Phone Advice

National Pediatric Nighttime Curriculum

Written by Jessica Myers, MD

Lucile Packard Children's Hospital at Stanford

Objectives

1. Identify the goals of phone advice
2. Review techniques for gathering medical information over the phone
3. Identify important components of phone advice documentation
4. Review options for management and disposition

Goals of Phone Advice

1. Answer simple medical questions
2. Advise disposition for a patient

(e.g., if needs to be seen immediately or can wait to be seen)

TRIAGE

*Diagnosis may **NOT** be necessary*

3. Recommend treatment if possible

Why is Phone Advice Important?

- 2/3 of calls from parents who initially intended to go to ED were deemed not urgent by call center
- 15% of calls from parents who intended to stay home were deemed urgent
- $50 per call saved if advice followed
- Statistically significant difference in satisfaction with care between parents using phone advice vs. other means

History over the Phone

- Get a call back number
- Start with most acute symptoms
- Use yes/no, either/or questions
- Avoid medical jargon
- Review problem list & PCP (confirm online if possible)

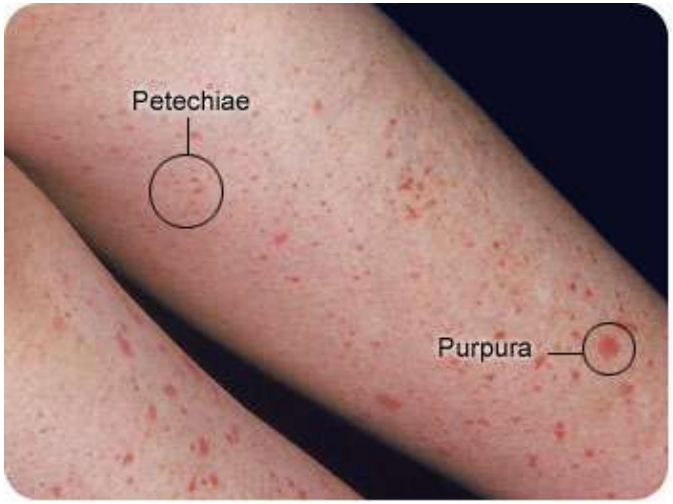
Social History

- May alter the patient's disposition

Social Factors – *RATE* the Patient	
• Reliability	○ Barriers from language, confusion, intoxication or limited education ○ Second-party callers ○ Truthfulness
• Abuse	○ Partner and elder abuse ○ Drug and alcohol abuse
• Travel Distance and Access	○ Distance from hospital and office ○ Access to car or other transportation ○ Ambulatory or bedridden
• Emotional	○ Anxiety, fear, hysteria

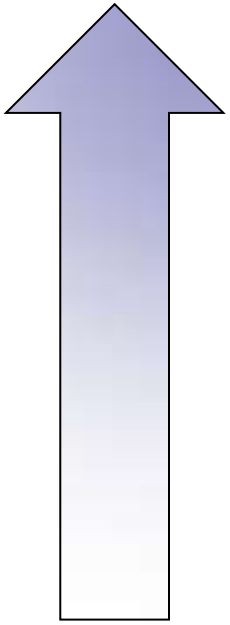
Physical Exam Over the Phone

- Mental Status
  - Sleepy, playful
- Respiratory
  - Cyanosis, respiratory rate, retractions
- Dehydration
  - Dry membranes
- Skin
  - Description of rashes



Management Options

- Where to Triage:
  - 911
  - ED immediately
  - Urgent Care
  - PCP next day
  - Phone follow up
  - Home care



