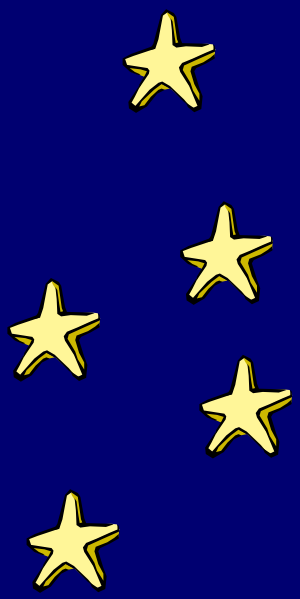
CENTRAL GRAMPIANS AFTER HOURS PRIMARY MEDICAL CARE TRIAL

PHASE 2



Report prepared by:

Alicia McGrath
After Hours Officer

January 2002

West Vic Division of General Practice
PO Box 1158 Horsham 3401
Ph: (03) 5381 1756
Fax: (03) 5381 0313

CENTRAL GRAMPIANS AFTER HOURS MEDICAL CARE TRIAL STEERING COMMITTEE

Michael Delahunty

Stawell District Hospital

Wendy Glenister

Stawell District Hospital

Melissa Howie

Consumer Representative

Stephanie Kean

Local Evaluator

Pete Marshall

Local Evaluator

Fiona Maughan

Chair
Stawell Medical Centre

Alicia McGrath

After Hours Officer
West Vic Division of General Practice

Jane Measday

West Vic Division of General Practice

Betty Meumann

Stawell District Hospital

Di Perry

Stawell District Hospital

Scott Shaw

Stawell Medical Centre

Terri Snowdon

Local Evaluator

John Stanton

Department of Human Services

TABLE OF CONTENTS

Executive Summary

The overall aim of the Central Grampians After Hours Primary Medical Care Trial has been to establish and assess the feasibility and acceptance of a nurse triage after hours service in a rural area. The trial aimed to show that nurse triaging can reduce the number of calls to doctors on duty by 20% or more, whilst maintaining professional after-hours advice to the consumer.

The trial commenced the first stage in October 1999 and the second stage in October 2000. The trial has involved the communities of Stawell, Ararat, Beaufort, Casterton, Coleraine and Edenhope. The trial has resulted in the reduction of over 50% of GP calls after hours. Further the trial has been highly successful with positive formal and informal feedback from GPs, nurses and consumers.

Through Phase 2 of the trial, a number of significant findings have been identified which impact on the provision of after hour nurse telephone triage services. Firstly it is clearly evident that rural consumers have the right to access to and want quality after hour services. In a small rural community the provision of quality care is shared between the rural GP and the local hospital. Share service provision often leads to complex relationship issues, any after hours initiative must value add to the relationship not detract from future sustainability issues. The local politics of the small rural communities must never be under estimated. It is important to identify who are the key change agents and the strategic thinkers within the nursing and GP workforce.

The trial sponsors have identified that small rural hospitals do not have the capacity to staff suitably qualified dedicated triage nurses from existing staff. In this regard, the trial sponsors have successfully appointed three dedicated triage nurses. The dedicated triage nurses have been appointed from Stawell Regional Health, Wimmera Health Care Group and East Grampians Health Service. All have received specialised training in telephone triage and will provide triage services in a rotating roster between the hours of 6pm and 11pm seven nights a week. After this time, calls continue to be answered by supervising nurses at Stawell Regional Health Service until 8am in the morning.

Existing systems have been refined to ensure quality service delivery. A significant amount of negotiation and consultation has occurred with widely recognised experts in the area of triage protocol development, education and quality assurance policy development.

In addition a kit has been produced outlining the key factors to consider when establishing and implementing an after hours nurse telephone triage service. This kit is of significant benefit to other organisations in their endeavors to develop models of after hours care.

Triage training sessions have been developed and run for those supervising nurses who may have a patient referred to attend A&E for assessment as a result of a Telephone Triage decision (ie. Satellite Supervising Nurses). This training has been implemented due to the recognition of local GPs of the significant role of the supervising nurses.

Further, a new committee of management will be convened to ensure that there is full representation from all areas involved in service delivery.

These significant advancements ensure that the trial is ready to move to a service that will be offered to more GP's within the Division. The service aims to support recruitment and retention of GP's in the Division whilst providing access to quality after hours care for patients.

1. Introduction

As a society we value and expect a health care system that can provide high quality medical care regardless of the nature of illness or time of day. We therefore value and expect quality after hours medical care. Traditionally, General Practitioners (GPs) have provided after hours care for their own patients. However, in a society that increasingly expects access to services 24 hours a day, a changed health care system that emphasizes shortened hospital stays and additional GP service rosters all lead to increased demands for out of hour care. Clearly it is not reasonable to expect a single GP to provide 24-hour coverage.

The physical and mental stress of such expectations are generally acknowledged, but there are also concerns about other and often unnoticed issues. These include safety of doctors, concerns about patient access to services, standard of care and training of doctors, workforce requirements, lifestyle issues for doctors and remuneration have been identified as problems with the current after hours arrangements (Karabatos, 1999).

