RISK MANAGEMENT IN TELEPRACTICE
(3 CE Hours)
PART TWO: Two Expert Views

The author, Sheila Wheeler, interviews two legal experts, exploring their perspectives on recent developments in legal issues over the last 15 years. Ms Wheeler expands on their comments to describe a few new areas of risk.

Attorney Robert Smith sets the stage. Mr. Smith describes in detail, the elements of a negligence lawsuit, as well as the types of questions that attorneys might pose to the defendant nurse. He also compares the telephone triage encounter to the ED encounter. Mr. Smith shows how the "layers of protection" approach to risk management can help protect practitioners, while supporting improved practice. He warns of the dangers of using UAPs and inadequate systems for telephone triage.

Laura Mahlmeister, PhD, RN, a legal expert, describes complex clinical situations that can lead to risk exposure. Dr. Mahlmeister highlights areas of unexpected risk for vulnerable patient populations, revealing new access issues, inadequate policies and proposing safer approaches. She touches on a myriad of legal issues surrounding telephone triage, including the concept of "exit strategy," the "duty to terrify," human error and nursing intuition.

RISK MANAGEMENT IN TELEPRACTICE: PART TWO

Audience
RNs and NPs (novice and experienced) interested in learning more about the current legal issues related to telephone triage

Methodology
Participants will read on line course material, and answer 20 multiple-choice questions.

Course Description
The purpose of this course is to educate telephone triage professionals about the current issues in risk management related to telephone triage.

Behavioral Objectives:
Upon successful completion of the course, the participant will be able to:

1. Discuss the elements of negligence in telephone triage
2. Discuss reasons for increased lawsuits and verdicts related to negligence in telephone triage
3. Differentiate between vicarious and corporate liability.
4. Discuss community standards as they relate to telephone triage
5. Discuss one major research study examining how working conditions affect patient safety and relate it to telepractice.

Faculty: Robert Smith, Attorney at Law
Robert Smith is an attorney and founding partner in the law firm of Lowis and Gellen in Chicago. He represents physicians, hospitals, nurses and other healthcare practitioners. He is a frequent speaker at state, regional and national conferences.

Faculty: Laura Mahlmeister RN, PhD
Dr Mahlmeister is president of Mahlmeister and Associates. She has been a maternal-newborn nurse for 34

years, and currently serves as a clinical professor at the University of California, San Francisco. She serves as an expert witness in nursing malpractice cases, for both plaintiff and defense firms.
Faculty: Sheila Wheeler RN, MS Since 1995, Ms. Wheeler has served as an expert witness for both plaintiffs and defendants in telephone triage malpractice cases

Accreditation PROVIDER TeleTriage Systems. Provider has been approved by California Board of Registered Nursing, Provider #10680 for 3 contact hours.

WHEELER: Can you elaborate on the issue of negligence as it relates to telephone triage?

SMITH: One way to approach it is within the legal context of a lawsuit. I think the starting point in this analysis should be that a telephone triage lawsuit is the same as any other professional negligence case. Of course, there are nuances between an obstetric case, or an Emergency Room case, a nursing home case or a telephone triage case. But in terms of a general overview, they're all professional negligence cases. So whether a lawsuit arises out of a call that went bad or care that went bad, the legal analysis is going to be the same for all of those cases

ELEMENTS OF NEGLIGENCE

SMITH: The elements of a negligence case are duty, breach of duty, proximate cause and injury. So to have a lawsuit, you have to have a duty owed by the nurse; a breach of duty or a deviation from the standard of care. That's really where the negligence comes in. Did the nurse who received the call breach the duty that's imposed by law? Has s/he failed to follow reasonable steps? Did the breach of duty proximately cause injury? There has to be injury in order for there to be a lawsuit.

In a negligence case, we analyze those features. The issue that comes up is that once the nurse accepts the call and begins to dispense advice, then the law imposes a duty, even if there is no duty otherwise. So in a typical setting where a call is received—for example, a call center or a physician's office that has delegated the responsibility to a nurse—there then is a duty. The duty, of course, is to act in a reasonable fashion. In analyzing whether there is a breach of duty, which is the heart of any negligence case, the question is: did the nurse behave in a reasonably prudent fashion?

The definition of negligence will vary from state to state, but the common thread is that the nurse has a duty to act in a reasonable, careful or prudent fashion. Analyzing that in a telephone triage is unlike almost any other setting. That is because the information is being collected and dispensed over the phone rather than based on a physical exam.

The analysis centers on what took place during the context of that phone call, what information was given by the caller, what was recorded by the nurse? It involves not only what information the patient volunteered, but also what information the nurse elicited during the course of the call. The analysis focuses on whether the appropriate information was elicited. That is, how did the nurse analyze, apply or use that information?

The issue of the nurse's procedure calls into question whether or not the particular call center had protocols that the nurse was following—written or electronic protocols or any other form of protocols or guidelines. In a sophisticated telephone triage setting, one might expect to see some algorithm or protocols. So the attorney is going to ask: What information did you receive? Have you documented it? What information did you elicit? What questions did you ask to try to decipher what the particular problem was and the urgency of the problem? How did you apply the information? What particular protocols did you use? Did you document the protocol you used?

A good lawyer is going to ask: Are the protocols sound? What protocols were applied? Did

they make sense in this particular case? Was the nurse using the right ones? Are the protocols reasonable? ? (See Box A) Are they literature-based or research-based? Ultimately, what advice was dispensed and what instructions were given? Was there a sense of urgency, and were there follow-up instructions?

BOX A: Reasonably Safe Protocols

In many areas of the country, nurses perform telephone triage without any protocols or guidelines at all. In other areas, software companies have created powerful, sophisticated, electronic software programs to assist the nurse in the process of triage. Whether in paper or electronic format, these tools are now considered decision support systems.

