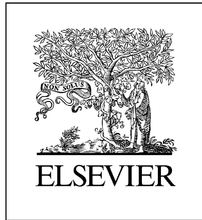

Telephone Nursing in Radiology: Managing the Risks

■ Carol Rutenberg, MNSc, RN-BC, C-TNP; and M. Elizabeth Greenberg, PhD, RN-BC, C-TNP

ABSTRACT: **Radiology is increasingly used in the clinical management of patients, many of whom are at risk for complications. Nurses in this setting are often responsible for patient screening, preparation, and postprocedure follow-up, much of which takes place over the telephone. This article will focus on patient care standards, common clinical pitfalls, and critical elements of care delivery over the telephone to help radiology nurses reduce the risks inherent in this practice. (J Radiol Nurs 2014;33:63-68.)**

KEYWORDS: **Telephone triage; Telephone nursing; Risk management.**

INTRODUCTION

The role of the nurses in radiology is growing in both presence and significance. Not only is the nurse responsible for patient monitoring during procedures but pre- and post-procedure assessment has also become an important element of care. Although the majority of the radiology nurse's (RN) time with the patient undergoing radiologic procedures is face-to-face, both before and after the procedure, telephonic interactions are often a significant element of care of the patient. These calls typically provide patient education and instruction, but as the role of the RN has evolved, they also involve monitoring for postprocedure complications. Identifying high-risk patients and performing postprocedure assessments usually takes place over the telephone, a difficult task because the nurse is not able to see or touch the patient. In light of the fact that radiologists are among the most often sued physicians (Irish, 2008) and the second most common cause of these suits is postprocedure complications (Cannavale, Santoni, Mancarella, Passariello & Arbarello, 2013; Chen & Nemeth, 2011), this challenging facet of telephone care by the RN is especially important.

Carol Rutenberg, MNSc, RN-BC, C-TNP, is from Telephone Triage Consulting, Inc., Hot Springs, AR; M. Elizabeth Greenberg, PhD, RN-BC, C-TNP, is from Northern Arizona University in Tucson, AZ.

Corresponding author. Carol Rutenberg, Telephone Triage Consulting, Inc., 118 Clover Ridge Court, Hot Springs, AR 71913. E-mail: carol@telephone-triage.com

1546-0843/$36.00

Copyright © 2014 by the Association for Radiologic & Imaging Nursing.

http://dx.doi.org/10.1016/j.jradnu.2013.12.004

Although the practice of telephone triage is growing in both scope and prevalence, in many settings, this practice is unrecognized. However, any nurse evaluating a patient over the telephone, even in the radiology setting, must be prepared to identify the nature and urgency of the patient's problem, which is the very definition of telephone triage (AAACN, 2011).

THE UBIQUITOUS TELEPHONE

Although education and training regarding interventions such as the administration of conscious sedation is a key element of training of the RN, competence in the use of the telephone is usually taken for granted. Perhaps because talking on the telephone is a skill we all learn in childhood, education regarding the provision of nursing care over the phone is often neglected in basic and continuing education for RNs. None-the-less, **nurse-patient interactions over the telephone do constitute the practice of nursing and are thus subject to the basic standards of nursing practice** (American Academy of Ambulatory Care Nursing [AAACN], 2011). Failure to adhere to the standard of care may result in poor outcomes and create unnecessary exposure to potential lawsuits for the nurse and the institution (Rutenberg & Greenberg, 2012).

Many of the calls made or taken by the RN may be routine. In fact, follow-up calls often focus on relatively common problems such as pain or bleeding; sometimes nurses even use procedure-specific checklists. These checklists, such as telephone triage guidelines, although helpful, may inadvertently limit the nurse's attention to anticipated complications and create an environment in which less common problems may be overlooked (Rutenberg & Greenberg, 2012). The prudent RN

must be prepared in each telephone encounter to identify and address a wide variety of potential problems. Even if the primary focus of the follow-up call is to measure patient satisfaction, RNs must be ever alert for unanticipated complications. And when problems do present, the nurse must perform an adequate assessment to determine the nature and urgency of the problem. Each call then, regardless of the overt intent of the contact, must be recognized as a potential telephone triage call, thus requiring use of the nursing process, the basic standard of nursing practice (Rutenberg & Greenberg, 2012).

