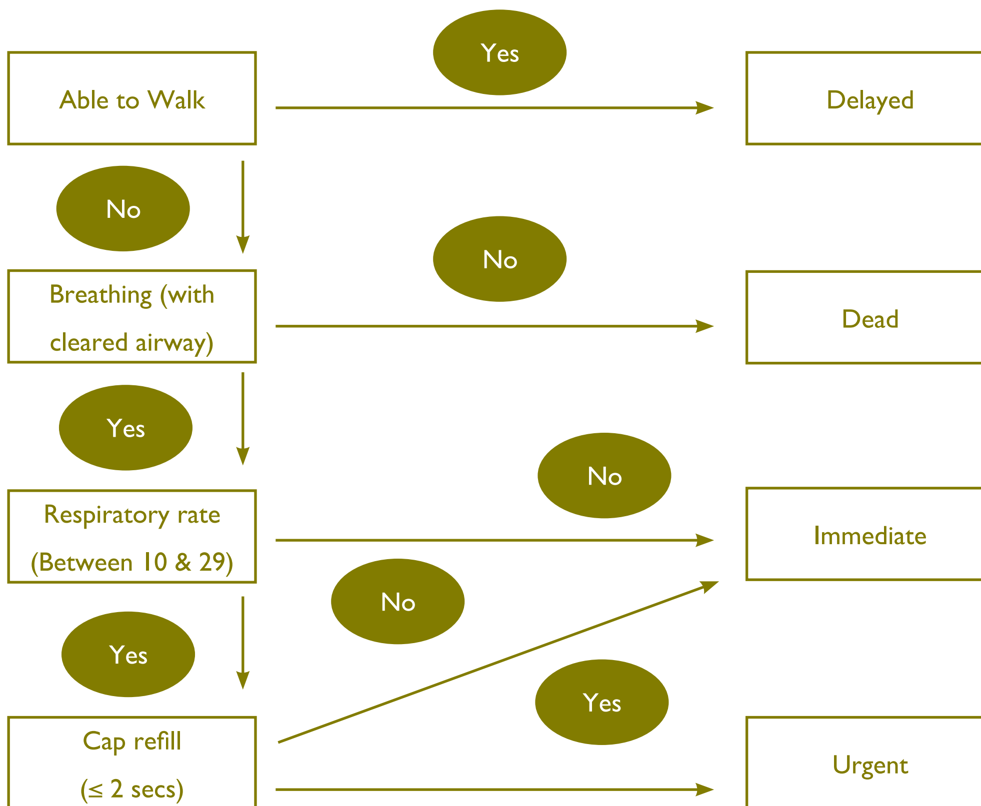
- Initial triage decisions need to be made quickly, safely and be reproducible
- Triage is dynamic and categories will change
- It reflects only a snapshot at a particular point
- A number of different systems exist
- Triage 'Tags' are a universal tool for recording emergency information

## Multi-casualty triage is a two step process - Sieve and Sort

### Triage Sieve

The Triage Sieve is performed in the field as soon as practicable by the first responder and is designed to rapidly identify seriously injured patients. See Figure 4.

### Figure 4: Triage Sieve and Sort Process Triage Sieve 'Walk ABC' Model



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## Notes

Walking casualties are assigned to the DELAYED category. The remaining patients are then sorted following an ABC assessment.

The patency of the airway is then assessed. If not patent, it is opened using a simple airway manoeuvre. Those patients remaining not breathing are categorised as DEAD.

If the patient is now breathing – and the respiratory rate is low (< or equal to 10) or is high (> or equal to 30), the casualty is triaged to the IMMEDIATE category.

If the rate is between 11 and 29 breaths per minute, the circulation is then assessed based on capillary refill time. If the capillary refill is less than or equal to two seconds the patient is assigned to the URGENT category. If the capillary refill time is greater than two seconds the patient is put in the IMMEDIATE category.

Where it is difficult to assess capillary refill the pulse can be assessed - a rate of more than 120 b/min leads to IMMEDIATE and pulse less than 120 b/min URGENT.

# Triage Sort

The Triage Sort is more comprehensive and should be performed in the Casualty Clearing Post or on arrival at the hospital. Priorities are based on the Triage Revised Trauma Score.

