

Structure of a Tele-Support RNCM Call

April 20, 2020

Structure of a Tele-Support Call

Introduction and Specialty Program Identification

Failure to clarify your role creates risk of misrepresentation

NAME OF PROVIDER ORGANIZATION, I AM A NURSE with (Specialty Program if applicable)

Notification and Identification

Failure to fully verify results in a mishandled call.

Verify all relevant patient/caregiver information in the electronic health record (EHR).

Every call must stand on its own – prep your Telesupport patients. Educate with all calls, to safe guard information, you will need to always ask for these details.

For all outbound calls, we must notify call may be recorded.

This is (XXX State Law - if applicable).

Patient safety initiatives requires identifiers (two) for both the patient AND caller (if it is a caregiver or family) PRIOR to discussing PHI.

You must always obtain:

1. Full name
2. DOB of the patient
3. Verify DOB in chart

If caller is not the patient, you must obtain:

1. First and last name of the caller
2. Relationship to the patient.
3. Verify information in patient contact list

3rd Party Caller – at the beginning of the call you must obtain:

1. Caller's first name
2. Title (RN, LVN, pharmacist, med tech, etc.).
3. Location
4. Phone #

**Always ensure the patient's identity has been fully verified.*

Scripts for Opening the Call

Inbound Calls: Transferred call

NAME OF PROVIDER ORGANIZATION, this is _____. I am a nurse. How may I help you? Nurse obtains patient name and DOB in the (EHR) and asks "How may I help you?"

If necessary, ask the caller "Will you please repeat your full name and DOB to assure I am in the correct chart?"

The goal for the inbound nurse is to handle the call if at all possible, especially symptom based calls!

Outbound Calls

Calls to a Patient: "Hello, this is Nurse _____ with NAME OF PROVIDER ORGANIZATION. This call is recorded for quality." (if applicable). "May I speak with _____?" (ask for patient using first and last name). "May I have your DOB to assure I am in the correct chart?"

Scripts for Opening the Call

Number dialed and stated name of facility count as identifiers. Now you must verify patient information.

Acknowledge reason for call or purpose for outbound call; take ownership and provide an EMPATHY Statement

Outbound Calls (continued)

Calls to caregiver/family: "Hello, my name is (NAME), a nurse with NAME OF PROVIDER ORGANIZATION",. "Is this" or "may I speak with" (full patient name)?" "Before we start I need to let you know this call is recorded for quality." (if applicable). "May I please have your full name and relationship to the patient? To assure I am in the correct chart will you please repeat patient's full name and DOB?"

Calls to a third Party: (Third party answers). "Hello, my name is (NAME), a nurse with NAME OF PROVIDER ORGANIZATION. This call is recorded for quality." (if applicable). "May I have your first name and title?" (Response). Remember to also ask for FACILITY NAME if not provided when call was answered. "I need to ask you a few questions about (PATIENT'S NAME). To assure we are both looking at the same patient information, would you mind repeating the full name and DOB? Thank you."

Stating the purpose of the call (what is important for the patient to discuss) or acknowledging the chief complaint/reason for inbound call, helps clarify, provides validation; builds rapport and may help put the caller at ease.

Examples of ownership and empathy statements:

- This call supports our scheduled visit in order to check in on your health and see how we can help support you.
- I am calling to complete our regularly scheduled visit to see how you are doing. Is there anything in particular you would like to discuss today?
- That sounds very uncomfortable, let me see how I can help
- I'm sorry to hear that. I will be able to help you with that today
- That must be frustrating, let me take care of that for you.
- I'm sorry that this happened and I will do my best to fix this situation
- That sounds very uncomfortable, let me see how I can help
- I am sorry you are dealing with that, we can help.
- I am sorry you are not feeling well, let me see how I can help"
- I understand, I would like to see if I can fix that for you

Preliminary Assessment

Assessment is the first step of the clinical process.

Actively listen for a sufficient amount of time. Hear the patient out without interrupting.