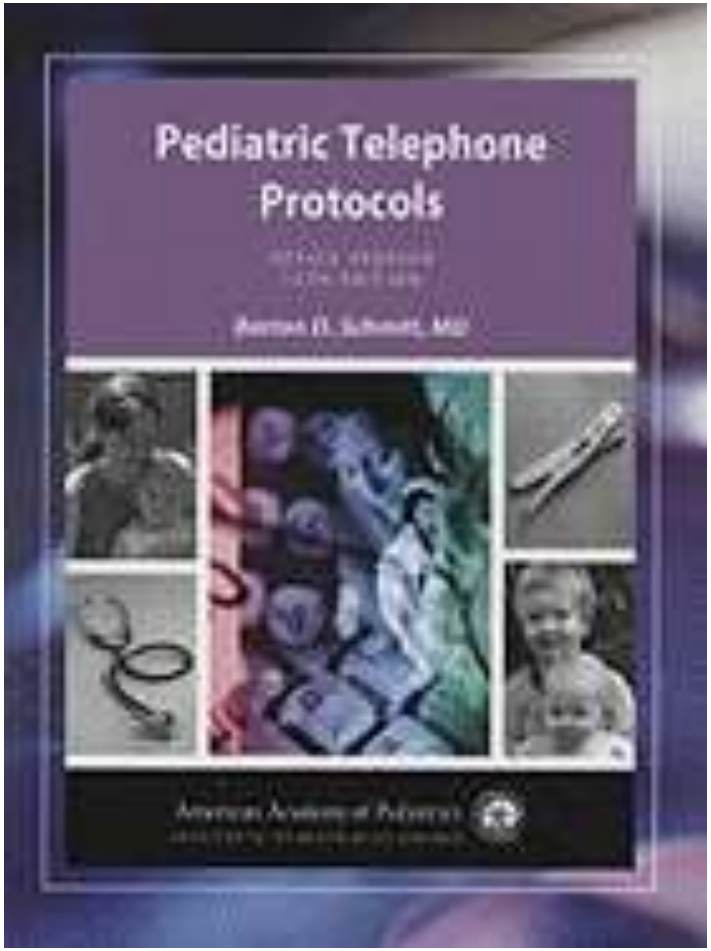
Severity of Symptoms
(remember patient's condition may change)

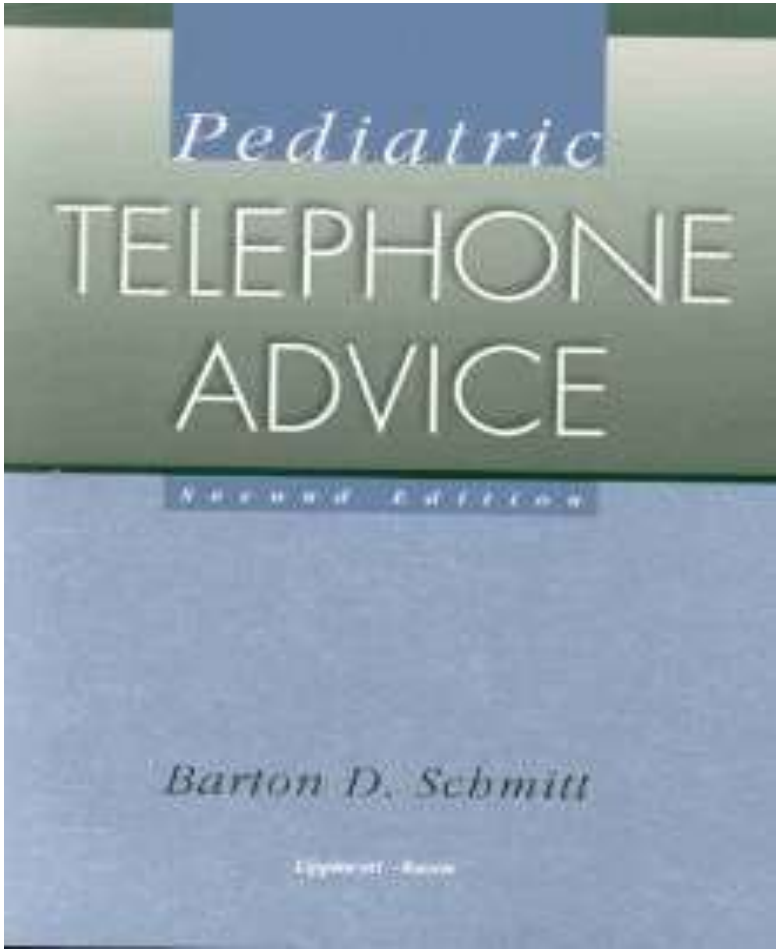
- Prescriptions: Simple prescriptions or refills
- **ALWAYS** review precautions
  - Signs/symptoms for the parents to be aware of and return to medical attention if present

