

# ONE HUNDRED AND ELEVEN WAYS TO IMPROVE YOUR TELEPHONE TRIAGE & TELEPHONE CONSULTATION

HLP Study Morning

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# The Past



## “The Doctor” by Sir Luke Fildes - 1887

*The Doctor* was painted on commission from the industrialist Sir Henry Tate, for £3000 and was offered by Tate as a gift to the nation in 1897 shortly before the opening of the Tate Gallery in London.

# The painting received much comment

- *‘What do we not owe to Mr Fildes for showing the world the typical doctor, as we would like to be shown — an honest man and a gentleman, doing his best to relieve suffering? A library of books in our honour would not do what this picture has done and will do for the medical profession in making the hearts of our fellow man warm to us with confidence and affection.’*

BMJ 1892

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□ *‘The child lies desperately ill while the parents huddle in the background, fearful, helpless, and grief-stricken. There is nothing more the physician can do medically to save the child. Why, then, is he still there? He can only keep vigil-watching as the girl's delicate breath grows ever more shallow. Now picture a different scene — one with the physician's chair empty, and the two distraught parents clutching a phone receiver.’*

Lancet 1887

# To successfully adopt any new way of working we have to:

- WANT TO – believe that change is necessary and that what is proposed will be successful
- KNOW HOW TO – make use of established skills & develop new ones
- CHANCE TO – no conflicting priorities. Time and resources.

# Therefore we want this session to:

- Confirm the purpose and benefits of telephone triage and consultation in primary care
- Highlight concerns and difficulties
- Identify 111 useful ways of managing typical situations and overcoming common problems
- Give you opportunity to develop confidence and skills

# Understanding Benefits and Problems

- *Think about the challenge of doing telephone triage as part of your work. Try and identify what benefits and problems are:*
- Do you believe that you need to change – that telephone triage should be part of your work, that what has been proposed will work for you and be beneficial?
- Do you know what to do to carry out telephone triage successfully, can you use existing skills or will you need to develop new ones?
- Is doing this a priority, have you time to do this work properly and consistently, have you the necessary support and resources?

# WANT TO: Benefits and Problems

- Huddle up with the person either side of you and tell each other about the benefits and problems of telephone triage and telephone consultation
- And then share with each other what you are hoping to get out of this morning

BENEFITS

PROBLEMS



# Hopes for the Session



# Benefits

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- Get the patient to the right level of care, with the right provider, in the right place, at the right time
- Manage patient problems safely and appropriately over the telephone
- Improve patient access and experience
- Manage clinician and service capacity

# Telephone triage successes – Do You Agree?

- Provides a more personal and responsive service
- Clinicians able to focus on more complex problems
- Improved case mix across the team
- Reception staff under less pressure
- Reduces inappropriate appointments
- Reduces patient anxiety, gives reassurance and increases patient satisfaction
- Educates patients re self care, use of other health services and future use of the surgery

## - and some more

- “Easier to manage my own work”. GP
  - “ I hear less complaints and the staff are less stressed”. Office manager
  - “ I can make sure the patient sees the right person.” GP
  - “You can always offer the patients something on the day”. Reception apprentice
  - “I don’t see the patients I don’t need to and I can see straight away those I do need to. “ GP
  - “ We are not putting patients off now.” Receptionist
  - “ More flexibility when dealing with results & letters “ GP
  - “There is now space for me to book patients in with GP.” HCA
  - “ Seeing patients I have triaged helps me keep to time.” GP
  - “ I can prepare better for patients I am going to see.” GP Trainee
- but - “ I have only heard comments from patients that it is difficult to book to see the GP.” Practice nurse

# Cannot see the patient    Patient not seen

- Cuelessness
- Rapport difficult
- Task orientated
- Difficult balancing efficiency and safety
- Stereotyping and bias
- Mismatch of agendas
- Confrontation
- Organisation

# Cannot see the patient

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- Cuelessness
- Rapport difficult
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- Stereotyping and bias
- Mismatch of agendas
- Worry about confrontation
- Organisation

