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| **Name of Policy:** | **Triage Protocols And The Handling Of Phone Calls In The Ambulatory Setting**<br>**RUPPERT MEDICINE CLINIC** |
| **Policy Number:** | 3364-101-03-09E |
| **Department:** | Ambulatory Services |
| **Approving Officer:** | Associate Vice President<br>Associate Executive Director |
| **Responsible Agent:** | Administrator, Ambulatory Services & Behavioral Health<br>Director, Ambulatory Services |
| **Scope:** | Ambulatory Services |

THE UNIVERSITY OF TOLEDO

**Effective Date**: March 27, 2009

Initial Effective Date: February 1, 2008

_____ New policy proposal
_____ Major revision of existing policy
__X__ Minor/technical revision of existing policy
_____ Reaffirmation of existing policy

## (A) Policy Statement

Triage by phone will only be performed by the RN. Triage is defined as the assessment of the patient after pertinent information has been gathered via the phone, with the patient and/or significant other, and following standard protocols and determining the course of action. Only RNs may perform this due to their training in nursing process and critical thinking.

## (B) Purpose of Policy

To provide appropriate professional disposition to all triage calls coming into the Medicine Clinic and Medicine Sub-Specialties.

## (C) Procedure

1. All triage nurses will follow call process as stated in triage guidelines for Medicine Clinic.

2. Each call will be handled in a professional manner with the nurse identifying self with title to caller.

3. The RN will ask caller all related patient information, determine through education and experience the level of concern and urgency/severity of patient status and need for physician care. The physician driven template will schedule patient appointments. **If the patient is experiencing chest pain, shortness of breath, temperature above 102°, loss of consciousness, or new onset of the following: seizures, headaches, agitation, combativeness, threatens to harm him/herself or others, bleeding, loss of bowel or bladder control, paralysis, vision loss, speech loss, or severe pain, they should speak to a registered nurse or physician immediately.**

4. The RN will educate caller per, Telephone Triage Protocols for Adult and School-Age Populations with Women's Health and Infant/Child Protocols, 2nd Edition: Sheila Wheeler, RN, MS, Unit specific triage guidelines, or takes information and confers with Physician for advice.

5. When a patient appointment is needed, the appointment will be scheduled into MYSIS, under acute list when needed for same day appointments or with PCP when available.

6. All information will be documented related to the call the telephone triage progress notes.

7. The telephone note will be given to the physician for review and signature, then placed in the patient's chart.

| **Approved by:** | **Review/Revision Date:** 3/27/2009 |
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| Norma Tomlinson 3/31/09<br>Norma Tomlinson, RN, MSN, NE-BC — Date<br>Associate Vice President, Associate Executive Director<br>*Review/Revision Completed By:*<br>*Ambulatory Services* | **Next Review Date:** 3/1/2012 |
| **Policies Superseded by This Policy:** | |

*It is the responsibility of the reader to verify with the responsible agent that this is the most current version of the policy.*