Assessment often provides a quick way to establish urgency.

Assessment helps identify the correct specific symptom based protocol or guideline.

Assess the presenting symptom in detail and within the context of the patient history and current situation (primary assessment including verification of back story).

Start with the preliminary assessment questions for sense of direction, which will lead you to the most appropriate protocol.

Goal: To Elicit Information

Perform a structured assessment utilizing the prompts below to obtain a comprehensive and well-informed understanding of the situation:

Symptoms

- What are the primary and associated symptoms?

Characteristics

- Obtain qualitative and quantitative descriptors of severity of the symptoms. Are the symptoms better, worse, or same?

History

- What was done in the past? How were these symptoms managed?

Onset

- When did the symptoms start? Was it gradual or sudden (Note - sudden onset tends to be more serious).

Location

- Is the pain localized or more generalized? (Note localized pain tends to be more serious than generalized pain).

Aggravating Factors

- What makes it worse?

Relieving Factors

- What makes it better?

Activities of Daily Living - Always compare current ADLs with baseline state:

- Intake (fluids, foods),
- Output (urine, emesis, BM, diaphoresis: quality and quantity)
- Activity level (compare to normal daily activities)
- Mood (marked change)
- Color (pale, red, blue, grey, ashen)
- Skin (turgor) lips/tongue

For aphasic, elderly or extremely poor historians - Always include the following assessments:

- Any extreme behaviors
- Difficult to awaken or keep awake
- Affect: is the affect appropriate?
- Movement: Is there little or no spontaneous movement?
- Eye contact and ability to focus

Obtain the patient history -

- Recent History - What is the recent history of any of the following? (Injury, ingestion, infection or illness, international travel, immune compromised)
- Allergies - What allergies does the patient have to medications or others (food or other substances etc).
- Medications - What medications is the patient taking? Are there any concerns or issues with medication regimen?
- Pregnancy/Breastfeeding - Is the patient pregnant or breastfeeding?

Preliminary Assessment (Continued)

Assess the severity/acuity of the presenting symptoms/situation -

- Severe, suspicious and strange - *Severe (i.e., high pain 8/10 or vomiting 8 x in the past 4 hours,).
- Strange - Novel, atypical, unusual, worst, new, sudden, unexpected, or recurrent.
- Suspicious - "Big Six" head, chest, respiratory, abdomen "flu" and dizziness.
- Age - Patients who are 55 years and older are placed in a higher severity level; females between the ages of 12 and 55; and males over 35.
- Veracity - 2nd or 3rd -party caller, speaks no English, aphasic or confused elderly, drugged or confused state
- Emotional State - Anxiety, or denial, previous psychiatric history, severe reaction to current illness. Multiple calls are a high alert that something is wrong!
- Debilitative/Distance - Clients with chronic disease or living a great distance or traveling at peak traffic time.

Impression of Symptoms and/or emergent complications (Red Flags)

Your impression or working diagnosis can help determine severity; disposition and the most appropriate symptom based protocol.

Active symptoms are potential emergent complications (Red Flags) and most likely will take priority over other routine care delivery.

To formulate an impression of symptoms, several components must be present:

- A symptom-based, generic protocol title (abdominal pain, nose bleed) and/or optional classifiers (severe, moderate, mild) as well as presumptive terminology (possible, apparent, unknown etiology).

Do not try to diagnose the symptoms or establish a cause for them.

- A working diagnosis or impression is defined as a provisional estimation of the seriousness of the symptoms
- Examples: "Severe nose bleed, etiology unknown," or "moderate abdominal pain, possibly related to constipation."
- CHF disease management knowledge deficit related to medication management, diet management, awareness of disease progression

Use NAMED PROVIDER ORGANIZATION Symptom Management Protocols as appropriate

Choose the protocol for the symptom that seems most serious, or choose the generic guideline (change in condition)

Ask the remaining questions

Advance Care Planning/GOALS OF CARE DISCUSSIONS

Assure you know what the patient's health care related goals are prior to providing advice

Separate goals from care, personal goals evolve with knowledge of disease state.

