Clinical Update

For Telephone Triage Nurses

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Review and Documentation of Patient's Medical History: How Much is Necessary During Telephone Triage?

A growing number of call center triage nurses now have access to the patient's electronic health record (EHR) during many of their triage encounters. The EHR usually includes a list of medical problems (diagnoses), medicines, and documentation of recent medical visits.

Increased access to a patient's medical history has prompted such questions as: "*How can our call center best include the review of the patient's EHR in our standard triage call process?*" and "*How much of a patient's medical history needs to be assessed and documented for each triage call?*" Access to the EHR can improve telephone patient care, especially when the patient has complex chronic health problems. However, a comprehensive review of a patient's medical history is not necessary for most triage calls and can drive up call times. This can lead to longer caller wait times and caller dissatisfaction.

For telephone triage (with or without access to an EHR), we recommend an individualized approach to review and documentation of a patient's pertinent medical history. This approach focuses on what is relevant to the patient's chief complaint (main symptom or symptoms).

Focus Your Nursing Assessment on the Chief Complaint

- The triager should start by assessing the patient's chief complaint (main symptoms).
- Further review of the relevant medical history should be focused on what is relevant to the caller's chief complaint. This requires some critical thinking on the part of the triager.
- Further assessment of medical history (e.g., medicine use, chronic health problems, recent surgery) is also guided by the triage guideline prompts.
- This approach helps keep the review of patient's medical history focused on what is important to the concern at hand.

Review and Documentation of Chronic Medical Conditions

- The triager should review and document ***active*** (current) ongoing chronic medical conditions for most triage calls. The triager does not need to review and document a comprehensive list of every medical and surgical problem the patient has ever had. Rather, focus on what is relevant to the call. For example, with minor cuts or puncture wounds, the patient's tetanus vaccination status should be documented.
- The **higher the acuity** of the disposition, the **less the triager needs to document chronic medical problems**. Little or no documentation of medical history is needed when a patient obviously requires an EMS 911 or GO TO ED NOW disposition. An example is an adult who develops sudden severe breathing difficulty.
- The Schmitt-Thompson guidelines contain **additional prompts** for the triager to assess key chronic illnesses pertinent for certain symptoms. See examples in table, page 2.
- When documentation of chronic illness is indicated, the recorded information can often be very brief (e.g., *PMH – diabetes, PSH – coronary bypass surgery).*

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Review and Documentation of Medicines

It is reasonable and appropriate for the triager to review and document medicines when they: (1) are **pertinent to the chief complaint** and (2) **affect the disposition**. For example, the triager should document the use of amoxicillin (and start date) when triaging a child who develops a widespread rash while on this antibiotic. It is usually not necessary to document dose and frequency of medicines taken.

- The triager does not need to review or document every medicine that a patient takes for every call. This is time-consuming and usually not necessary.
- The **higher the acuity** of the disposition, **the less the triager needs to document medicine use**. Little or no documentation of medicines is needed when a patient obviously requires an EMS 911 or GO TO ED NOW disposition. Rare exceptions would include a life-threatening reaction to the drug (e.g., anaphylaxis) or severe hypoglycemia in a patient with diabetes. In these cases, documentation of medications given (e.g., Epi-Pen, glucagon) should not delay ending the call and having caller dial 911.

Allergies to medicines are only rarely pertinent to the chief complaint and triage decision-making. However, the triager should document drug allergies in the following circumstances:

- Chief complaint is rash or other suspected drug reaction symptoms.
- Triage nurse authorizes a new prescription or refill (per approved call center policy and approved standing order/protocol).
- Nurse recommends an OTC medication (per call approved center policy and protocol).

The Schmitt-Thompson guidelines contain **additional prompts** for the triage nurse to inquire about medication use that is pertinent for certain complaints. See examples below.

Table 1. Examples of Additional Prompts for Triage

Guideline	Prompt
Heart Rate and Heart Beat Questions (Pediatric)	Initial Assessment (IA) Question: *CARDIAC HISTORY: "Does your child have any history of heart disease or heart surgery?"*
Puncture Wound (Adult)	Triage Question: *[1] Diabetic AND [2] puncture wound of foot*
Headache (Pediatric)	Triage Question: *[1] High-risk child (e.g., bleeding disorder. V-P shunt, CNS disease) AND [2] new headache*
Asthma Attack (Pediatric)	Initial Assessment (IA) Question: *MEDICATIONS (MDI or nebs): "What is your child's asthma medicine?" and "What treatments have you given so far?"*
Head Trauma (Adult)	Triage Question: *Taking Coumadin or has known bleeding disorder (e.g., thrombocytopenia)*

Key Take-Away Points

Documentation of Medical History

- Focus on what is ***relevant to the chief complaint/***concern.
- Review/document ***ongoing (current)*** medical problems.
- Review/document ***medicines*** when they are ***pertinent*** and ***affect the disposition***.
- The ***higher the acuity*** of the disposition***, the less the triager needs to document.***

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