- Loss of social capital
- Psychological distance
- Mismatch of agendas
- Need to confront
- Organisation
- Loss of trust in you as a clinician and in the service as a whole

# DOCTOR: PATIENT TRUST

- A rapidly changing NHS can lead to a loss of trust between the patient and the NHS ( and therefore the professional involved in episode of care)
- Trust is most important in situations that are characterised by risk
- Telephone triage is associated with increased risk

# ORGANISATION

- Will require increased telephone capacity
- Receptionists need training in telephone skills, managing high priority problems and growing role as problem sorter
- Patients need to experience benefits in other areas of their care
- Patients with communication problems need a different way
- Must have forward appointment schedules in place to be able to book into
- Need “right” balance of pre-booked and same day telephone and surgery appointments
- Need protocols for use of pre-booked appointments for follow up of letters/results etc., how long term conditions are monitored and how patients can book agreed follow ups
- Must have agreement between GPs re how On Call GP works and how GPs book appointments with each other to maintain continuity

# KNOW HOW TO:

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- Make use of established skills and develop new ones
- 111 ways of improving your telephone triage and telephone consultation

# 1. Apply your tried and tested consultation models

- Preparation
- Initiating the call
- Building and maintaining rapport
- Gathering information
- Understanding, explanation and agreed management
- Ending the call
- Administration

## 2. Prepare and Plan before picking up the phone

- Who contacted you?
  - patient, relative, carer, professional
- What is the degree of urgency and priority?
- Does the time line of this call contain any delays for the caller?
- Have you considered all available information?
- With what you know so far - what do you think the outcome of the call should or could be?
- Therefore what strategies do you need to consider?

### 3. Build and Maintain Rapport

1. Reduce caller's initial anxiety by clear introduction that reassures them that they are using a helpful service.
2. Make early empathic statement.
3. If caller expectation is made explicit early on then acknowledge and make commitment to it which can then be revisited
4. Use record of past contacts or other info to demonstrate a degree of longitudinal care
5. Don't repeat question patient has already answered
6. Balance open and closed questions

### 3. Build and Maintain Rapport

7. Respond to cues and recycle information
8. Monitor level of rapport and take action if deteriorating
9. Identify likely issue/point for each call when the patient's agenda will challenge you most and use a variety of strategies to overcome it.
10. Stress benefits to the patient rather than problems to the service
11. Ensure caller appreciates service access and hours
12. Emphasise that your record will inform any future contacts with the service
13. Address concerns and expectations of family and carers as well as patient's
14. Consider following up progress later



Practise makes  
perfikt, perfekt, perfect

# Establishing rapport, expressing empathy

- In pairs take turns to be the doctor and then the patient.
- Friday evening
- Practise:
  - identify & introduce yourself
  - confirm identity of “answerer” and relationship to patient
  - start to build rapport & relationship
  - invite the patient’s story

# IN PAIRS

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1. Sylvia Black, 78 yrs. Thinks she has cystitis again.  
Caller self
  
2. Denise Clarke, 48yrs. D&V for 5 days after holiday  
in Morocco. Caller husband Derek.

## 4. Start with the end in mind and an eye on everything else

- Current problem, past history, likely causes, possible outcomes
- Striking a balance acknowledging patient's expectations and not promising the unnecessary
- Will patients who need to be seen after your triage see you or another clinician ?
- Priority of call against other work
- No reply – engaged, no answer

# NO REPLY

- Have you dialled correctly?
- Is the number correct?
- Why would the patient not answer the phone?
  - Not well enough to
  - Does not want to
  - Not there
- Complete the call after three no replies – refer back to reception for action or await patient call back

# Initiating the Call

1. What can I do for you?
2. Something about your head?
3. I have been asked to phone you about your headache. I'm sorry you have got problems again, can you tell me what has been happening?
4. I hear you have got another headache, I see you had the same this time last year, I think it best to have the same tablets again and I have organised the prescription. Goodbye.