As technology has surged forward, many authorities assume that these guidelines are reasonably safe and user friendly. Thus, the issue of protocol standards remains essentially unexamined. New research hints that protocols may provide a false sense of security (Brillman et al., 1999), but more research is needed. From a legal perspective, the lack of research combined with the fact that we are using newly created tools may represent a looming risk. Are existing protocols (electronic or paper-based) reasonably safe decision support tools? How do we measure that safety? Could they contribute to error in some way?

Standards for decision support tools are beginning to emerge, partly in response to the Institutes of Medicine's (IOM) research on Human Error in Medicine (1999). In general, minimum standards might require that telephone triage protocols be comprehensive and "system-based".

Comprehensive protocols would be defined as those that address the most commonly encountered emergent, urgent and routine level symptoms and conditions. System-based protocols should have integrated components that work together: documentation form, "exit strategy", training program, standards and QA tools. The protocols are but one element of that system.

Essential to the system would be an integrated documentation form that complements the protocols and facilitates thorough documentation. It should enhance risk management through "forcing functions," requiring users to elicit and document key required information.

Protocols and policies (standards) should provide for a "fall-back" protocol or exit strategy. This strategy is designed to support nurses in cases where they find themselves having an "out-of-protocol experience" (in industry parlance), or when existing protocols may not apply.

Specialized training should address how to properly operate "the system" and the documentation form, whether in paper or electronic format. It should include standards and directives for "exit strategies" and a complete understanding of the overall design and assumptions. In the case of electronic protocols, training in the operation of the software (a technical skill) does not take the place of training in the proper use of an electronic decision support system for telepractice (a critical thinking skill).

In 1996, Farnsworth and Mariani set forth a set of criteria for decision support technologies. Listed below are their basic criteria, applied to telephone triage protocols:

1) Validity - if followed, it will lead to expected outcomes (a reasonable, safe disposition).
2) Reliability/reproducibility - given the same data, another set of nurses would arrive at the same dispositions.
3) Clinical applicability - the protocols explicitly state the populations to which they apply.
4) Flexibility – the User's Guide contains complete operating instructions, explaining

underlying assumptions and exceptions to recommendations, in other words, "Exit strategies". 5) Clarity -- the protocols are written in unambiguous language, using precisely defined terms in an easy to follow mode of presentation. In other words, are they "user friendly"?

THE IMPORTANCE OF NURSING QUALIFICATIONS AND THE DECISIONMAKING PROCESS

SMITH: During a trial, the jury is instructed that a nurse has the duty to possess and apply the knowledge and utilize the skill and care ordinarily used by a reasonably well-qualified nurse. So, in that context, the skills, the training, the knowledge of the nurse, or whoever takes the call, is central.

There will be questions about the nurse's qualifications and experience. So, as a starting point: Who took the call? Was it a receptionist? Was it an RN? Was it an LPN? There will be questions regarding the level of experience within a telephone triage setting: How many calls have they handled? Have they handled calls similar to this? Did they appropriately apply the protocols? Were they well trained? All those kind of peripheral issues that would go to the heart of whether somebody has behaved in a reasonable fashion.

The lawyer will ask questions about the nurse's educational background, professional experience, about any training programs at their place of work, their experience in taking calls. That's relevant in telephone triage.

They will be asked: What kind of advice did they give? Was it to go immediately to the Emergency Room? If so, did they orchestrate that or facilitate the transport to the Emergency Room? Did they call the Emergency Room ahead of time? If it was a referral the next day to an MD, did they supply the number? Did they verify that that had taken place? Did they verify that the instructions were heard and understood, which of course, are two different things. Or did they just say, "follow up"?

The lawyer may ask about follow-up calls. Was there a callback that day, or the next day? Was there a system for callbacks? I know that in some sophisticated telephone triage call centers, there may be policies regarding follow-up calls and callbacks. I believe that this process is one of the best things that you could do—a policy or procedure to do follow-up calls.

Then the lawyer might ask: Was the nurse free to apply his/her professional judgment per the protocols in making a particular decision? Did any economic factors influence her decision? Is there somebody the nurse can turn to when in doubt? In a telephone triage setting, beyond the protocols, the nurse should be able to access additional information or resources—a physician, a charge nurse or whatever, if in doubt or if in question.

COMPARISON OF TELEPHONE TRIAGE TO ED ENCOUNTER

SMITH: The telephone triage cases are probably most similar to the cases we see in Emergency Room settings. In the Emergency Room setting, we see cases in which patients present, a history is taken, an exam is done, testing is done and then a decision is made. That decision is to either admit the patient to the hospital or discharge them. And they are discharged with follow-up instructions. That's very analogous in my mind to the telephone triage encounter, where you're assessing the patient's complaints, you're trying to make decisions about what's going on with the patient, and then you're trying to make a decision relative to how you're going to resolve the case, or whether the patient needs to be seen immediately.

The common thread in all of these cases is that lawsuits are outcome-driven, bad outcome-driven. Every lawsuit springs from something bad that happened. In telephone triage, there may be

thousands of calls, thousands of sound decisions made. Then there will be a small number of calls in which a decision is made, presumably based on good protocols, and yet something bad will happen, just like in ED settings.

For example, in the ED somebody presents with chest pain, an assessment is made, an EKG is done; chest x-ray is done; blood test is done; patient is sent home; patient has a myocardial infarction and dies. The lawsuit will center on questions such as: Did we assess the patient correctly? Did we run the proper tests? Should we have admitted the patient? In similar fashion, the call comes in; the patient has a particular complaint; you assess the patient's history; you gather the information; you ask the right questions. you apply the protocol; you tell the patient to follow up with his or her physician the next day. In the interim, something bad happens and a lawsuit will result.

