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If you would like further information, training or assistance in modifying and using this Protocol in your Practice, please contact the SE NSW Division of General Practice.

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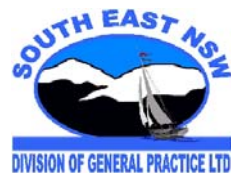
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POPGUNS



Prioritisation Of Patients: a Guide to Urgency for Non-clinical Staff



24h

Introduction

This POPGUNS protocol has been developed by a working group consisting of General Practitioners, Nursing Staff, Practice Managers and Reception staff, an Emergency Department Nurse, Pharmacist and Consumer. The process is an initiative of the SENSW Division of General Practice, in response to requests, from GPs, and was funded by a grant from the National Council for Safety & Quality in Health Care.

Background

Basic triage, or prioritising the allocation of appointments, is something that General Practice reception staff undertake every day. Many of them have extensive experience and skills in this regard while many others do not. In most cases this process is not formalised, and is difficult to document or define.

Recent legal cases suggest that practices are increasingly accountable for patient outcomes, even when contact with the practice may amount to only one phone call, and that GPs are ultimately responsible for the actions of their staff, especially with respect to patient interactions.

The primary objective of this project was to provide a standardised approach that practice staff could use to guide these patient interactions, and that GPs and Practice Managers could rely on to provide a measure of safety and quality to patients of their Practice.

About the Protocol

The protocol is designed to be:

- simple and workable: so that it is readily available and accessible to reception staff, and easy to understand and use.
- non-exhaustive: so it does not attempt to cover every possibility which might arise but to deal with those that might constitute a serious situation.

- non-diagnostic: so it is framed in terms of 'presenting problem' and deals with decisions about timely access to care. It does not assume or suggest that reception staff will be making clinical decisions about care and treatment, or diagnosing the patients condition.
- comprehensive & patient focused: so it provides advice regarding further actions to support care of the patient including advice for self care, first aid and ongoing monitoring.

General Practices operate in many different ways. For this reason the protocol has also been designed to be tailored to the needs of individual practices. The protocol provides a framework for the decision making process but can be modified to reflect these individual preferences. The best way to do this is probably through a collaborative approach such as a practice meeting and discussion with relevant staff. Support with modifying the protocol is available from the Division.

Using the protocol

Triage is the process of sorting casualties according to the urgency of treatment required. The responsibility of reception staff in this context is to alert clinical staff (nursing or medical) to people who possibly have a serious medical condition.

This process contains four key components:

1. Screening questions.

These are designed to elicit important, relevant information and include a 'trigger' for working out when to apply the triage process to decisions about allocating appointments. Always double-check that you have the right patient.

2. Condition categories according to presenting problem.

Remember that conditions are not framed in terms of diagnosis but as the nearest approximation of a problem as the patient might describe it.

3. Patient advice.

This includes very basic first aid and instructions for appropriate self-care, monitoring changes in the patients condition or knowing when to take further action.

4. Actions & documentation.

These are an important part of comprehensive patient care and are necessary to fulfil legal obligations. Please note that the protocol suggests that a GP be informed about every request for a non-routine appointment.

While the protocol is intended to describe and guide a standardised process of assessment and decision making, intuition and common sense will form part of any judgement. They should not be ignored. If, on the other hand, a staff member is unsure what to do in any case the GPs or other appropriate clinical staff within the practice should always be consulted.

In general, always err on the side of caution or default to a higher category

Whether you use a computer or paper based system, your documentation should have a means of describing whether the proposed action occurred. For example, did the patient keep the appointment, or attend the ED?



A word about legal issues...

There is a legal obligation on GPs, practices **and** receptionists to ensure that patients requiring appointments are dealt with appropriately. The following are excerpts from the *Alexander vs Heise* (NSW Supreme Court, 2001).

"...the GP had a duty of care to properly instruct the medical receptionist on the proper management of patients who presented with complaints which may warrant urgent attention..."

"...It is common ground that a well trained receptionist would inquire about specific complaints, their severity and duration of the complaint..."

"...a GP has a the responsibility to ensure that the patients seeking appointments are properly prioritised. The medical practice should have guidelines in place..."

In a nutshell.....

it is the responsibility of receptionists to act appropriately, and the responsibility of GPs (practice principals) to ensure receptionists are provided with adequate training and guidelines to assist them to do so. RACGP, AGPAL and GPA Accreditation Guidelines currently reflect these expectations.