Documentation Tips

- Name of caller, relationship, patient DOB
- Medication dosages if
  - Specific medication question
  - Adverse reaction or side effect suspected
  - Calling in prescription, include pharmacy name
- Allergies if
  - Chief complaint of rash
  - Recommending treatment
- Specifics of disposition and call back reasons
  - Name of PMD for follow up, when phone follow up done
  - When 911 was called, name of emergency room

Resources: Barton Schmitt Manuals





No financial conflicts of interest to disclose

Resources: Barton Schmitt Manuals

Earache

- SYMPTOM DEFINITION -
* Pain or discomfort in or around the ear * Child report
nonverbal child acts like he did with previous ear infec
and awakening during a cold) * Includes child who rec
an ear infection and an earache has returned * pain is not due to a traumatic injury

Determining severity

- INITIAL ASSESSMENT QUESTIONS -
1. LOCATION: "Which ear is involved?" 2. ONSET: "When did the ear start hurting?"
3. SEVERITY: "How bad is the pain?" (Dull earache vs screaming with pain)
- MILD: doesn't interfere with normal activities - MODERATE: interferes with normal activities or awakens from sleep - SEVERE: excruciating pain, can't do any normal activities
4. URI SYMPTOMS: "Does your child have a runny nose or cough?" 5. FEVER: "Does your child have a fever?" If so, ask: "What is it, how was it measured and when did it start?" 6. CHILD'S APPEARANCE: "How does your child look?" "What is he doing right now?" 7. CAUSE: "What do you think is causing this earache?"

- BACKGROUND INFORMATION -
CAUSE * Usually due to an ear infection (otitis media) * Ear infections peak at age 6 months to 2 years * The onset of ear infections peak on day 3 of a cold
AAP GUIDELINES: TREATING MILD OTITIS MEDIA WITH ANALGESICS RATHER THAN ANTIBIOTICS (200 * Because of rising antibiotic resistance, recent AAP clinical practice guidelines (2 for courage the use of antibiotics for non-severe ase
* 'Non-severe otitis is defined as MIL ever). The safest age group for observation is children over age 2 years. * If all 3 criteria are present, these children can be offered symptomatic care and safely observed for 48 to 72 hours.
* In follow-up, ear symptoms improved in 60% by 24 hours and resolved spontaneously in 75% by 7 days.
* This approach assumes that all children with ear pain are examined but the AAP does not give a timeline. * If the children over age 2 years with mild earache and no fevers were seen within 72 hours during office hours (rather than within 24 hours), many weekend ED referrals could be prevented.
* The 2008 Earache guideline now uses these recommendations to defer visits of low-risk children with earache until office hours. Again, the 3 low risk factors used in the guideline are: age > 2 years, MILD otalgia (earache) and no fever (rather than the AAP cutoff of fever < 102 F or 39 C).

AAP Guidelines

- TRIAGE -

See Physician within 4 Hours (or PCP triage)

[1] SEVERE pain (excruciating) AND [2] not improved 2 hours after analgesic eardrops and ibuprofen
R/O: severe otitis media, severe head
CA: 53,13,14,3,8,7
[1] Pink or red swelling behind the ear AND
R/O: mastoiditis
CA: 53,2,8,7
Walking is very unsteady
R/O: associated labyrinthitis CA: 53,8,7

Concerning symptoms

- CARE ADVICE (CA) -

1. REASSURANCE: Your child may have an ear infection, but it doesn't sound serious. Diagnosis and treatment can safely wait until morning if the earache begins after office hours.

2. PAIN OR FEVER: For ear pain or fever > 102 F (39 C) give acetaminophen every 4 hours OR ibuprofen every 6 hours, as needed. (See Dosage table)

3. LOCAL COLD: - Apply a cold pack or a col r 20 min. to reduce pain while medicine takes effect - al heat for 20 minutes - (CAUTION: hot or col burn or frostbite.)