Steps to support Advanced Care Planning:

- Personal goals
- Updates on illness state and prognosis
- Update of personal goal
- Opportunity to explore end-of-life care planning
- Documentation or modification of end-of-life care plans: POLST, DPOA.

Prior to Intervention/Disposition/Advice assure you have:

- Identified the patient's health care goals?
- POLST?
- Healthcare Directive? (DNR/comfort measures only or Full Code/aggressive care).

Has there been a change in condition? Do goals need to be readdressed? Remember goals may be long term or they may be fluid and can change from visit to visit.

Disposition and advice will be significantly different for a terminally ill patient with the desire to die comfortably in their own home; does not want to return to the hospital and wants comfort measures only versus a terminally ill patient seeking aggressive care.

Ask! What do you want to do in the next few days, weeks, month? What matters most to you?

Personal goals → Updates on illness state and prognosis → update of personal goals → opportunity to explore end-of-life care planning → documentation or modification of end-of-life care plans: POLST, DPOA.

Understanding - Has your care team talked with you about your prognosis? What questions may I answer for you?

Reflecting - What are your hopes and fears of what is to come?

Discussing - How would you like to spend your time?

Formulating a plan - Is it more important to you to possibly access additional treatments (that may or may not be helpful) or would you prefer to be as comfortable as possible?

Coaching

Chronic Disease Management

Facilitate self-management of advanced chronic illness through coaching and patient/caregiver empowerment

Use Provider Organization policies/procedures to facilitate patient education.

- Ensure educational tools are health literate.
- Utilize a language line for translation.

Terminal Disease Management

Hospice providers utilize their specific clinical policies/procedures

Intervention/Disposition/Advice

Duty: To Facilitate Shared Decision Making

May include a 24-hour medication review and medication management instructions

- Home care instructions provided

May include need to change or increase in medications for change in condition

- Page MD, dispatch RN and home care instructions

May need next day follow up

- Home care instructions provided, next day RN visit requested or f/u with MD

MD visit next day or next business day

- Home care instructions/MD Page/appt next business day

Follow-up Instruction

Provide adequate instructions about symptom management.

Provide call back instructions:

- To avoid a delay in care, patients must be taught how to monitor their progress effectively and to call back within a specific time frame if the symptoms fail to improve.
- Possible complications
- A time frame within which to call back if there is failure to improve
- Always instruct patients to call back if further questions arise or home
- Treatment fails to work
- Final Instruction – “always call back if you experience new or worsening signs or symptoms.”

Teach Back and Contract

Goal: To Communicate Significant Information & Verify Understanding

Teach-back is a way to confirm that you have provided the information the patient needs to know in a manner that the patient/caregiver understands

- Reinforces what was taught because patient has to put teaching in own words
- Verifies understanding

A contract is an agreement entered voluntarily by two or more parties.

- Does the patient or caregiver agree to the plan?
- Will you call me back if the medication does not seem to be working in one hour or sooner for worsening?

Documentation

Bold sections are required

Areas not documented, are to be deleted from documentation

Call out urgency and next day needs above template details, first line of documentation.

Clinical Triage

Situation: Patient is a *- year -old -male/female with the chief complaint of *

Position: *
Patient call: *

Background:

Primary diagnosis: *

Allergies: +

Related medications: (include new and/or recently discontinued meds): *

Assessment: (include symptoms, characteristics, course, onset, location, aggravating and relieving factors). *

Recommendations/Plan: * (include any recommendations/intervention/instructions/teach back

Disposition: * (include statements such as “home care advice provided or home care advice provided/rn dispatch, etc.)