Priority 1 needs immediate treatment

Priority 2 needs urgent treatment within four hours

Priority 3 needs management when priority 1 and 2 patients are attended to

## Tricky triage

There are groups of patients that present particular challenges in relation to all types of triage in any setting. In particular mental health patients, obstetric patients, children, aggressive patients and patients from culturally and linguistically diverse backgrounds or with impaired communications can be difficult to assess accurately.

### Considerations for tricky triage

- ✓ Eliciting information to underpin the patient assessment
- ✓ A thorough assessment to determine the level of urgency
- ✓ Limited exposure to these patient groups and varying skill level of clinicians
- ✓ Minimal resources in rural settings to support specialisation

A useful resource for applying triage scores to mental health patients has been developed by Myhill, K, Tobin, M (2001) (see additional information on page 98).

## Summary of Principles

All triage applications revolve around a core set of principles:

- The use of established and approved protocols helps to provide consistency in assessment and standard of care for all patients
- Comprehensive documentation is mandatory
- If patient attendance at hospital is not required, advice on home care must be given
- The nurse must always be a strong patient advocate and seek out optimal solutions for the patient

### Readings to support this section
### See RAHTER CD ROM

**Australasian College of Emergency Medicine** Guidelines for Implementation of the Australasian Triage Scale in Emergency Departments www.acem.org.au. Accessed 10th October 2004

**Australasian College of Emergency Medicine** Policy document. The Australasian Triage Scale www.acem.org.au. Accessed 10 October 2004

**Australian Nursing Federation Victoria Branch (2002)** Policy Statement - Telephone Advice Lines. Australian Nursing Federation (Victoria Branch)

### Additional Information

**NSW Rural Critical Care Committee** (2003) Triage in NSW Rural and Remote Emergency Departments which have no on-site Doctors

**Myhill K, Tobin M** (2001) Mental Health First Aid for South Australians. South Australian Department of Health www.dh.sa.gov.au/mental-health-unit/

**Monash Institute of Health Services Research** (2001) Consistency of Triage in Victoria's Emergency Departments Literature review

**Tchernomoroff R & Knight K** (2003) Telephone Triage Education From rhetoric to reality. Collaborative Health Education and Research Centre

**Wakefield Regional Health Service** Mental Health Triage Guidelines. South Australian Department of Health

Additional Resources

Grossman V (2002) Telephone Triage Course www.rnceus.com Accessed September 2003

# SECTION FIVE

## *Professional Issues*

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In the unique setting of rural health services there are a number of issues that relate to the use of triage as a central component to accessing health services.

The objectives of this section include a review of the following key professional issues:

- Legal considerations
- The roles of ethics and advocacy
- Professionalism in the rural context
- Consumer views
- Quality management processes

## Specific objectives of this section

- **Overview** the legal and professional considerations in providing after hours triage services
- **Discuss** the issues of ethics and advocacy in triage decision making
- **Consider** the limitations and boundaries for nurses providing advice to patients
- **Explain** the important messages for consumers
- **Discuss** consumer expectations and issues in relation to triage services
- **Describe** quality processes that can be considered in evaluating triage services
- **Determine** processes to facilitate continuation or expansion of after hours triage services and discuss the infrastructure, policy, insurance and legal structures and processes that exist or need to be developed to support nurses in this role
- **Discuss** debriefing and support mechanisms for nurses engaged in after hours triage



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## Medico-Legal Issues

Nurses are expected to practice in a manner consistent with local and national legislation and standards.

### In South Australia these include:

- The Nurses Act South Australia (1999)
- National Competency Standards for the RN and EN (ANMC)
- Code of Professional Conduct (ANMC 2003)
- Code of Ethics (ANMC 2002)

Whilst different states and countries have different requirements many are similar to the South Australian requirement where nurses are responsible for self-declaration of their competence to register with the Nurses Board.

### Activity Seventeen

Consider the following questions and note your answers below:

1. Are you clear about your legal responsibilities as a nurse?
2. What are self responsibilities?
3. What responsibilities does your employer have?

There are a number of legal concepts important to nursing practice.