To illustrate this point, let's contrast assessment in the face-to-face setting to the same assessment over the telephone. If the patient presents to the radiology suite with unusual bruising, cyanosis, dehydration, or other evident problems, the nurse will surely turn his or her attention first and foremost to the obvious problem at hand. In other words, much of the patient assessment in the face-to-face setting is performed automatically and without conscious effort. However, when providing care over the telephone, these types of findings won't be identified unless the nurse keeps an open mind and remains on the lookout for unanticipated and less than obvious problems. The nurse on the telephone must systematically assess the patient, looking not only for common potential problems but also being alert for uncommon problems as well. For example, although the patient complaining of a postmyelographic headache is likely experiencing a postdural puncture headache, the nurse must anticipate and assess the patient for more uncommon problems such as meningitis (Berlin, 2009).

The checklists are useful for the identification of common problems after interventional procedures such as delayed allergic reactions to contrast media, hematoma, or pseudoaneurysm. However, the nurse must look beyond the most common possibilities relying on his or her specialized critical thinking skills, to identify and address less common problems such as hemodynamic compromise or sepsis (Chen & Nemeth, 2011). The prudent RN should recognize such dire complications and bring the patient in for evaluation. However, if she or he isn't looking for unanticipated problems, they may go unnoticed until it's too late.

Nursing standards of care require that the RN perform an adequate assessment to recognize the nature and urgency of the patient's problem and develop an appropriate plan to achieve desired outcomes (AAACN, 2011). And, the job of the professional nurse doesn't stop there. Because the RN isn't in the position to physically intervene by providing care to the patient directly, the nurse must give attention to the patient's ability to carry out the plan of care based on factors such as their knowledge and existing resources (such as available transportation). Finally, implementation of a plan of care requires evaluation of the effectiveness of that plan, occasionally necessitating additional follow-up telephone calls.

Because many high-risk complications are difficult to anticipate and thus may often go unrecognized, they should routinely be anticipated and ruled out (Rutenberg & Greenberg, 2012). Attention to practice perils and pearls (discussed later in this paper) decrease the likelihood of a clinical oversight and thus increase patient safety.

TELEPHONE TRIAGE AND THE NURSING PROCESS

The nursing process provides the basis for professional nursing practice, regardless of the specialty or the setting. Nursing over the telephone requires attention to the same standards of care as nursing in the face-to-face setting and in fact is often associated with a higher risk, in that the RN can't see or touch the patient. In an effort to illustrate the depth, breadth, and significance of the telephone encounter, this article will address the nursing process in the context of the delivery of care over the telephone in the radiology setting.

Assessment

The first step of the nursing process can be mismanaged over the telephone. Nurses often focus directly on the task at hand (preadmission screening or postprocedure follow-up) without first performing an adequate assessment of the patient. Overfocusing on the preadmission or postprocedure form without first having an overview of the patient to identify any unanticipated problems could result in an inadequate assessment.

The bulk of the assessment that takes place over the telephone is subjective information reported by the caller, but an objective assessment can and should be performed when indicated. Objective data fall into two categories: parameters that the RN can assess directly using the sense of hearing and objective observations provided by the patient.

The first and most direct form of objective assessment would include audible assessment of the patient's respiratory efforts, neurological status, and affect. On occasion, background noises can be meaningful as well. The nurse can potentially hear tachypnea, dyspnea, coughing, hoarseness, or wheezing. Slurred speech, disorientation, confusion, or inappropriate conversation could point to a potential neurologic complication. If the patient sounds extremely sick or weak, this is also a red flag. Although this represents a subjective assessment, it's often based on objective observation of the patient's voice and speech patterns. Thus, affect, although not always possible to interpret accurately, can certainly be observed and reported, such as "patient's breathing

Download English Version:

https://daneshyari.com/en/article/2668025

Download Persian Version:

https://daneshyari.com/article/2668025

Daneshyari.com