INCREASING RISK, INCREASING LAWSUITS

WHEELER: In your experience, have lawsuits related to telephone triage increased over the last 12 to 15 years?

MAHLMEISTER: I find that because of the high volume in many of the obstetric units, the doctors or midwives are increasingly advising women to call in advance before they walk into a Labor and Delivery. I meet nurses who have backgrounds other than obstetrics, who are experiencing claims of negligence related to telephone advice, both in formal call centers and in physicians' offices. Because there are more phone encounters due to higher call volume, there are more lawsuits that involve claims that the initial contact involved a negligent phone encounter, or negligent disposition of the patient's problem.

SMITH: I practice in Cook County, which is in Chicago. It's a vibrant jurisdiction, lots of lawsuits, big damages. In terms of jury awards, it's the second-highest jurisdiction in the United States. In the last 10 or 15 years, we have seen a couple of major developments in relation to all professional malpractice suits, including telephone triage suits.

Statistically, the risk of going to trial is low. However, the most dramatic change over the last 10 or 15 years has been that multi-million-dollar verdicts are far more common today than they were years ago—whether it's telephone triage, or an Emergency Room case, or an obstetrical case.

WHEELER: Talk about why that is.

SMITH: There are a variety of theories about why that's the case. Part of it is the theory that as technology has gotten better, expectations have risen. People expect perfection—everyone expects that they'll have a baby with Apgar scores of 9 and 9; nobody expects that their child will be born with cerebral palsy, or brachioplexus injuries, or with any number of other deformities. Even though there are risks associated with surgery, everyone expects surgery to go perfectly.

Some people think that the value of cases has gone up because we now have multi-million-dollar salaries for baseball players and movie stars. Whereas 10 years ago, a million dollars sounded like a bucket load of money; today it doesn't quite have the impact or the power that it used to have. So as verdicts go up, and the risks for defendants go up, the settlement values go up, and, of course, it's no different for telephone triage cases.

INDIVIDUAL, VICARIOUS AND CORPORATE LIABILITY

WHEELER: My understanding is that vicarious liability comes into play when an employee in a physician's office makes an error in telephone triage and the physician is held responsible. Is that the meaning of vicarious liability?

MAHLMEISTER: Vicarious liability is a general principle of law, which says that some person is responsible for, or liable for, the acts of others who are considered subordinate. Vicarious liability is the umbrella term. There is always an issue for the physician or corporation in terms of vicarious liability, if you are hired by them to provide telephone triage.

So, if the individual is an employee of the physician—the midwife, an advanced practice nurse, an RN, LVN or LPN, or an unlicensed office worker – they are always considered under the control of and working under the authority of the physician.

Separate from that, if you are a licensed professional, either an ANP or an RN—you are licensed and authorized to do telephone triage, and you may be independently accountable as well.

WHEELER**:** Does vicarious liability relate to the failure to provide such things as protocols, documentation, and training?

MAHLMEISTER**:** Yes it does.

WHEELER**:** What about corporate liability?

MAHLMEISTER**:** Corporate liability is a component of vicarious liability. So, in that case, corporate headquarters is accountable for the training and the supervision of people who they hire either directly or indirectly within the health network to do telephone triage.

Managed Care and Access

WHEELER: It sounds as if you consider managed care to be a major force in this new trend, in that it's creating a higher volume. Would you say that access is more difficult now, as a result?

MAHLMEISTER: What happens is that patients who might have ordinarily called the office to make an appointment now end up talking first to an advice nurse, due to managed care, and that evolves into claims regarding negligence. In general, those types of advice systems work well. But once you encourage patients to call the advice nurse first, you're going to have more claims related to telephone advice.

ECONOMIC INCENTIVES DELAY ACCESS

WHEELER: In 1993, there were no electronic protocols, and managed care was relatively new. I don't remember this issue of delay and denial of care being on the radar screen. What is the relevance to telephone triage nurses?

SMITH: Ten or fifteen years ago that issue almost never surfaced; it's crept into some recent cases relative to HMOs and PPOs. It focuses on whether there was an economic incentive. Again, the law varies widely from state to state, but for delay or denial of care to be an issue in telephone triage, the plaintiff must demonstrate that the denial or delay of care was influenced by economic decisions. Then it would be relevant and it could have disastrous consequences, but it's fairly difficult to

demonstrate.

So, for example, if a telephone triage nurse is told that there will be a surcharge if too many patients are referred to the hospital, or if there's any economic incentive that can be demonstrated that alters professional decision-making, that would be a serious issue. It is a serious area of liability for the nurse and for the organization dictating, controlling or imposing those criteria upon the nurse. The nurse really has to say, "I assessed the patient and applied the protocol regardless of any economic pressures."

MAHLMEISTER: Again, one of the goals of telephone triage is to reduce inappropriate office and ED visits in order to control costs. And in the best sense of this practice, that is reasonable. However, if a patient demands to be seen and is refused an appointment or delayed in some way, there is always a question raised, about whether that refusal or failure to direct the patient to an ED or timely office appointment, was motivated by a higher concern for cost savings in the system.

Interestingly, within larger healthcare systems, there is a trend toward the development of urgent care centers, to provide options other than an Emergency Room. I believe this trend is the result of having been hit with denial-of-care claims; patients have been told not to come in, that the Emergency Room is inappropriate, and that there are no routine office appointments.

There is a second issue related to delay and denial of care. That is denial of timely access to a specific specialty care in a system where, for instance, a family practice primary care provider is seeing a woman. She becomes pregnant and calls in for an appointment with an obstetrician, for what she believes is an obstetric problem. The person answering the phone tells her, "You must first see your primary care provider; you need to call and make an appointment. Your primary care provider will determine if you need to be seen by your obstetrician." An inordinate and inappropriate delay ensues before the patient can be seen in the obstetrician's office, which is often in the same complex or building!