## Duty of care

Duty of care requires that 'everything reasonable' be done to protect the health and safety of others. The duty of care extends to protecting patients from dangers which may result from the patient's mental and physical condition, as well as external circumstances within the control of the health care facility such as the environment, appropriate equipment and systems of organisation. Breach of duty of care results in negligence. Nurses have a legal duty to provide care and this is very dependant upon ensuring that 'standards of care' exist and are adhered to.

## Scope of practice

Scope of practice encompasses nurses' knowledge, context of practice and competence. It refers to the broad framework and context of practice for the profession. The actual scope of practice of any nurse is generally more specifically defined than the broad scope of the profession as a whole. The scope of practice of nursing and midwifery is defined as the range of roles, functions, responsibilities, tasks and decision-making capacity for which a nurse or midwife is educated, competent and authorised to perform within the context of their nursing or midwifery practice (Nurses Board of SA 2005).

The context of this scope of practice is influenced by the practice settings, the health needs of the patients, the level of education of the nurse, authorisation, competence and the policy requirements of the service provider, public health policy and legislation.

## Activity Eighteen

Can you define your scope of practice in your current role? Write a statement defining your scope of practice.

______________________________________

______________________________________

______________________________________

______________________________________

______________________________________

______________________________________

## Professional ethics and conduct

A Professional Code of Ethics identifies the moral commitment of the profession, provides nurses with a basis for professional and self reflection and is a guide to ethical practice. The Code of Professional Conduct outlines the minimum requirements of the nursing profession to provide responsible, safe and accountable nursing care for the individual, groups and community.

### Activity Nineteen

How does the Professional Code of Ethics impact on your practice? Are you familiar with the content and intent of these documents?

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________



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# Quality Practice

To ensure that we provide a safe level of care to the communities we serve, processes must be developed and implemented to attain and maintain a safe standard of care. Nursing practice should be based on current evidence and may be benchmarked against similar service providers as a mechanism to measure the quality of the service. There are a number of ways to ensure safe, consistent and best practice.

## Guiding principles

Traditionally organisations have established policies and procedures to describe the minimum practice standard required. In the rural and remote context, especially after hours, rigid protocols do not always apply to the situation at hand. One important mechanism to influence quality of patient care is to develop and implement guiding principles for the management of after hours presentations including processes and clinical management.

### Guiding principles assist in care delivery as they:

- Set clear lines of responsibility and accountability
- Provide direction on how to manage a collection of signs and symptoms in order to keep the patient safe and to hopefully reach a provisional diagnosis and initiate management e.g. ensure consistency of advice and management [26]

It is important that there be stakeholder involvement in the development of guiding principles. Research has shown that it is extremely difficult to change practice amongst nurses and GPs through passive means. The same research shows that their involvement in the development of guidelines increases the uptake significantly. The guidelines must be evidence based and supported by a rigorous review process to ensure compliance and currency.

There may be a need to include disclaimers to support guidelines. For example, for telephone advice it may be recommended to incorporate into the conversation or at the end of the conversation a statement to the caller such as 'if you have any concerns you should …….'.

More specifically with telephone advice it is important to define the options that the individual has; either calling back or presenting to the hospital. Be careful not to make promises to call patients back if you are not absolutely confident that you can do so. Failure to keep such a promise will greatly impact on your professional/patient relationship. Likewise it is also important to clearly state the advice you have given to anyone presenting or telephoning. Always seek clarification from the patient/carer that your message was clearly understood. Emphasise that telephone diagnosis and recommendations are a poor substitute for face to face consultation.



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## Documentation

The importance of adequate documentation cannot be over emphasised both as a communication tool and as a legal requirement.

Documentation of initial face to face assessment may be improved by the use of standard forms or guiding principles/protocols to prompt the questioning and recall of information.