Patient or caller verbalized agreement to plan: * (patient understands and agrees with advice provided, “yes”)

Protocol: * (list protocol used and referenced – should be the same as your wrap up code)

Soft Skills, Reminders and Tips

- Remember the patient can talk all they want, however prior to giving any advice you will need to obtain patient and caller identifiers. Don't get fixated on obtaining the identifiers first if caller has urgency – listen, ask questions and then obtain identifiers.
- Complete a chart review to include: Dx, co-morbidities, medication profile, last nurse visit, multiple calls, and Advanced Care Plan (ACP) or POLST
- Vocalize your actions when there is dead space, i.e., **"I am locating Mr. Smith's chart; this may take just a moment."** Avoid saying, **"my computer is slow"** or **"I can't find you in the computer."** (This decreases confidence and adds additional stress for the caller).
- Manage the focus of the call – focus on chief complaint and assessment process. Be prepared with scripts to help pull caller back on track. **"I am sorry you are having problems with the mailman, but I am really worried about your stomach pain right now – when did your pain start?"**
- Never leave a detailed message – ever. You may say **"This is _____ from NAMED PROVIDER ORGANIZATION, Please return my call at _____."** or **"I will call back within the hour."** Do not indicate who you are trying to reach or why you are calling.
- Always ask if there is anything else. **"Is there anything else I can help you with or you are concerned about?"** You may modify to fit the situation, i.e., **"Anything else?"**, **"Do you have any other questions?"** or **"Have I answered all of your questions today?"**
- Conclude your call by thanking the caller, i.e., **"Thank you for calling"** or **"Thank you for taking my call."**

**Remember hospice services include care and support for direct caregivers/ family members.*

Structure of a Tele-Triage Call

April 20, 2020

Structure of a Tele-Triage Call

Introduction and Branding

Failure to clarify your role creates risk of misrepresentation

"Name of PROVIDER ORGANIZATION"

■ I AM A NURSE

Notification and Identification

For all outbound calls, we must notify call may be recorded. This is (XXX State Law - if applicable).

Failure to fully verify results in a mishandled call.

Patient safety initiatives requires identifiers (two) for both the patient **and** caller (if it is a caregiver or family) **PRIOR** to discussing PHI.

Every call must stand on its own

You must always obtain:

1. Full name
2. DOB of the patient
3. Verify DOB in chart

If caller is not the patient, you must obtain:

1. First and last name of the caller
2. Relationship to the patient.
3. Verify information in patient contact list

3rd Party Caller – at the beginning of the call you must obtain:

1. Caller's first name
2. Title (RN, LVN, pharmacist, med tech, etc).
3. Location
4. Phone #

**Always ensure the patient's identity has been fully verified.*

Scripts for Opening the Call

Responding to Inbound Calls

"Name of Provider Organization", this is _____. I am a nurse. May I have the patient's full name and date of birth?" (Caller responds). "Thank you, and what is your **full name and relationship** to the patient? How may I help you?" (Caller responds). "I am sorry to hear you are having more pain today."

"Name of Provider Organization", this is _____. I am a nurse. How may I help you?" (Caller responds). "To clarify, your primary concern sounds like pain. Let's see what we can do to fix that. May I first get the patients full name and date of birth?" (Caller responds). "Thank you, what is your full name and relationship to the patient?"

Making Outbound Calls

Call to a Patient: "Hello, my name is (Name) and I am a nurse with "Name of Provider Organization", May I speak with (ask for patient using first and last name)." "Before we get started, I need to let you know this call is recorded for quality (if applicable). May I have your DOB to assure I am in the correct chart?"

Call to a caregiver: "Hello, my name is (Name), a nurse with "Name of Provider Organization",. "Is this" or "may I speak with" (full patient name)? "Before we start I need to let you know this call is recorded for quality." (If applicable). May I please have your full name and relationship to the patient? To assure I am in the correct chart can I get the patient's full name and DOB?"

Rerunning Inbound Calls

Return call to a patient at home "Hello, this is (Name) the nurse with "Name of Provider Organization", calling you back. Because this is a new call I need to let you know this call is recorded for quality. (If applicable) And to assure I am in the right medical record chart can I get the patient's full name and DOB one more time. Thank you and your full name and relationship to the patient one more time as well. Thank you".