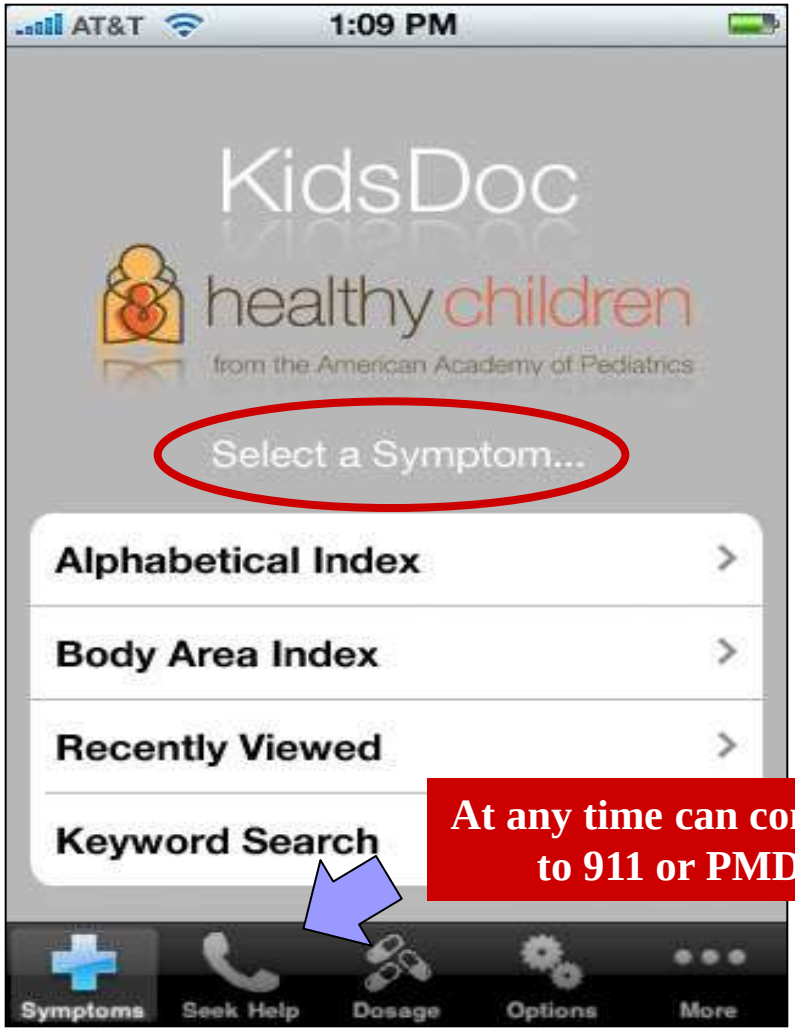
4. ANALGESIC EARDROPS: (Requires PCP prior approval) - (Exception: ear discharge, ear tubes or hole in eardrum) - If severe pain or earache unresponsive to oral pain medicine, call in a prescription for generic analgesic eardrops. - Instill 3 drops every 4 hours as needed. - CANADA: Use Auralgan eardrops for severe pain. Available OTC in Canada.

5. EAR DISCHARGE: - If pus or cloudy fluid is draining from the ear canal, this means the eardrum has a small tear in it caused by the pressure. - This usually heals nicely after the ear infection is treated. - Wipe the discharge away as it appears. - Avoid plugging with cotton. (Reason: retained pus can cause infection of the lining of the ear canal)