### Essential for phone triage is a minimum data set that includes:

- Name
- Age
- Timing
- Details of the consult
- Advice given

## Consumer Issues

Consumers expect that the health system:

- Is a confidential and reliable service
- Provides prompt access in a timely manner
- Provides appropriate referral
- Is non-threatening

## Tools for review of systems and performance:

The aim of a system review is to assess if the systems are working and to what extent. Tools for monitoring service provision include:

- Use of actual examples in practice for auditing against guidelines
- Case study reviews
- Patient follow up on advice given
- GPs reviewing after hours telephone and/or advice given to patients that have not been seen by the GP
- Setting of minimum criteria for data and auditing including the type of information to be audited and the frequency
- Establishing and managing a complaints process for consumers and stakeholders
- Consumer/Community Education programs



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## Activity Twenty

Are consumer expectations realistic? How can you better inform your local community about the after hours health service being provided?

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# Support

There are different aspects of support that can be provided to Registered and Enrolled Nurses to assist them in the provision of after hours services.

## Professional resources

- Clear lines of internal communication so that everyone involved knows how to access the GP after hours and what options are available if that first line of call assistance is unavailable
- Accessing other specialist/tertiary level services such as Rural and Remote Mental Health Line and Metropolitan Emergency Departments
- Other agencies such as poisons information services and pharmaceutical information resources

## Patient resources

- Information available to facilitate referral of patients and carers to support and advice around specific issues such as palliative care help line, child health line and cancer support groups

## Personal and professional support

The provision of first line health services is challenging. This is compounded by the isolation experienced in rural and remote settings. At various times members of the hospital staff may need additional support. It is important to be aware of debriefing opportunities that are supported by your organisation. There are external services available either from your employer or self initiated such as the Bush Crisis Line (CRANA)[27]. Confidence in your practice is also an important self supporting mechanism and there are educational opportunities to continually update knowledge and skills.

## ANF Statement

The Victorian Branch of the ANF provided a statement on telephone advice lines and you may like to consider its relevance to your setting. It makes reference to most of the issues discussed in this section including scope of practice, responsibility and accountability, documentation requirements, use of evidence based guidelines and quality processes. See readings to support this section, page 110.

## Readings to support this section See RAHTER CD ROM

**Australian Nursing Federation Victoria Branch** (2002) Policy Statement - Telephone Advice Lines. Australian Nursing Federation (Victoria Branch)

**Nurses Board of South Australia (NBSA)** Draft Document Scope of Practice

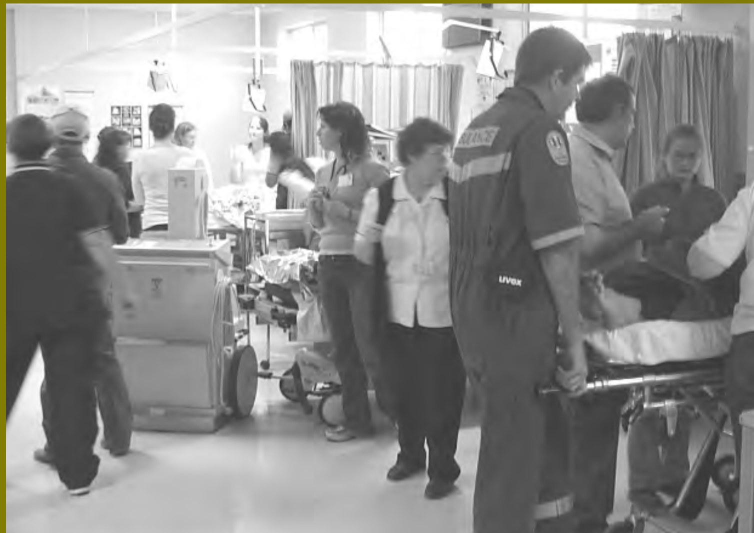
## Additional Information

**Nurses Board of Western Australia** Scope of Nursing Practice Decision Making Framework. Supporting those who care

**Queensland Nursing Council** (1998) Scope of Nursing Practice Decision Making Framework: Application of the Framework in Nursing Practice – June 2002



0184 Training Manual.indd 110 8/9/05 10:09:40 AM



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# SECTION SIX

## *Sustainable After Hours Services*

0184 Training Manual.indd 113 8/9/05 10:09:41 AM

The development of sustainable strategies to improve and support the provision of after hours triage within the local context is challenging. The final component of this package requires that you work in groups and challenges nurses and GPs to apply their learning and develop suggestions for the improvement of the delivery of after hours triage and emergency care in their hospital. Your discussion may include how to develop a sustainable network to support nurses in providing after hours triage and strategies to address issues raised from meetings of GPs and hospital nurses.