Documentation

Good record keeping and documentation is a critical part of good patient care. With increasing pressure on practices to demonstrate the quality of care they provide to patients, documenting telephone contact is also important. Remember that patient consent is important; this may mean that suggestions need to be put to the patient as offers rather than instructions. Any verbal consent given will need to be documented. Notation can be done in a range of ways, depending on what best suits your practice. Here are some possibilities:

PracSoft Option

Phone calls where an appointment is not made can be recorded in a "nonsession" slot. Text in the slot might read, for example:



"ph, 3.12pm, Joe Bloggs, burn, catB, AR"

Meaning: "Phone call taken by AR at 3.12pm from Joe Bloggs and the usual action taken and advice given for a category B patient with a major burn (e.g. cool burn with cold water, go to Casualty, A&E informed—or whatever standard protocol is in the Practice Manual for this category/problem)".

If the patient is not an existing patient and an appointment is not being made (ie file not to be created) select "nonpatient" - PracSoft will colour the bar accordingly.

If an appointment is to be made, a similar note can be made in the appointment slot to highlight for the doctor and front desk that this is an urgent problem.

Paper/Appointment book Option:

There are numerous ways of doing this:

- Duplicate phone message-type pads
- Codes in appointment books
- Phone Logs
- Patient records



None will be perfect but they should fit your Practice.

We suggest you record the following against the patient name. This can be done using agreed codes (following in brackets):

- Date and time of call.
- Category patient assigned to (category A, B, C etc)
- Advice given (advise as per protocol)

What do we mean by....?



ACUTE

Recent onset.

PAIN

We have used this term broadly. Pain is one of the most common presenting features of many different medical conditions. You will note that the protocol does not ask you to attempt to differentiate between different types of pain. This means that conditions that present as a type of pain for example, headache or stomach ache, should be dealt with as 'PAIN'. Many other problems such as constipation or inability to urinate may also fit under this description.

DEHYDRATION RISK

This refers to people with poor oral intake, fever, vomiting and/or diarrhoea. Remember, this problem is worse in the very young and very old, and includes those who are simply not interested in taking fluids orally. In babies, a sign of dehydration risk may be the absence of wet nappies for a period of time but remember this can't be observed if they have diarrhoea.

PERSISTENT FEVER

This is a temperature over 38°C for a prolonged period of time. In children, the threshold for obtaining medical assessment will be lower, both in terms of temperature and length of time.

ALTERED LEVEL OF CONSCIOUSNESS

This includes patients who are dizzy or confused as well as those who are semi-conscious or unconscious.

ACUTE NEUROLOGICAL CHANGES

Patients may experience a range of symptoms including dizziness, confusion, numbness, weakness, paralysis, pins and needles, slurred speech or ringing in their ears.

EXTREME CONCERN

This is the patient who is particularly anxious, distressed or worried about their condition, regardless of whether they can describe other clinically significant features.

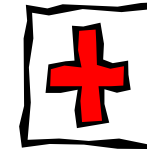
ABUSE OR ASSAULT

This includes any patient you would consider to be in danger of abuse or assault based on the information provided.

WARNING BELLS!

Remember there are a number of conditions or responses that should sound a warning when you are working through the protocol with a patient. They include:

- **Patients with a history of serious illness including:**
 - Diabetes
 - Heart disease or a heart attack
 - Asthma
 - Epilepsy.
- **Patients who are 'immunosuppressed'.** This means they are less able to protect against infections and includes those on or with:
 - HIV
 - Cancer treatments and chemotherapy
 - Cortisone tablets.
- **Babies under 3 months.**
- **Other problems or patients flagged by the GP.**



First Aid/Usual Advice

The protocol is accompanied by a table of suggested advice which can be given to patients. This can be adapted by your practice to comply with instructions GPs are comfortable with staff providing. Remember this is not medical treatment or care, but immediate action until medical assistance is available. Patients may feel reassured knowing there is something they can do while they wait for further assistance, or simply knowing what to look for. This advice, along with appropriate actions for each category would form part of what is deemed to be 'usual advice' for the purpose of documentation.

Remember too, that it is sometimes appropriate to stay on the line or to ascertain the whereabouts of the patient so you or someone else can check on them. Consider the option of calling the patient back to check on them, and discuss this with them if you think it's appropriate.

It is important to reassure patients and to explain what you will do about their call. Confirm that you will act on the information they have provided. Making it clear that 'things are under control' is a useful part of management in an urgent situation.

In general, patients with injuries should not be given anything to eat or drink until seen by a doctor.

If a patient is not breathing or has no pulse, advise the caller to start CPR if they know how. They have nothing to lose and immediate action is important.