And so, there are new malpractice claims, arising from policies designed to make the system more cost-efficient, in terms of services, and effective in providing the most expeditious and timely care. However, sending patients to their primary care provider is sometimes neither timely nor appropriate.

What I recommend is that a primary care provider, who sometimes sees specialty patients—obstetric, pediatric or oncology patients, for example—should develop a short list of complaints. That list would immediately dictate a transfer of the call to the specialty provider, so that the patient can be seen immediately.

Let me give you some examples: a woman who is pregnant calls in and says, "I have chest pain, nausea, vomiting and a terrible headache, and I don't know what's wrong." She has just described signs of preeclampsia. You don't want to waste time having the primary provider see that individual. Another example, from OB, is that there are so many general complaints that could be wrongly assessed, as "sinus headaches," "food poisoning" and other minor conditions, but that are, in fact, severe life-threatening conditions

For an oncology patient, it might be someone who suddenly exhibits certain signs and symptoms that indicate chemotherapy complications, which can include pulmonary embolus.

This short list of critical conditions would allow the person on the telephone to say "you need to see your specialty provider immediately" or "you need to go to the ED immediately based on your complaints". If you have patients who are also seeing a specialist, it means you must have some kind of fall-back position because they cannot waste time being seen by a family practice physician or a GP.

RISK MANAGEMENT

THE ROLE OF POLICIES AND POSITION STATEMENTS

WHEELER: What are the key sources of legal opinions regarding telephone triage?

MAHLMEISTER: I would include specifically the Nurse Practice Act, and the licensing board rules, regulations, advisories or position statements. The reason is that we now know that many boards of registered nursing have developed and promulgated position statements, standards or rules about telephone triage. People should know that position statements and opinions often bear the same force as law. The Nursing board is authorized to create those documents so they form part of our legal resources.

Finally, once a protocol is developed and published, people then utilize that protocol to illustrate the standard of care or as an example of the standard of care. Published protocols, textbooks, and even journal articles are huge resources that expert witnesses use to establish the standard of care. In some states, the law now requires that, before someone renders an opinion about the standard of care, that they provide appropriate current literature supporting that opinion, as well as any published standards or guidelines that organizations put out.

RISK MANAGEMENT TOOLS: LAYERS OF PROTECTION

WHEELER: I have been told in the past that if one ever had to appear in court, it would be best if that person had this laundry list: guidelines and protocols, documentation form, policies and procedures that are dated, telephone triage training materials, a job description and qualifications, and a quality improvement program. Would you agree with that list and is there anything you would add to it?

MAHLMEISTER: I would agree. Generally what happens is that well before the person gets to court, the attorney representing the plaintiff will ask for all of those things from the telephone triage center or the physician's office or the clinic, wherever the telephone triage occurred.

A plaintiff's attorney will ask for these things even when the incident occurred in in-patient settings, where people answer the phone in a very informal way. This is one of the big issues in cases involving Labor and Delivery or Nursery. Many systems toss telephone triage into the lap of nurses who work in Labor and Delivery or Nursery. They take calls about newborn symptoms, pregnancy symptoms or post-partum symptoms, but many times in a very informal way.

If the organization cannot produce these risk management tools, then it has a problem, because then the plaintiff's attorney will assert that the organization did not have the appropriate tools to offer safe telephone triage and advice. If you can't produce those written or electronic documents to validate that you have a systematic approach to the process, you can't be viewed as reasonable or prudent as a corporate entity.

SMITH: I always think of these elements as layers of protection. You could have one of the ten, and you've got one layer of protection, but to really control risk, you need many layers of protection: people who are well-trained, sound protocols, a quality management program. It's sort of like concentric circles; you're building layers of protection around yourself.

WHEELER: Would you say that being able to produce all of these tools is evidence of a given

institution's attempt to provide infrastructure or support to the nurse doing telephone triage; that it's a starting place? It doesn't mean that she's necessarily done a good job with the call, but at least all the components were there, right?

MAHLMEISTER: Correct. In terms of the evolving nature of healthcare today, we're moving towards what we call a high reliability systematic approach to the provision of care. I will tell you that telephone triage and advice is going to probably be the next frontier.

In other words, they've developed patient safety standards for hospitals, ambulatory settings and ambulatory surgical settings. Next they will be looking at specific recommendations for safety in telephone triage. I think it will be the area of scrutiny for consumers and advocates for patient safety in that regard.

WHEELER: As related to the standard of care, is there anything you want to say about what is reasonable and prudent for a practitioner?

MAHLMEISTER: Whether it's a provider, advanced practice nurse, or a registered nurse, what is reasonable and prudent practice is comprised of the knowledge that they should possess to conduct telephone triage appropriately and safely. It is possessing the skill, and it's a unique skill, to conduct an interview and assessment, to develop a problem list or to make a nursing diagnosis on the phone. So it's both knowledge and skill.

COMMUNITY STANDARDS

WHEELER: Community standards are an area of confusion. How does that concept relate to telephone triage?

MAHLMEISTER: With legal reforms occurring state-by-state, there are individual states now that do not recognize a national standard for any area of practice. So, when I am in one of those states as an expert witness, I am frequently asked what I understand to be the standard of care. I say that, in this state, the standard of care is what "a reasonable and prudent nurse would do in a comparably sized community in a comparable facility with the type of patient that s/he encountered in this case." You can't use a national standard. But I can say that, while there are national published guidelines and standards for the act in which the nurse was engaged, I wouldn't expect that patients in this state should expect a lower standard of care.

For instance, if a nurse was in a medium-sized semi-rural town, I could not say that there needed to be an electronic protocols available or that they needed to have certain types of resources." That's not how they do it there. However, I could say that they needed to provide their staff with basic training and guidelines for answering the phone, and instructions on how to deal with emergencies. I could also say that there needed to be some type of quality review; the physician needed to be able to identify misses and near-misses on the disposition of problems, and that there needed to be oversight."