Return Call to a Third Party "Hello, this is (Name) the nurse with "Name of Provider Organization", calling you back. Is this "Ashley the med tech at the River's Edge?" Because this is a new call I need to let you know this call is recorded for quality. (if applicable) And to assure I am in the right medical record chart can I get the patient's full name and DOB one more time. Thank you".

**Note: Because we dialed the phone # that they gave us on the first call, we do not need to obtain it on a return call.*

Acknowledge reason for call, take ownership and provide an empathy statement.

By providing a genuine empathy statement while acknowledging the chief complaint validates and confirms purpose of call, builds rapport and may help put the caller at ease.

Examples of ownership and empathy statements:

- That must be frustrating, let **me** take care of that for you.
- I'm sorry that this happened and **I** will do my best to fix this situation
- I'm sorry to hear that. **I** will be able to help you with that today
- That sounds very uncomfortable, let **me** see how **I** can help
- "I am sorry you are dealing with that, **we** can help.
- " I am sorry you are not feeling well, let **me** see how I can help"
- "You must be feeling pretty frustrated, let's see what **we** can do to help"
- I'm sorry that happened, let **me** see how **I** can help
- I understand, I would like to see if **I** can fix that for you
- Ok, Let **me** get that taken care of for you

Preliminary Assessment

Assessment is the first step of the clinical process.

Actively listen for a sufficient amount of time.

Hear the patient out without interrupting.

Assessment often provides a quick way to establish urgency.

Assessment helps identify the correct specific symptom-based protocol or guideline for care delivery.

Assess the presenting symptom in detail and within the context of the patient history and current situation

Start with the preliminary assessment questions for sense of direction, which will lead you to the most appropriate treatment protocol.

GOAL: To Elicit Information

Perform a structured assessment utilizing the prompts below to obtain a comprehensive and well-informed understanding of the situation:

■ Symptoms

- What are the primary and associated symptoms?

■ Characteristics:

- Obtain qualitative and quantitative descriptors of severity of the symptoms. Are the symptoms better, worse, or same?

■ History:

- What was done in the past? How were these symptoms managed?

■ Onset:

- When did the symptoms start? Was it gradual or sudden (Note - sudden onset tends to be more serious).

■ Location:

- Is the pain localized or more generalized? (Note pain tends to be more serious than generalized pain).

■ Aggravating Factors:

- What makes it worse?

■ Relieving Factors:

- What makes it better?

Activities of Daily Living:

Always compare current ADLs with baseline state:

- Intake (fluids, foods),
- Output (urine, emesis, BM, diaphoresis: quality and quantity)
- Activity level (compare to normal daily activities)
- Mood (marked change)
- Color (pale, red, blue, grey, ashen)
- Skin (turgor) lips/tongue.

For aphasic, elderly or extremely poor historians:

- Always include the following assessments:
- Any extreme behaviors
- Difficult to awaken or keep awake
- Affect: is the affect appropriate?
- Movement: Is there little or no spontaneous movement?
- Eye contact and ability to focus

Obtain the patient history:

■ Recent history

- What is the recent history of any of the following? (Injury, ingestion, infection or illness, international travel, immune compromised)

■ Allergies

- What allergies does the patient have to medications or others (food or other substances etc).

■ Medications

- What medications is the patient taking? Are there any concerns or issues with medication regimen?

■ Pregnancy/breastfeeding?

- Is the patient pregnant or breastfeeding?

Assess the severity/acuity of the presenting symptoms/situation:

■ **Severe, suspicious and strange:** *Severe (i.e., high pain 8/10 or vomiting 8 x in the past 4 hours,).

■ **Strange:** novel, atypical, unusual, worst, new, sudden, unexpected, or recurrent.

■ **Suspicious:** "Big Six" head, chest, respiratory, abdomen "flu" and dizziness.