## The objectives of this section:

This section is designed as a workshop activity for nurses and GPs and others involved in rural after hours medical services, however you can develop an action plan on an individual basis if you wish. The emphasis is on identifying issues within current practices that could be addressed to improve after hours triage and emergency care.

## Specifically this section will:

- Consider issues raised during the program and discuss possible solutions to the challenges presented by after hours triage in your local setting
- Discuss the development of a local network of nurses to facilitate the further improvement of after hours triage training and education and to provide peer support for nurses undertaking this role
- Consider strategies to foster further collaboration between nurses and GPs to support after hours triage strategies
- Develop a draft action plan that considers clear definition of the issue(s), desired outcomes, actions to be undertaken, time frames, resources, people and responsibilities



0184 Training Manual.indd 114 8/9/05 10:09:41 AM

# Developing an Action Plan

The best approach to achieving the objectives of this session is to conduct a workshop for hospital nurses and GPs to discuss issues and identify action goals. If possible other hospital stakeholders should be included in this exercise. The workshop requires careful facilitation to encourage open discussion of the issues that are raised during the workshop and to assist participants to identify possible solutions that can be forwarded to those responsible for the hospital and/or general practice services.

Experience in the program has shown that this session provides a very positive forum to enable both GPs and nurses to identify issues and develop a process of addressing them.

Eighteen towns involved in the SA Rural After Hours Triage Education Program identified 77 issues as part of the action planning session and a summary of these is provided below:

- Community issues (n=11)
- Staffing (n=10)
- Telephone triage (n=10)
- Safety (n=9)
- Management of presentations (n=8)
- Policies and procedures (n=6)

The Action Plan template is located at the back of this Resource and on RAHTER CD ROM

## Action Planning - Step One

Participants are asked to brainstorm significant issues or challenges that they see in the provision of after hours services. They should then consider as a group the top five priority isses. Participants will have raised a broad range of issues and it is important to focus the group on those issues which the group agrees are important and in which there is some scope for practical (and local) action to result in change and improvement. For example issues requiring action at the level of Federal Government are unlikely to progress whereas local issues concerning hospital resource allocation or safety can be tackled quite effectively. Typically nurses and GPs express concern about a range of issues that can be described under the following headings:

- Community expectation of the hospital service
- Systems of care including documentation, data collection and referral
- Scope of practice of nurses including legitimate extension of practice
- Private practice and public hospital interface issues
- Medico-legal issues including indemnity and liability
- Security and safety issues focused on practices and building/environment

Note: This exercise is intended to meet local needs and other headings or concerns might be more appropriate in your context. Participants should be assisted to develop a list of four or five top priority areas/issues that can be the focus of strategic initiatives. The facilitator may be required to merge issues that address common ground such as managing aggressive clients and hospital security.

## Action Planning - Step Two

Develop an action plan for each priority. The action plan can be completed with the assistance of the attached template and should address:

- Clear definition of the issue
- Desired outcome
- Actions to be undertaken
- Timeframes
- Resources
- People who will own the process and see it to conclusion

## Action Planning - Step Three

### Activity Twenty One

Identify a review date, possibly 3-6 or 12 months after the workshop and plan to hold another meeting to consider how well you have done in achieving the goals that the group has set during this action planning process.

________________________________

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## Readings to support this section

**Zeitz K, Malone G, Arbon P, and Fleming J.** (unpub). 'Australian issues in the provision of an after hours primary medical care service in rural communities' Australian Journal of Rural Health. Submitted December 2004

## Additional Information

**Department of Health and Ageing** (2002) Triage Education Resource Book. Australian Government

Contact Details: Australian Government, Department of Health, Costing and Ambulatory Classification Section P: 02 6289 1555 or www.health.gov.au/casemix

The Australian Government has published this curriculum document to support triage training. This resource in particular has a number of practical triage scenarios.

# Action Plan

Issue No.