6. CALL BACK IF: Severe pain persists > 2 hours after analgesic eardrops and

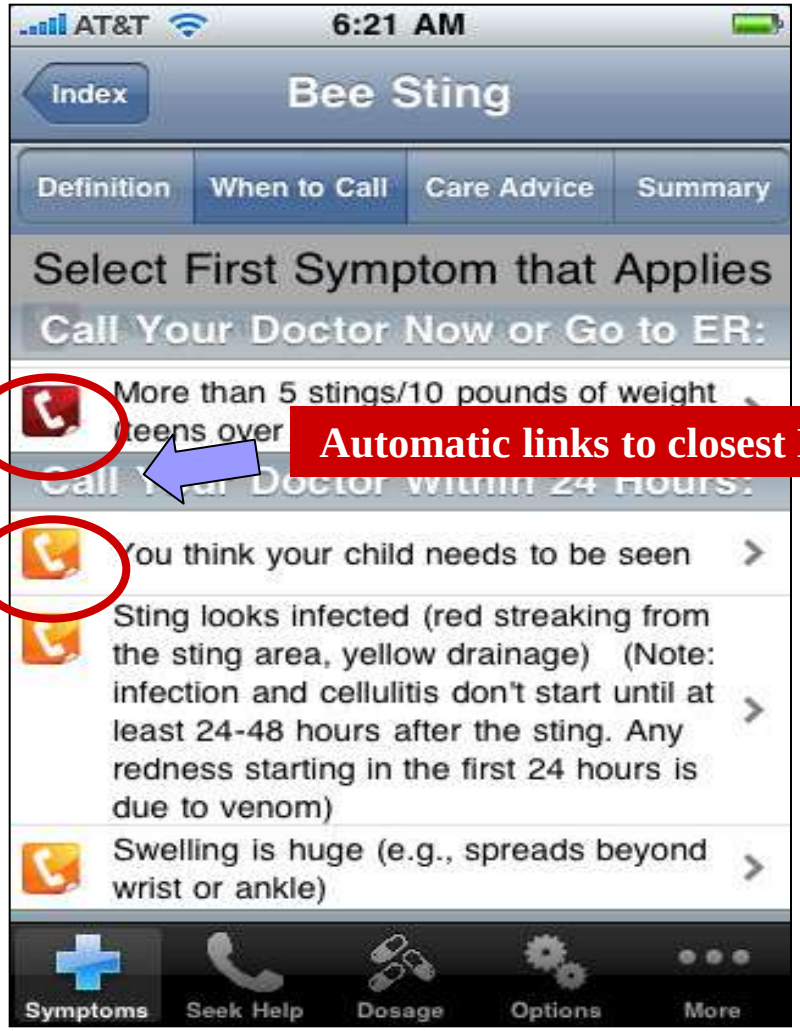
At home care advice

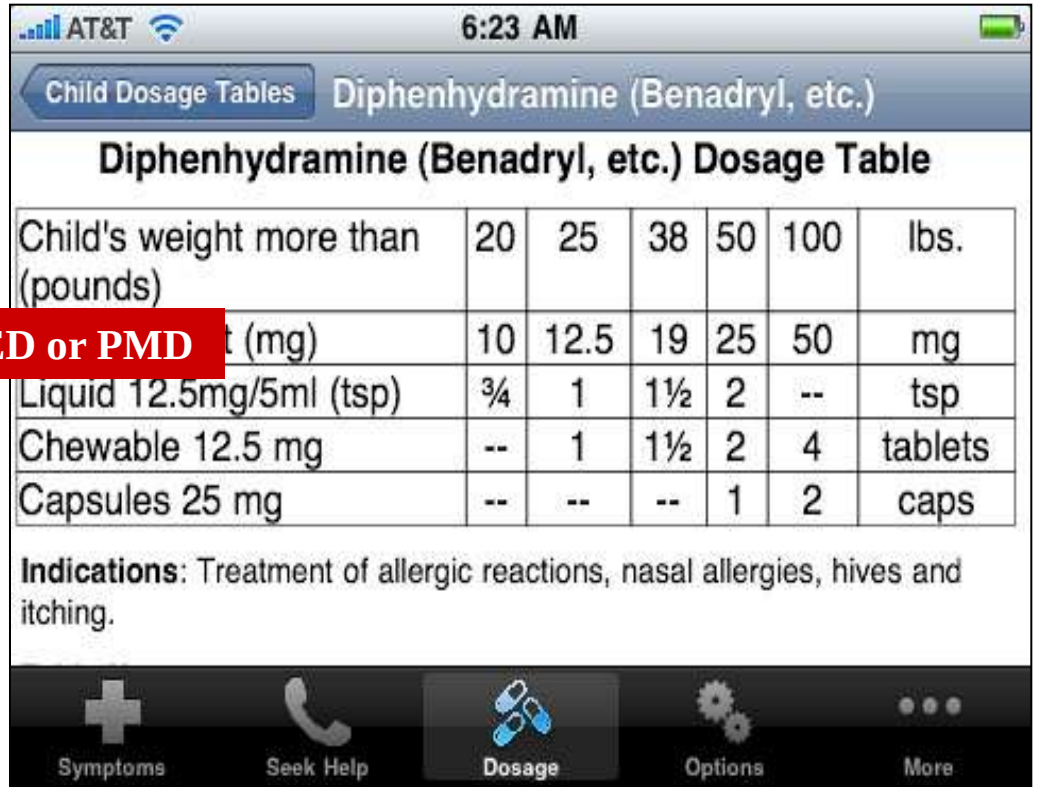
Resources: KidsDoc



At any time can connect to 911 or PMD

Resources: KidsDoc





Case 1

You are the resident on-call and take the following phone advice call from a parent.

