

Clinical Complaints or Condition Change
History and
Assessments Communicated by
Telephone in the ECRC



*A Program to Provide Guidelines for
Effective Telephone Communication
Between Nurses and "On-Call" Doctors*

Abdominal pain

History

How long ago did the pain start?

Other symptoms the patient has today:

- Nausea
- Vomiting
- Diarrhea
- Constipation

Exam

Current vital signs

Abdominal exam

- Bowel sounds present?
- Tender to palpation?
- Distended?

Agitation/confusion/altered mental status

History

How long ago did the symptoms start?

Other symptoms or events in the last 24 hours:

- Fall
- Constipation
- Medication changes
- Cough
- Fever
- Pain
- Urinary symptoms

Exam

Current vital signs

Oxygen saturation

Finger stick (blood glucose), if diabetic

Other pertinent information may include neurological assessment, signs of injury, dehydration or infection

Blood pressure, HIGH

History

Has the patient had other high BP readings in the past week?

Other symptoms occurring in the last hour:

- Headache
- Problems with vision
- Dizziness
- Chest discomfort
- Shortness of breath
- Pain

Exam

Current vital signs

Blood pressure, LOW

History

Has the patient had other low BP readings in the past week?

Other symptoms in the last hour:

- Dizziness
- Chest pain
- Cough
- Fever
- Abdominal pain
- Urinary symptoms

Exam

Current vital signs

Is the patient's mental status altered from baseline?

Chest pain

History

How long ago did symptoms begin?

Other symptoms associated with the chest pain?

- Arm pain
- Jaw pain
- Dizziness
- Shortness of breath
- Nausea
- Sweating

Has the patient had chest pain like this before?

Exam

Current vital signs

Oxygen saturation

Are the lungs clear?

Constipation

History

When was the patient's last bowel movement?

Is the patient on any narcotic pain medicines?

Does the patient's medicine list include any stool softeners or laxatives?

Associated symptoms:

- Nausea
- Decreased appetite
- Abdominal pain or cramps

Exam

Current vital signs

Abdominal exam:

- Is the abdomen distended?
- Are bowel sounds present?
- Is the abdomen tender to palpitation?

If patient has not had a bowel movement for 3 days or more, consider performing a rectal exam to check for impaction. *****Do NOT** perform rectal exams on patients who are undergoing XRT to the prostate or rectum, OR have a diagnosis of proctitis OR if the patient has neutropenia (low white blood cell count). If you are not sure, check with the doctor first.

If you do perform a rectal exam:

- Was the patient impacted?
- Was disimpaction successful?

Diarrhea

History

Has the patient been on antibiotics within the last 2 weeks?

Is the patient on laxatives or stool softeners?

Other symptoms today:

- Fever
- Is diarrhea bloody
- Nausea
- Vomiting
- Pain

Exam

Current vital signs

Is the patient's mental status altered from baseline?

Other pertinent information may include signs of dehydration (dry mucous membranes, decreased urine output) and abdominal exam.

Dizziness/Unsteadiness

History

How long ago did this symptom start?

Has the patient had these symptoms on other occasions?

Any changes to the medication list or doses in the last week?

If yes, what medication changed?

Any prn medication doses given in the last 24 hours?

If yes, what medication?

Exam

Blood pressure and pulse (sitting and standing)

Finger stick (blood sugar), if diabetic

Other pertinent information may include a neurologic exam and assessment of mental status.

Dyspnea/Shortness of Breath

History

How long ago did this symptom start?

Has the patient reported shortness of breath before in the last week?

Other symptoms today:

- Cough
- Chest pain
- Increased edema

Exam

Temperature, blood pressure, pulse oxygen saturation and amount of oxygen patient is currently receiving

Are the patient's lungs clear?

Is the patient in distress at rest because of problems breathing?

Fall

History

Is the patient having new pain anywhere since the fall?

Did the patient hit his/her head?

Any loss of consciousness before or after the fall?

Exam

Can the patient ambulate as well as he/she could before the fall?

Any obvious injuries (lacerations, deformities)?

Blood pressure and pulse (sitting and standing)

Other pertinent information may include joint assessment for range of motion, assessment of mental status (level of consciousness, orientation, speech), blood glucose if patient is diabetic

Fever

History

Symptoms occurring in the last 24 hours:

- Shortness of breath
- Pain
- Pain with urination
- Cough
- Headache
- Diarrhea
- Sore throat
- Rash
- Change in condition of a wound
- Altered mental status

Has the patient had a fever in the last week?

Has the patient been on antibiotics in the last week?

Have blood or urine cultures been obtained in the last 3 days?

Exam

Blood pressure, pulse, respiratory rate

Oxygen saturation

Hyperglycemia

History

Other symptoms today:

- Cough
- Fever
- Abdominal pain
- Urinary symptoms
- Change in status of wound

Has the patient had other elevated glucose measurements in the past week?

Other history

- Is the patient on prednisone?
- Any changes in diabetes medication in last week?
- Any high carb snacks or non-diabetic meals today?

Exam

Current vital signs

Other pertinent information may include signs of dehydration (dry mucus membranes, decreased urine output) or infection.

Hypoglycemia

History

Has glucose gel/ensure/juice already been given?

Is the patient eating (or receiving tube feeds) normally in last 24 hours?

Have diabetes meds been changed in the last week?

Exam

Current vital signs

Finger stick blood sugar

Finger stick blood sugar AFTER glucose given

Is the patient's mental status altered from baseline?

Musculoskeletal Complaint

History

What is the location of the complaint (which body part)?

How long has the symptom been present?

Has the patient ever experienced this problem before?

Any falls or other trauma in the last 24 hours?

Exam

Blood pressure, pulse, temperature

Other pertinent information may include a local exam for bruising, swelling, range of motion, tenderness, or abrasions/lacerations.

Nausea and/or Vomiting

History

How long has the patient had nausea/vomiting?

- Has the patient vomited?
- Any blood in vomitus?

How many times in the last 24 hours?

Other symptoms in the last 24 hours:

- Diarrhea
- Abdominal pain
- Constipation

Any new medications in the last 48 hours, including prn's?

Is the patient receiving chemotherapy or radiation?

Exam

Blood pressure, pulse, temperature

Other pertinent information may include an assessment for impaction (rectal exam) or abdominal exam for bowel sounds, pain, distention)

Urinary complaints/Positive urine culture or UA

History

How long have the urinary symptoms been present?

Does the patient have a foley catheter?

Has the patient been on antibiotics this week?

Current symptoms or complaints:

- pain with urination
- urinary frequency
- blood in urine
- foul-smelling urine
- inability to urinate or difficulty passing urine
- urinary incontinence
- decreased amount of urine

Exam

Temperature, blood pressure, pulse

CHAT: Presenting patient information to the on-call MD by phone

Chief Complaint, Context / Code status

History

Assessment / Exam

Talk with the physician / Agree on a plan

1. **After Hours** a veteran has a new **C**omplaint or **C**linical Change



2. Gather information from the patient

- New set of vital signs
- History and Physical Assessment
Use pocket guides or CPRS note for cues



3. Review Record



- Code status
- Context — Why is veteran in ECRC?



4. Begin CPRS ECRC — Nursing After Hours Telephone Note

- Answer the questions in the template
Return to patient if necessary
- Medication and Problem list appear in the note
- Save note without signature



5. Page the Provider



- Talk & Take Action:**
- Complete progress note & include actions taken

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