■ **Age:** Patients who are 55 years and older are placed in a higher severity level; females between the ages of 12 and 55; and males over 35.

■ **Veracity:** 2nd or 3rd –party caller, speaks no English, aphasic or confused elderly, drugged or confused state

■ **Emotional state:** Anxiety, or denial, previous psychiatric history, severe reaction to current illness. Multiple calls are a high alert that something is wrong!

■ **Debilitative/Distance:** Clients with chronic disease or living a great distance or traveling at peak traffic time.

Working Diagnosis and Impression

Your impression or working diagnosis can help determine severity; disposition and the most appropriate symptom based protocol

To formulate a working diagnosis, several components must be present:

■ A symptom-based, generic protocol title (abdominal pain, nose bleed) and/or optional classifiers (severe, moderate, mild) as well as presumptive terminology (possible, apparent, unknown etiology).

Do not try to diagnose the symptoms or establish a cause for them.

■ A working diagnosis or impression is defined as a provisional estimation of the seriousness of the symptoms

■ Examples: "Severe nose bleed, etiology unknown," or "moderate abdominal pain, possibly related to constipation."

Protocol Selection

Choose the protocol for the symptom that seems most serious, or choose the generic guideline (change in condition)

**Use your organization-specific protocol/guideline)*

Assure you know what the patient's health care related goals are prior to providing advice

Prior to intervention/disposition/advice assure you have identified the following

- patient's health care goals?
- POLST?
- Healthcare Directive? (DNR/comfort measures only or Full Code/aggressive care).

**Disposition and advice will be significantly different for a terminally ill patient with the desire to die comfortably in their own home; who does not want to return to the hospital and wants comfort measures only versus a terminally ill patient seeking aggressive care.*

Advice and Follow-up Instruction

GOAL: To Communicate Significant Information

Provide adequate instructions about symptom management.

- Use (organization- specific) protocols for guidelines
- Include pharmacological instruction within role scope
- Include non-pharmacological interventions as appropriate

Provide call back instructions:

- To avoid a **delay in care**, patients must be taught how to monitor their progress effectively and to call back within a specific time frame if the symptoms fail to improve.
- Instruct on possible complications and the signs and symptoms to watch out for.
- Provide a time frame within which to call back if there is failure to improve
- Always instruct patients to call back if further questions arise or home treatment fails to work
- Final Instruction should include **"always call back if you experience new or worsening signs or symptoms."**

Teach Back and Contract

GOAL: To Facilitate Decision Making

Ask! How confident or comfortable are you with this plan?

Teach-back is a way to confirm that you have provided the information the patient needs to know in a manner that the patient/caregiver understands:

- Reinforces what was taught because patient has to put teaching in own words.
- Verifies understanding

A **contract** is an agreement entered voluntarily by two or more parties.

- Does the patient or caregiver agree to the plan?
- Does the patient/caregiver agree to and is able to call back if the medication does not seem to be working in one hour or sooner for worsening?

Documentation

Bold sections are required

Areas not documented, are to be deleted from the documentation template.

Call out urgency and next day needs above template details, first line of documentation, i.e., VISIT NEEDED!!!

Implementing Clinical Triage

Situation:

Patient Is A () Year -Old -Male/Female With The Chief Complaint Of
Polst:
Purpose Of Call:

Background:

Primary Diagnosis:
Allergies:
Related Medications: (Include New And/Or Recently Discontinued Meds):

Assessment:

Include Symptoms, Characteristics, Course, Onset, Location, Aggravating And Relieving Factors). *
Recommendations/ Plan: * (Include Any Advise Given, Any Recommendations, Include Medication Dose Instructions)

Disposition:

What Resulted From This Call? "Home Care Advice Provided Or Home Care Advice Provided/Rn Dispatch, Etc.)
Patient Or Caller Verbalized Agreement To Plan: *
Ask!!! – "How Confident/Comfortable Are You With This Plan?"