I can talk about general principles, but I can't necessarily produce any written national standards because none of the providers in that community uses those resources. So, defining the standard of care is problematic and may get more complex as every state develops different ways of dealing with its own definition of the standard of care.

WHEELER: You seem to be saying that in a state that uses strictly community standards there

should at least be a bare-bones system in place—something like a guideline, some kind of form, something related to a policy, something related to training—even if it's very minimal; there should be something in place that addresses the issue of standard of care, correct?

MAHLMEISTER Yes, when it comes to demonstrating a failure to provide any standards, we have a strategy that demonstrates to a jury the lack of even a bare-bones minimum systematic approach. We ask three different people in the office to say how they would have answered the call and what their disposition would be. Each will say something different. And then we can say, "Do you see how not having had a basic training program, a basic set of guidelines, a list of problems, a policy of how to contact the doctor—how all this resulted in chaos, and why the patient fell through the cracks?"

How one establishes community standards is based on consensus among the providers in that community. However, the citizens in that community, and the patients who go to those local hospitals, should be able to expect that there is still some type of uniform approach to telephone triage.

EMPLOYER RISK AVOIDANCE

WHEELER: Do you have any recommendations for key steps an employer might do to avoid risk?

MAHLMEISTER: First of all, the new HIPAA guidelines require a training process for the process of how the individual answers the phone call, and begins the process of triage. There are cases evolving every day that involve accidental release of confidential information, or a family member calls about a concern and information is shared inappropriately.

Secondly, there has to be some—again, you've used the word and I'll use it—bare-bones guidelines so that the person taking the telephone call can identify potential or real emergencies and get that individual to the appropriate level of care as quickly as possible. Finally, there should be documentation of the process, so that should questions arise later, one can open the patient's medical record and see what happened and what was done about it. It never can be just word-of-mouth anymore; it has to be a documented process.

DIVIDING TASKS APPROPRIATELY: UAPs

WHEELER: Should any unlicensed assistive personnel or LVN or LPN be handling symptom-based calls?

SMITH: Absolutely not, and that's a slam-dunk. Absolutely, unequivocally no. I would never advise any hospital, any call center, any nurse, any employer to do this, because the employer's ultimately going to be responsible. So if the employer thinks that they're going to save a few dollars by employing clerical personnel, they've just bitten off more than they want.

WHEELER: Isn't this still a widespread practice? Aren't many doctors' offices using LPNs, LVNs and unlicensed assistive personnel to take calls that should be handled by a RN?

SMITH: Yes, unquestionably and especially with the shortage of RNs. My sense of it is that offices vary widely in their practice; they try to divide up what they perceive as clerical task—lab values, follow-up appointments and given those calls to clerical personnel. But we've all seen cases where abnormal lab values have reported to the patient as normal. It has implications beyond the lab

value.

If you told me you had clerical personnel calling patients for all the normal values, I would tell you I'm not too worried about it. If you told me your clerical personnel are calling about all values, including abnormal values, now I'm worried, now I think it's more risk than you want to take. And if you're talking about taking calls that are symptom-based, then it's clearly inadequate to have unlicensed personnel or LPNs rather than RNs.

MAHLMEISTER: Who is the best person to perform telephone triage? Some physicians have told me that they've trained their office staff --right off the street -- with no credentials to do telephone triage. They claim that they are better at triaging than the nurses. However, they have to understand that there is a huge vicarious liability; it's all on their shoulders. It is difficult to sue an office worker with a high school diploma who you say is going to be competent and capable to do triage.

Secondly, in some states, the boards of nursing are writing specific opinion statements, saying that an LVN or LPN cannot perform telephone triage. Two states that do allow it are Texas and California.

RIGHTFUL ROLE OF NURSE AND PROTOCOLS

MS WHEELER: What are your thoughts about guidelines versus protocol terminology?

MAHLMEISTER: Should we call it a standard or a protocol or guideline? I don't care if you call it " a nice to-do list"—when they project this "nice to-do list" on a large screen in front of a jury—and you didn't do these "nice things," there are going to be questions asked, and you're going to be accountable for the answers.

WHEELER: There still seems to be a controversy in telephone triage about whether paper or electronic protocols are decision-support of decision-making tools. My opinion is that they are decision-support tools and the bottom line is the trained, experienced nurse with good common sense.

MAHLMEISTER: Yes, protocols are only a support. Ultimately, you have to factor in the decision-making skills: clinical judgment, common sense, and what I call nursing intuition, for which there is scientific evidence. Nursing intuition is a sense of "knowing without articulating it," that something is not right. Nurses develop that ability over time. In fact, nurses have much more strongly developed clinical intuitions than doctors do. Although there are some exceptions.

For example, when you ask somebody what makes a good diagnostician, it's the fact that they're tapped into their intuition, combined with their clinical knowledge base, which makes them excellent diagnosticians. It doesn't matter whether you are using paper protocols or electronic decision trees, it is a support tool and the rest is the clinical judgment, common sense, and nursing intuition that really governs ultimately what the nurse does with that protocol.

Providing an Exit Strategy

WHEELER: So then, what effect does that have on the negligence issue? In other words, if the bottom line is not the protocol but the nurse's judgment, then it sounds like what you're saying is the protocol can never be found to be at fault. Could there be an area of risk to protocol developers as well?

MAHLMEISTER: The risk is not having an exit strategy. The same rule holds for any kind of

policy or procedure. Realize that nothing is ever written in stone; there are always exceptions to the rules. Guidelines are support tools. However, there must be an exit strategy that the nurse can employ when it is obvious she cannot follow whatever protocol, policy, algorithm, or decision tree she is using. Nurses should be trained to use it, and policies should address it. There needs to be an exit strategy with additional guidance, support, and back-up information.