# Considering the possible outcomes

- I think we do not need to see this patient
- I will need to be given a good reason for seeing the patient
- I will need to be given a good reason for not seeing this patient
- I think we need to see this patient

- 
- MUST be seen today ( by whom, where and when)
  - SHOULD be seen today unless...
  - COULD be seen today if...
  - NO NEED to see today ( never, never unless, later, after)

# MUST be seen today – 5 Cs

- **Clinical**
- **Communication problems**
- **Context**
- **Capacity**
- **HunCh**



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## 5. Take account of all the Relative Risks & Benefits

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- ▣ Caller has own agenda
- ▣ Patient not present
- ▣ Calling on behalf of patient
- ▣ Patient unable to talk or hear
- ▣ Patient “not well enough” to talk

## 5. Take account of all the Relative Risks & Benefits

- Inform risk assessment
- Provide information
- “Confirm” diagnosis
- Enable management by providing care, monitoring progress and applying safety-net advice
- ICE different than patient’s
- Can block or interrupt information gathering
- Own agenda can sabotage management plan
- “While I’ve got you on the phone...”

## 5. Take account of all the Relative Risks & Benefits

- ▣ Confirm identity and relationship to patient
- ▣ Ask to speak to patient unless inappropriate, so that relative needs to be explicit why may not be possible.
- ▣ Protect patient confidentiality , recognise relative's own ICE and enable their involvement with management
- ▣ Ask about something the relative does not know the answer to. If the patient then answers the relatives' questions ask something more personal and then offer to speak to the patient yourself
- ▣ If you speak to relative at the start then speak at the end as well



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## 6. Spend just long enough gathering information

- The empathic listener
- The good clinician – reviewing relevant systems
- The efficient worker
- Strike a different balance for each patient depending on:
  - your initial impression of diagnosis and risk
  - patient's ideas, concerns and expectations
  - likely outcome
  - demands of other patients and tasks

## 6. Spend just long enough gathering information

- Make good use of available information
- Don't be afraid to use silence
- Mix open, closed, and key questions
- Use patient's language
- Limit use of jargon and explain when used
- Summarise to check accuracy and demonstrate listening

## 6. Spend just long enough gathering information – useful questions

- When was the last time you were in hospital?
- When did you last see a doctor/nurse from the surgery? Did the doctor see you at home then or in the surgery?
- Do you do your own shopping?
- When did you last go out of the house?
- Never mind if you can't remember about why you see your doctor tell me what tablets you take?
- What time are your carers next due?
- If you were to phone your own doctor about a problem like this what would she/he usually do?

## 6. Spend just long enough gathering information

### Initial Prioritisation of High Risk Patients

- Determine those patients who need urgent appointments/other actions
- Expert clinicians quickly build a picture through – chunks of information, patient's age, chief complaint, language level, emotional state and previous medical history
- Utilize “red flags” to rapidly identify high-risk problems or populations.
- Often takes as little as 60 seconds e.g. chest pain.
- Other problems require more time spent on gathering detailed information, e.g. vague abdominal pain, elderly
- Stay aware of emergent situations and deteriorating patient when may need to abandon detailed gathering of information

## 6. Spend just long enough gathering information

### Assessing Risk Level- SAVED

- S – Severe, strange or suspicious symptoms
- A – Age
- V – veracity
- E – emotional status
- D – debilitation and status

## 7. Make a Diagnosis and Take Decisions

- Experienced triagers elicit less information from the callers, are quick to make management decisions and spend more time explaining and advising.
- Novices ask more questions before reaching a diagnosis through long-winded hypothesis generating and testing, and are weaker on explanation and advice

# Managing Urinary Concerns and Symptoms

- MSU rates vary from 40/1000 to 160/1000 patients
- Asymptomatic bacteriuria in elderly is very common and not associated with increased morbidity. Investigation and treatment will increase side effects. Only sample if 2 signs of infection – dysuria, fever, new incontinence
- Routine MSU unnecessary in adult women with no complications.
- Use symptoms, urine appearance and dipstick tests to diagnose and reduce antibiotic use and lab investigations
- 3 or more typical symptoms and no vaginal discharge/irritation then give empirical antibiotic treatment