Protocol:

List Protocol Used And Referenced – Should Be The Same As Your Wrap Up Code)

Soft skills, reminders and tips

- Remember the patient can talk all they want, however prior to giving any advice you will need to obtain patient and caller identifiers. Don't get fixed in obtaining the identifiers first if caller has urgency – listen, ask questions and then obtain identifiers.
- Complete a chart review to include: Dx, co-morbidities, medication profile, last nurse visit, multiple calls, and Advanced Care Plan (ACP) or POLST
- Vocalize your actions when there is dead space, i.e., "I am locating Mr. Smith's chart; this may take just a moment." Avoid saying, "my computer is slow" or "I can't find you in the computer." (This decreases confidence and adds additional stress for the caller).
- Control the focus of the call – focus on chief complaint and assessment process. Be prepared with scripts to help pull caller back on track. "I am sorry you are having problems with the mailman, but I am really worried about your stomach pain right now – when did your pain start?"
- Never leave a detailed message – ever. You may say "this is _____ from "Name of Provider Organization". Please return my call at _____ or I will call back within the hour. Do not indicate who you are trying to reach or why you are calling.
- Always ask if there is anything else. "Is there anything else I can help you with or you are concerned about?" You may modify to fit the situation, i.e., "Anything else?" "Do you have any other questions?" or "Have I answered all of your questions today?"
- Conclude your call by thanking the caller, i.e., "Thank you for calling" or "thank you for taking my call."

**Remember hospice services include care and support for direct caregivers/family members. Address those needs if appropriate to do so.*

Structure of a Tele-Support RNCM Call

April 20, 2020

Technical Quality Checklist							
Category	Stage	Quality Issue	Net	Metric	Score	Comments	Question Changes
Opening							
Opening		(01) Did the nurse identify themselves and use the appropriate greeting and branding?					
		(02) Did the nurse provide a statement of ownership or commitment to help?					
		(03) Did the nurse obtain the appropriate patient identifiers and confirm the correct patient account?					
		Patient Name					
		Patient DOB					
		(04) Did the nurse determine the caller's name and relationship to the patient?					
		Caller's Name (Full or Partial and title depending on call)					
		Caller phone number (as applicable)					
		Caller relationship to Patient					
		Caller location (as applicable)					
		(05) Did the nurse make the call in the correct phone queue?					
		(06) Did the nurse verify the contact number for the patient if a callback is needed?					

Technical Quality Checklist

Category	Stage	Quality Issue	Net	Metric	Score	Comments	Question Changes
Conclusion							
Conclusion		(07) Did the nurse accurately complete the correct action?					
		Route encounter to correct pool and status correctly (open/closed)					
		Accurate smartphrase/ template with all fields completed					
		Page request entered correctly					
		Correct procedures used to page Dr. or contact field nurse					
Call Control							
Call Control		(08) Did the nurse limit/preface excessive silence?					
		(09) Did the nurse keep the caller informed of their actions?					
		(10) Did the nurse exhibit acceptable customer service standards?					
		(11) Did the nurse hold and transfer the call correctly?					
		Permission and agreement for holds / transfers					
		Estimate reasonable hold time					
		Thank the caller for holding					
		Check back within estimated timeframe/ Manage extended holds					
		Mute used in place of hold					
		Dropped call during transfer					

Technical Quality Checklist

Category	Stage	Quality Issue	Net	Metric	Score	Comments	Question Changes
Notes							
Notes		(12) Did the nurse complete documentation per required standards?					
		Documentation clear and concise and void of spelling or grammatical errors					
		Notes/comments consistent with the "Reason for Call"					
		Consistent with audio transcript					
		(13) Did the nurse accurately record the end of the call?					
		What should the code have been?					
Call Handling							
Call Handling		(14) Was the call handled correctly? (not mishandled?)					
		Release of Information/HIPAA					
		Compliance					
		Medical					
		Other					
		(15) Did the nurse conduct themselves correctly?					
		Misconduct					
		Misuse of time					
	Other						
Comments							