So, okay don't follow that protocol; it doesn't make sense to follow it. What is that office's or call center's policy? This is crucial—a template for getting additional help when you can't follow the guidelines

On the other hand, you can't hold someone with absolute rigidity to an algorithm, protocol, guideline or a policy. There will always be exceptions to the rule. That's where clinical judgment and this intuition come into play. But the nurse in the call center or in the office does still need guidelines.

Developing a Continuous Quality Improvement Process

WHEELER: Are there any new areas of risk in the field you'd like to discuss?

MAHLMEISTER: We are finding problems in large call centers related to continuity. For example, patients will call nurses and tell them 'the doctor has never called me back'. The nurses know that according to their protocol, with certain types of problems, the physician provider has four hours to call back. There has to be a quality improvement tool to document provider non-compliance or difficulties with the protocols, for example.

So we need to develop a variance report form, or an unusual occurrence form, that nurses can use when they encounter problems with the system or the process, to begin the process of evaluating and fixing it. There needs to be a quality improvement tool where you can talk about near-misses and variances.

Awareness of Staffing Issues

WHEELER: Do you ever hear or have you ever read anything about safe staffing standards for telephone triage?

MAHLMEISTER: I often hear this magic number of about seven minutes a call.

WHEELER: Around 7 to 10 minutes per call sounds reasonable to me as well. That's around 48 to 60 calls per 8-hour shift. I wonder how often nurses involved in these cases are placed in an untenable position of having to answer more than 70 to 80 calls per shift. That's a huge volume of calls, and it makes it very difficult for any human being to conduct them safely and prudently.

BOX B: What are Telephone Triage Staffing Standards?

While there is no universally accepted standard for telephone triage staffing, the American Academy of Ambulatory Care Nursing states: "Adequate numbers of competent telehealth nursing staff shall be available to meet patient care needs. Staffing should be provided in sufficient numbers to address the quantity, quality and complexity of telehealth encounters."

In concrete terms, what does this standard imply? It means that the safe time frame for each call

will vary with the population served: with healthy, educated populations, the volume may be such that for every 60 calls, one nurse should be available. In elderly or high-risk, low-literacy populations, each nurse may only be able to handle 40-50 calls per shift.

At the moment, there is little or no research on staffing standards in telephone triage. Extrapolating from a comparable nursing sub specialty will be difficult. Perhaps we will need to compare our working conditions to those of Emergency Medical Dispatchers (EMD). However, new research on working conditions in healthcare sheds light on the issue of understaffing. There is a known direct correlation between nursing shortages and patient injury. (See Box C). However, just what constitutes a "shortage" in the telephone triage setting is still unknown.

Awareness of Human Error, Stress and Fatigue

WHEELER: Is it incumbent upon the employer to provide adequate coverage in the way of telephone triage staff?

MAHLMEISTER: This is one of the areas where they need to do what we call *human factors research*. They have done this research in other areas of clinical practice and in other high-risk industries.

In high-quality call centers, people have conducted informal studies, where they know what the limits are. They get feedback from the nurses, or they keep track of the number of near-misses and problems near the end of the day, when people are tired or distracted. They know when people are getting fatigued and need relief.

I know they've done some basic research on call times and call stress for EMS and 911 calls. How many calls can one individual take? There have been times when the emergency medical dispatcher has fallen asleep during a call, or their level of stress is so high that their response to the caller is inappropriate. In those cases, I often wonder: where were they in their day, and how many calls had they taken, and how fast were the calls coming in? We haven't even begun to ask those questions, but it's part of human factors research, and it revolves around the issue of fatigue. (See BOX C)

BOX C: ***Telephone Triage Working Conditions and Patient Safety***

Do the working conditions of telephone triage personnel contribute to the incidence of medical errors? A study performed in 2003 by the Agency for Healthcare Research and Quality (AHRQ) examined the effect that healthcare working conditions played in contributing to medical errors and patient injury. Researchers examined working conditions. Not surprisingly, they utilized categories from previous studies of the aviation and nuclear power industries, where human error can lead to serious error and harm. (AHRQ, 2003)

In the study, AHRQ found that working conditions either served as "resources that improve work quality" or as "demands that impede work quality". As illustrated in the summary of these factors below, currently, telephone triage work represents less than optimum working condition, possibly contributing to the potential for error and patient injury.

In reviewing the brief analysis below, bear in mind that telephone triage, as an emerging subspecialty, is still in the process of "consciousness raising" regarding standards, training, and a culture of safety, while simultaneously, making efforts to build the infrastructure required to provide the safety net for this practice.

- **"Workforce staffing (volume of work, professional skills and experience)":** Study results indicated that increases in staffing improved patient safety. In addition, increased experience on the part of staff led to a reduction in medical error. Research on telephone triage performed in the ED, showed that staff experience of 10 years or more in telephone triage lead to better decisions (Patel, 1995).

- **"Workflow design (job activities)":** Reductions in interruptions and distractions reduce error. Possibly with the exception of large call centers, many nurses perform telephone triage as part of a larger job description. In any nurse's job (ED, Office, Labor and Delivery), the potential for frequent interruptions is high. One strategy for error reduction might be a policy that stipulated that telephone triage task always be considered "dedicated" (performed to the exclusion of any other tasks) and formally assigned. Thus, the nurse on the phone is not responsible for any other tasks and is not to be interrupted.

  Another area which has never been adequately addressed, but which presents a major "disconnect" in the workflow, is the lack of feedback, a gap that could easily be remedied through the use of new technology. Telenurses work in a virtual vacuum – rarely learning outcomes of their decisions. This faulty design feature prevents the feedback loop, which allows nurses to learn from mistakes and thereby improving the process. As suggested by Smith, follow up calls and call backs are an invaluable risk management tool.