# Prescribing antibiotics for tonsillitis

- Prescribe antibiotics for acute sore throat where 3 or more Centor criteria are present:
  - Tonsillar exudate
  - Tender anterior cervical lymphadenopathy
  - History of fever
  - Absence of cough

## 8. Use all available resources in managing patients

- Telephone advice with reassurance that can re-contact surgery if symptoms or concerns worsen.
- Telephone advice + follow up call
- Telephone advice and FP10
- Advise attend local pharmacy, MIU, A&E, optometrist
- Surgery appointment/s – when? with whom?
- Home visit by GP, Community Nurse, other

## 8. Use available resources in managing patients

- I - express experience & validate
- THEY - normalise
- YOU - empathise and enable
- WE - commitment, follow up

## 8. Use all available resources in managing patients

- Mum worried about her child with earache
- Woman with cystitis symptoms
- Wife worried about husband who cannot move because of his low back pain
- Elderly man with constipation
- Child with feverish illness
- Vomiting and diarrhoea
- Sore throat
- Cough that is not getting better



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## 9. End the call satisfactorily, safely and ready for the next one

- Have you met the patient's immediate needs?
- Does the patient know what will happen next?
- Does the patient know what to do if the situation changes?
- Would another clinician know what has happened and what is planned from the record?
- Would it help to involve anybody else?
- How has that call left you feeling?
- Are you ready to deal with another patient?

## 10. Avoid Common Pitfalls

- ❑ Inadequate talk time
- ❑ Insufficient history taking and documentation
- ❑ Mismatch between doctor and caller about the main reason for the call
- ❑ Stereotyping of patients and problems
- ❑ Second guessing or over-reliance on caller
- ❑ Premature closure
- ❑ Failure to use protocols properly

## 10. Avoid Common Pitfalls

Failure to use protocols properly can include:

- ❑ Fail to use the protocol – often occurs because no relevant protocol available
- ❑ Use the wrong protocol – not collecting enough information may lead to “wrong train syndrome”
- ❑ Use the protocol improperly – often involves choosing the wrong disposition

## 10. Avoid Common Pitfalls – mismatch of agendas

- ❑ Insufficient information gathered
- ❑ Mismatch between doctor and caller about the main reason for the call
- ❑ No identifiable diagnosis
- ❑ Wellness bias
- ❑ Confirmation bias
- ❑ Stereotyping the caller or the symptoms
- ❑ Second guessing by being dismissive of the caller's concerns or over-investing in the caller's assessment.

## Let's consider a common scenario

- What red flag features would you use when assessing severe low back pain?
- What can stop us asking patients about these red flag features?
- What can stop us hearing about these red flag features?
- What can stop us taking action?

# 111 Ways to Improve your Telephone Skills

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- 4. Start with the end in mind and an eye on everything else**
- 5. Take account of all the Relative Risks & Benefits**
- 6. Spend just long enough gathering information**
- 7. Make a Diagnosis and Take Decisions**
- 8. Use all available resources in managing patients**
- 9. End the call satisfactorily, safely and ready for the next one**
- 10. Avoid Common Pitfalls**

# 111 Ways to Improve your Telephone Skills

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9. **End the call satisfactorily, safely and ready for the next one**
10. **Avoid Common Pitfalls**
  
11. **Practise makes perfikt, perfekt, perfect ( gives you confidence)**

**11 + C (for confidence) =111**



Practise makes  
perfikt, perfekt, perfect

# Practising in Trios

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- 6 of my patient scenarios
- Your own patient scenarios

# WORKING IN TRIOS

- Position A – the patient, use the details and history as you will. An important opportunity to appreciate “the patient’s perspective”
- Position B – the doctor, act as you would, confirm established skills and practice new ones
- Position C – the observer, keep time, don’t interrupt, assess how the doctor does and give constructive feedback

# FINALLY



- Outstanding concerns and problems
- One thing you have learnt today
- Evaluation and Reflection