Definition of the Issue:

Desired Outcome:

| ACTIONS | TIMEFRAME | RESOURCES | PEOPLE INVOLVED | WHO WILL OWN THE PROCESS AND SEE IT TO CONCLUSION | PROGRESS/ISSUES (to be completed at Follow Up GP/Nurse Session) |
|---|---|---|---|---|---|
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# *Activity Pages*

0184 Training Manual.indd 119 8/9/05 10:09:42 AM

# Activity One

Outline the four steps in undertaking triage.

1 ______________________________

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2 ______________________________

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3 ______________________________

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4 ______________________________

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## Activity Two

List four different sources of information and support that rural nurses could seek out to assist in their clinical decision-making.

1 ______________________________

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2 ______________________________

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3 ______________________________

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4 ______________________________

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## Activity Three

List techniques that you use in undertaking a physical assessment.

# Activity Four

In undertaking a patient assessment, what risks should you be alert for?

# Activity Five

What cues are used to assess adequacy of the airway?

## Activity Six

What are the signs indicating effective ventilation?

# Activity Seven

What are the normal pulse ranges for:

Infants (up to 1 year old):

Child up to 5 years old:

Older child 6 - 12 years:

Adults/Adolescents:

# Activity Eight

What assessment skills do you use for undertaking the secondary survey?

## Activity Nine

Issues that can influence good communication.

Make a list of the factors that might affect your ability to communicate with others or to get the information that you need. You can be as specific as you like and could consider features of your work place that affect good communication or the way that the response to emergencies is organised or managed in your location.

## Activity Ten

It is Sunday evening and the mother of a sick child telephones you. The child has been wheezing for the last couple of hours and has had a cold for two or three days. The child does not have a history of asthma or any other respiratory disease. The only GP in your community is away for the weekend though their calls have been referred to a colleague some 90 minutes from your hospital. Do you:

- Reassure the parent and ask them to make an appointment for Monday
- Ask them to call or attend the GP practice (90 minutes)
- Ask them to bring the child in to see you
- Call an ambulance

Write a short statement explaining the option you chose.

## Activity Eleven

Read the scenario in activity ten, page 77 again and using the decision making process described in the 7 steps on the left, would you come to the same decision? Can you see how this closed circle from clarifying the decision - through making a decision and action - and back through evaluating the outcome and then considering the next step can work?

While we are not normally conscious that we make decisions like this it is useful to think about what you are doing in this way, particularly when you are uncertain about what to do.

Of course in emergencies we are often faced with decisions that are not easy or straightforward.

## Activity Twelve

Discuss with peers how you would set up a clinical/peer review process to consider cases and help each other to learn and improve your service.

# Activity Thirteen

What is the goal of triage?

# Activity Fourteen

Review Section Two Patient Assessment, and consider which patient information provides the most useful assessment of patient acuity, and therefore priority. Make a list and explain why you have chosen each.

# Activity Fifteen

List three steps in triaging a patient who presents to an emergency department in a rural hospital.

1 ______________________________

2 ______________________________

3 ______________________________

## Activity Sixteen

Identify four additional risks associated with undertaking telephone triage.

1 ______________________________

2 ______________________________

3 ______________________________

4 ______________________________

# Activity Seventeen

Consider the following questions and note your answers below:

1. Are you clear about your legal responsibilities as a nurse?
2. What are self responsibilities?
3. What responsibilities does your employer have?

# Activity Eighteen

Can you define your scope of practice in your current role?
Write a statement defining your scope of practice.

## Activity Ninteen

How does the Professional Code of Ethics impact on your practice? Are you familiar with the content and intent of these documents?

# Activity Twenty

Are consumer expectations realistic? How can you better inform your local community about the after hours health service being provided?

## Activity Twenty One

Identify a review date, possibly 3-6 or 12 months after the workshop and plan to hold another meeting to consider how well you have done in achieving the goals that the group has set during this action planning process.

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0184 Training Manual.indd 141 8/9/05 10:09:43 AM

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0184 Training Manual.indd 144 8/9/05 10:09:55 AM

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RURAL DOCTORS
WORKFORCE
AGENCY Inc.

57 Greenhill Road Wayville SA 5034 Ph 08 8357 7444
Fax 08 8357 7088 Email ruraldoc@ruraldoc.com.au
Website www.ruraldoc.com.au