- **"Personal/social factors (stress, job satisfaction, and professionalism)":** Due to the nature of the work, telephone triage nurses, like air traffic controllers, can experience severe job stress. Patel notes that when people have time pressure, they utilize less information and make poor decisions. Overall, professionalism is beginning to remedy this work conditions through the development of unique telephone triage standards and certification.

- **"Physical environment (light, aesthetics, and sound)":** Unlike nurses working in large call centers, telepractice is diffusely practiced and largely, an unacknowledged subspecialty. Thus, the physical environment for telenurses varies widely. While some nurses enjoy the luxury of a specialized ergonomic workspace, many nurses labor under less-than-optimum condition: airless, windowless rooms, noisy hallways or offices, which offer little in the way of privacy or sound abatement. The physical environment can influence concentration and thus, decisions. Considering the type of concentration that critical thinking requires, it would seem that the workspace should resemble that of a physician's office as much as possible.
- **"Organizational factors (organization and process)":** Organizational deficiencies, such as partial or poorly designed standard, protocols and processes, still exist in many settings where telephone triage is practiced, thereby paving the way for potential error. The obvious lack of infrastructure described by the experts in this article, point to the need to remedy this gap.

PRACTITIONER RISK AVOIDANCE

WHEELER: And for telenurses, what key steps should they take to avoid risk?

MAHLMEISTER: Number one, use the protocols or guidelines. Number two, when they cannot follow the protocol—and there are always exceptions—immediately access the supervisor or provider for consultation or advice.

And then, thirdly, making sure that again, their documentation process is complete. So, for example, if they have to deviate from an established protocol, it's clear why they did what they did. It should be evident that there was a prompt and timely disposition of the problem.

When and when not to Utilize Audio taping

WHEELER: What about audio taping calls?

SMITH: The audiotape obviously can be your best friend or your worst enemy. In sophisticated telephone triage call centers, I think it makes good sense to audiotape calls—if you're taking thousands of calls in your call center, and you have sound protocols, training, quality management, and can apply the kind of analysis that needs to be done. However, if you're an office-based practice and taking a limited number of calls or just learning to do this, then I don't think audio taping is warranted, or even makes sense until you get good at it.

Electronic Documentation: Pros and Cons

WHEELER: Is documentation still the issue in telephone triage that it used to be?

SMITH: This may not be specific to telephone triage, but what I've seen in recent malpractice cases in the last 20 years is an increased emphasis on documentation. In the beginning of my career, we had to constantly nudge people to document. In the last 10 or 15 years, the documentation seems to have become dramatically better. People are aware of its importance, and it is consistently better across the board in almost every setting —hospitals, office or call centers.

What's happened in the last two or three years is sort of a double-edged sword. There's been a tendency to used computerized charting. Frankly, as a lawyer and from my own perspective, I am concerned about computerized charting. While it is more efficient, it tends to be less informative. So we see charting that is efficient and computerized, but in terms of trying to figure out what was going on with a particular patient we see less narrative notes, less handwritten notes. Sometimes a sort of "checklist mentality". I think the danger for nurses is to check the box, check the box, and check the box. It tells you a little bit, but it doesn't give you much meaningful information about what was going on.

I always tell people that if you're stuck with a computer—and I understand it saves time—please try to include some narrative notes, some observations. I'm a huge fan, particularly in a telephone triage setting; of using the patient's own words in quotes. So if you're not taping calls, quote patients directly.

MAHLMEISTER: In informal settings, where people have been writing the telephone triage encounter on a Post-It note and sticking that in the chart, that won't work anymore. Whenever possible, the telephone encounter has to go on an official form of some kind that the doctor, the midwife, the family practice has created, and it gets placed in the medical record permanently.

In an informal setting, the ideal would be to write in the progress note in the chart. Ideally, it should be a special form, whether you staple it in, paste it in, or tape it in. It can't be a Post-It note.

Charting by Inclusion vs. Exclusion

WHEELER: Do you have any opinions about charting by inclusion versus exclusion?

SMITH: There's really no defined legal standard as to whether it should be charting by inclusion or exclusion. I think the important thing is for a nurse to be able to say I maintained this as my practice or routine; I always do it this way or I always do it that way, by inclusion or exclusion. So, for example, if they're only documenting significant changes and everything else is presumed to be normal, then they should consistently apply that.

Obviously, the more information the better. A lawyer would like to see more information so they can tell what the nurse was thinking. For example, did he or she do a neuro assessment or evaluate other categories of problems that the nurse ought to be thinking about?

However, if the nurse doesn't have the time or ability to do that, and is only charting pertinent findings, I don't have any difficulty with that, as long as the nurse consistently applies the method and covers the right questions or the right issues in the assessment.

Telepractice from Home

WHEELER: What about the new trend toward nurses working from home, taking telephone triage calls?

MAHLMEISTER I believe the standard of care is the standard of care regardless of where the call is received, where it's intercepted and processed. If a registered nurse, for example, is carrying out that process in her home, the standard of care doesn't change. You still have to have guidelines or protocols or algorithms; you have to have an exit strategy for when the protocol doesn't apply; you have to have some kind of process in place for 911 calls—how to manage them, regardless of where you are. The process may be slightly different in terms of how you access certain emergency services, but it should be basically the same.

WHEELER: Which subspecialties carry the most risk in telephone triage – between OB, Internal Medicine, General Surgery, General and Family Practice, and Pediatrics?

MAHLMEISTER: I think some of the biggest risk is in General and Family Practice medicine, because they have to take everything. They are often managing Pediatrics, OB, Geriatrics, diabetics, and general medical patients. The person answering the phone may have a general knowledge of medical-surgical problems, but cannot transfer that general knowledge to a population of obstetric or pediatric patients who are outside the normal range of symptomatology and medications. So they get into trouble.

