

SUBJECT: **CLIENT ASSESSMENTS BY TELEPHONE**  
APPROVED BY: VP Acute Care \_\_\_\_\_  
EFFECTIVE DATE: 2001 06 01  
REVIEWED /REVISED DATE: 2004 08 01  
2007 01 01  
2012 09 18

**Purpose:**

To provide Regional Nurses (RNs) with guidelines for the safe provision of medical and/or nursing advice over the telephone.

To provide Regional Nurses (RNs) with appropriate documentation guidelines when telephone advice is given.

**Policy/Standard:**

The Regional nurse is professionally and legally accountable for advice given to clients over the telephone.

The Regional Nurse may provide telephone advice when (s) he:

- has the appropriate education, skills and experience to provide the advice required;
- has current information available regarding the advice required;
- professionally judges that the caller is not impaired and has the ability to observe the client, assess the client and communicate the assessment over the telephone;
- appropriately documents the necessary information in SOAP format in clients chart;
- follows all professional guidelines;
- can ensure client confidentiality;
- follow -up unusual occurrences;

**Materials Required:**

Telephone Assessment Form LGH-172 - Appendix A  
Telephone Visits- After Hours Audit- Appendix B

**Related Policies:**

Human resources Policy and Procedure Manual HR-4-85  
[http://lghealth/policies/files/HR-4-85%20-%20Compensation%20for%20Telephone%20Consults\\_July2012.pdf](http://lghealth/policies/files/HR-4-85%20-%20Compensation%20for%20Telephone%20Consults_July2012.pdf)

**Procedure:**

The following information is required when giving telephone advice:

- Date and time
- Name of caller, relationship to client
- Presenting concern and symptoms
- Previous assessment of this problem; when and by whom
- Diagnosis
- Advice given
- Follow up recommended
- Advice to call back if concerned, or if the condition does not improve or worsens.

The RN is to document either on the:

- 1) Client Assessment by Telephone form. LGH-192( pink) which is to be glued to the out patient progress note
  - 2) In the client's chart using SOAP format and stamping the entry with the telephone assessment stamp
- If the RN claims this telephone advice on the fringe benefit form the nurse is required to document this in the client's chart using SOAP format and document the client chart number on the fringe benefit form. Document as a late entry.
  - The Regional Nurse II is responsible to ensure that 50% of telephone visits claimed are checked prior to signature on the fringe benefit sheet.
  - The clinical manager will audit these telephone visits on her site visits using the attached form in Appendix B



**Appendix A**

<b>Telephone Assessment</b>	<b>Date:</b>	<b>Clinic:</b>
Name:	DOB:	Nurse:
Presenting Problem:		
History and plan of care:		
L-GH-172(pink)		

<b>Telephone Assessment</b>	<b>Date:</b>	<b>Clinic:</b>
Name:	DOB:	Nurse:
Presenting Problem:		
History and plan of care:		
L-GH-172(pink)		

**Appendix B**



**Appendix B**



**COMMUNITY CLINICS**  
**Quality Assurance Audit**  
**Telephone Visits- After Hours**

Date: \_\_\_\_\_  
 Clinic: \_\_\_\_\_  
 Auditor: \_\_\_\_\_  
 Nurse: \_\_\_\_\_

Select 3 Charts from after hour telephone calls on overtime sheet

Chart Numbers							
	Yes	No	Yes	No	Yes	No	COMMENTS
Is the telephone call documented?							
SOAP format used for documentation?							
Is the date and time of visit noted?							
Is the telephone visit stamp used for this visit?							
<b>COMMENTS:</b>							