"Eva has been spitting up."

What do you want to know?

What is your advice?

Case 2

You are the resident covering after hours urgent care and take the following phone advice call from a patient's parent.

"Billy has a rash all over"

What do you want to know?

What is your advice?

Case 2

30 mins later, Billy's mother calls crying…

"Billy still has a rash, but now he is having a hard time breathing"

What is your advice now?

Case 2: Sample Documentation

Patient: Billy Jean
Caller: Mary Jean
Call back number: 650-555-9876

DOB: 9/1/2008
Relationship: Mother
Date/Time: 3/4/11, 10:05pm

ID: 3 year old male, previously healthy, with rash x 6 hours

HPI: Rash is generalized, worse on trunk, spares palms and soles. No fever. No difficulty breathing and no wheezing. Some extremity swelling, no lip swelling. Patient had a bite of mother's shrimp at dinner 2 nights ago. Mild cough and runny nose

PMH: PCP: Dr. Jackson. Seen last week for AOM

MEDS: Amoxicillin 480mg PO BID, finished 2 days ago

ALL: Mother unsure

SOCIAL: Sick contacts at daycare. Family lives 90 minutes from emergency room. Has access to neighbor's car.

Case 2: Sample Documentation

EXAM:

- No fever, respiratory rate counted by mom is about 20

- Doesn't hear any audible wheezing and no retractions

-Rash described as small pink flat dots, initially discrete but now dots are merging together. When mom presses on them the pink turns white. Rash is worse on the trunk and back, also extends to extremities.

IMPRESSION: Generalized rash, no respiratory distress, no urticaria. Likely viral exanthem given URI sxs.

PLAN:

-Follow-up with PCP, Dr. Jackson, within 24 hours

-Call back if any difficulty breathing, lip swelling, or concern that patient is getting worse

-Mother agrees with plan

Case 2: Sample Documentation

Patient: Billy Jean
DOB: 9/1/2008
Caller: Mary Jean
Relationship: Mother
Call back number: 650-555-9876
Date/Time: 3/24/11, 10:35pm

ADDENDUM: Patient's mother called 30 minutes after initial call stating that the patient now has a respiratory rate of 55 with audible expiratory wheezing.

IMPRESSION: 3 year male, previously healthy, with respiratory distress, wheezing, and generalized rash concerning for allergic reaction.

PLAN:

-Patient's mother called 911 on her cell phone. Continued to stay on the line with mother and advised "sniff position".

-Ambulance arrived at 10:44, Epinephrine administered by EMS, patient taken to local emergency room.

Take Home Points

1. Determining severity and triaging are often more important than making the diagnosis
2. Be specific and descriptive when gathering information over the phone
3. Management depends on symptom severity and patient's condition, which may change over time
4. Never underestimate ***GUT FEELING*** on either end of the telephone

References

- Bunik M, Glazner JE, Chandramouli V, Emsermann CB, Hegarty T. Pediatric telephone call centers: how do they affect health care use and costs. Peds,119(2): 305-13, 2007.
- Carbajal R, Barthez P, Viala J, Manceron V, Oliver-Martin M, Simon N. Evaluation of pediatric advise asked by telephone in emergency units. Arch Peds. 3(10): 959-63, 1996.
- KidsDoc Symptom Checker. American Academy of Pediatrics. http://www.healthychildren.org/english/tips-tools/symptom-checker/Pages/default.aspx, 2010.
- Oberlander TF, Pless IB, Dougherty GE. Advice seeking and appropriate use of a pediatric emergency department. Am J Dis Child, 147(8): 863-7, 1993.
- Schmitt, BD. Pediatric Telephone Protocols: Office Version, 12th Edition. American Academy of Pediatrics, 2008.
- Schmitt BD, Thompson DA. Triage Documentation: Setting a Best Practice. http://www.answerstat.com/articles/5/42.html, 2005.
- Thompson T, Stanford K, Dick R, Graham J. Triage Assessment in Pediatric Emergency Departments: A National Survey. Ped Em Care, 26(8):544-548, 2010.
- Wood PR. Pediatric resident training in telephone management: surveying programs in the United States. Pediatrics, 77:822-825, 1986.