The overwhelming majority of the cases involving telephone triage that I take as an obstetric expert witness are in the family practice office setting. The patient eventually gets to an OB provider or a pediatric provider. However, if an infant is quickly developing severe jaundice and the person in the family practice setting says, "Well, you know, babies get yellow; this is normal," then we have a problem.

What if the caller says, "I think I need an appointment with an optometrist; I can't read anymore"? The first thing an OB nurse thinks is," Here is a woman having blurred vision, possibly due to preeclampsia." In a pediatric office, there would be a similar level of vigilance about certain types of parental complaints. The same goes for oncology patients. However, in a family practice setting, it may be too much to expect. How can you be all things to all people?

WHEELER: I think that you're saying something extremely important here, and it's revealing a new area of potential risk. In the OB and pediatric settings, triage personnel know the red flags and these personnel are highly sensitive; whereas the advice nurse in family practice may not be as aware.

Informed Refusal and the Duty to Terrify

WHEELER: Dan Tennenhouse coined the term "duty to terrify". It applies to the duty of the nurse to inform or apprise the caller of the seriousness of his or her symptoms. He states, "It is a duty based on the liability from an injury, to the noncompliant person, who claims that his or her noncompliance was due to an inadequate understanding of the urgency of the situation" (1988). Any last thoughts on the "duty to terrify" and why that's important?

MAHLMEISTER: "Duty to terrify" is the process of informed refusal and the standard to which the telenurse will be held. It is what we call the "reasonable patient standard." In other words, what would a reasonable, competent adult want to know about the risk of not following the advice? It is a more stringent and broader concept, meaning that you do have a duty.

In one case I know of, the staff members were saying, "We didn't want to frighten the patient'. That doesn't work anymore. So the new yardstick against which the precautions or the disclaimer is given is: what would a reasonable patient want to know? It is *not* what a reasonable provider *thinks the patient should know.* That has changed; that's a big reversal.

And, secondly, under that category of what a reasonable patient would want to know is the principle that the patient has a right to informed refusal, and the key word is *informed*. If you haven't told them what a reasonable patient would want to know, how could they give informed refusal?

WHEELER: What I tell nurses is to tell the patient something like, "The symptoms you've described to me sound very serious, or even maybe life-threatening. I need you to come to the Emergency Room within the next 20 minutes. Can you do that?"

I believe that statement provides a very clear message to the patient of the seriousness of the situation. My understanding is it's not enough to simply say, "You need to be seen in the Emergency Room." It really needs to be impressed upon the patient the seriousness of the situation by giving a specific time frame and getting his or her agreement. At the same time, it is important to not be so specific in your assessment that you seem to be making a diagnosis or prognosis.

MAHLMEISTER: That is correct. In common parlance, it's the duty to terrify, or informed consent based on what a reasonable person would want to know. When you say life-threatening and within a certain number of minutes, you are discharging your duty. It is not adequate to simply advise the patient to come to the ED.

Telepractice: AN ALL-OR-NOTHING PROPOSITION

WHEELER: Do you have any final thoughts to add?

SMITH: Lawyers get worried when people dabble in this. You can't have your foot halfway in the water and halfway out. In office settings, or in a hospital unit, nurses talk about the fact that they take calls, but they try to limit the call or they limit the advice. The reality is that once the call begins and you begin to dispense advice, you're in the water—you can't be halfway in and halfway out. You'd be better off in a hospital setting refusing to dispense any advice. It's an all-or-nothing proposition.

In a small doctor's office, the advice will depend on whoever answers the phone. There's no consistent uniform policy, and so it varies widely from person to person. Frankly, those are situations that are most at risk. When they're giving a little bit of advice and thinking that they're limiting their liability, they are not. Maybe they're doing it in a haphazard manner: whoever happens by picks up the phone; the documentation is a scribbled note on a telephone message pad. That situation is more prevalent in office settings than almost anywhere else; it is a very risky proposition.

Telepractice Risk Management: Best Practices

Finally, people ask, "How can I be certain I won't get sued?" The answer is you can never be certain. We live in a risk-filled environment. The minute you answer the call, you've assumed some risk, and that's always going to be the case. So the issue then becomes, how do you best protect yourself? Good training, good qualifications, good protocols, back-up physicians or back-up nurses; if in doubt, follow-up phone calls—in my opinion, these steps represent layers of protection.

To me, you're building a structure to protect yourself; that's what I mean by layers of protection. But remember, no matter how many layers you have, you're never going to be immune. However, I do believe in the concept of risk containment and risk management.

At the end of the day, you're not talking about eliminating risk, you're talking about managing and minimizing it, in the context of providing the best professional care that you can. Sometimes we lose sight of that reason. The containment of risk affords the best possible care and that's your ultimate goal.

William Langewieshe, pilot and writer, put it best, when he reflected on the role of system error in the crash of ValuJet 592, in which all 105 passengers perished. He refers to "blizzards of small judgments" made by mechanics who employed a " good old-fashioned pencil whipping"(which resulted in the fire that led to the plane crash). He refers to this action as "widespread form of the 'normalization of deviance'". Langwiesche laments the failure of large systems that create an "entire pretend reality that includes unworkable chains of command, unlearnable training programs, unreadable manuals, and the fiction of regulations, check and controls" (1998).

Langewiesche's remarks have clear implications for both the healthcare system and telephone triage. It is clear that telephone triage is a newly recognized sub-system within the larger healthcare system. As such, it too is vulnerable to "system error".

Risk is a fact of life in telepractice. Ignoring the risks or providing half-solutions only deepens the liability. True solutions rest in the awareness of potential pitfalls, and commitment to the painstaking process of building "reality based" risk management infrastructure to support the emerging field.