A viable solution to assist GPs to provide quality care and service provision to their patients after hours, whilst minimising the workload and expectations of GPs is required.

1.1. Defining After Hours Care

After hours service provision can have differing definitions depending on service and location. Many general practice clinics define after hours as anything after their normal consultation time.

The definition taken for the After Hours Primary Medical Care Trial is that used by the Health Insurance Commission (HIC) who currently define after hours for the purpose of the Medicare Benefits Payments as:

> *"An after hours consultation or visit is a reference to an attendance on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or anytime other than between 8am and 8pm on a weekday not being a public holiday."*

The Medicare Benefits Schedule has also acknowledged the difference between social and unsociable hours of consultation and divided after hours consultations into two categories, with unsociable consultations between 11pm and 7am receiving a higher rebate.

There is, however, a condition that if a practice routinely opens during defined after hours times it needs to be an emergency service initiated outside the practice normal operating hours to attract after hour consultation rates.

Whilst after hours consultations are well recognised, consultation rates are only available if after hours consultations have been held at the clinic, for a home or nursing home visit.

This therefore excludes the large number of telephone consultations, which regularly occur.

1.2. Duty to provide After Hours care in Australia

The Royal Australian College of General Practitioners (RACGP) indicates that in order for GPs to maintain Vocational Registration they must:

> *"Accept direct responsibility to ensure that practice patients have access to care by an appropriately qualified medical practitioner at all times."*

There is therefore no obligation for the GP to be personally involved in the provision of after hours services, provided some form of formal after hours service has been made available.

1.3. What is After Hours in Rural Australia

GPs have an obligation to ensure that practice patients have access to care by an appropriately qualified medical practitioner at all times. Mira et al. (1995) conducted a random telephone survey of GPs to ascertain their after hours arrangements. Almost all rural GPs (95%) provided after-hours care whereas 50% of urban practices provided after-hours care for their patients. In metropolitan practices 35% provided their own after hours care exclusively compared to 52% in the rural sample.

Whilst rural GPs may provide a large percentage of after hours care exclusively, as indicated, this may not be due to preference but rather the limitation of alternative options. In the rural environment the GPs bridge the divide between a private business and a public good (Pegram, 2000).

Rural GPs not only differ in their obligations to after hours but often have highly demanding clinic days, visiting rights to the local hospital, and are often on call for other after hour rosters (for example, the surgeons' roster, the anesthetists' roster and the obstetricians' roster). The role of a Rural GP is highly demanding, strenuous and potentially stressful. From a GP's perspective, providing their own after hours care can lead to fatigue, sleep deprivation, increased stress and disruption to their home life (Cragg et al., 1994; Livingstone et al., 1989; Dale et al., 1996; Hallam, 1994; Pitts & Whitby, 1990; Foster et al., 1996). In an UK study, GPs describe out of hours work as being "the most important stress in their professional lives" (Dale et al., 1996). Clearly the commitment to rural general practice can be a significant burden, be time consuming and impact on both professional and personal life and can decrease both quality of care and professional satisfaction.

1.4. Models of After Hours Service Provision in Rural Australia

There are a variety of After Hour Service Provision Models currently in place in Australia and overseas. These models include GPs on call, GP cooperatives, GPs in emergency

departments, GP extend hour practices, Deputising Services, Rural Hospital Models and Telephone Triage services.

There is also considerable debate around these models as to which model provides the best after hours care in terms of sustainability, community acceptance, workforce, GP satisfaction and financial viability.

It is critical to acknowledge that not all models presented are available or viable in a rural area.

GP Cooperatives are possible in larger rural centres with more consulting GPs, however, in a rural area there are often solo or two GPs to a practice. Some rural areas have attempted to establish a cooperative with neighboring towns (i.e. 50km apart) which have had varied success.

GPs in the emergency departments and extending practice hour's increases the demands on overworked GPs and often are not viable solutions in small communities with 1-2 GPs.

Deputising services also have limited success on a rural area as financially it is not viable to have one GP cover and area and be expected to conduct house/clinic visits when the distances between the Deputising GP and the patient may be over 100kms.

Rural Hospital Models often are successful, however, evidence presented in this report indicates that Supervising nurses undertaking both telephone and face to face triage have little training in the area and often have no protocols and do not document. Further, the nurses involved in Small Rural Hospitals may often be dealing with more geriatric patients.

The triage nurse model has the potential to work well provided the infrastructure and capacity are available. These issues are discussed in this report.

1.5. PIP Payments

The Practice Incentives Program (PIP) has been developed to reward GPs for fulfilling certain desirable activities, which are intended to enhance the quality of general practice service delivery. The PIP provides supplementary direct payments to practices who provide a certain level of after hours care. Under the PIP there is a three tiered payment system for providing after hours services.

Tier 1	Payment received for practices having formal arrangements for after hour services.
Tier 2	Payment for providing after hours service by the practice GPs
Tier 3	Payment provided if all after hour service provision is provided through the practice.

In this scheme rural GPs are largely reflected in tier 3, as is evident from the figure below. Whilst tier 3 has been allocated largely for recognition of the after hours work undertaken by rural GPs it doesn't promote the concept of co-operatives or triage nurse services.

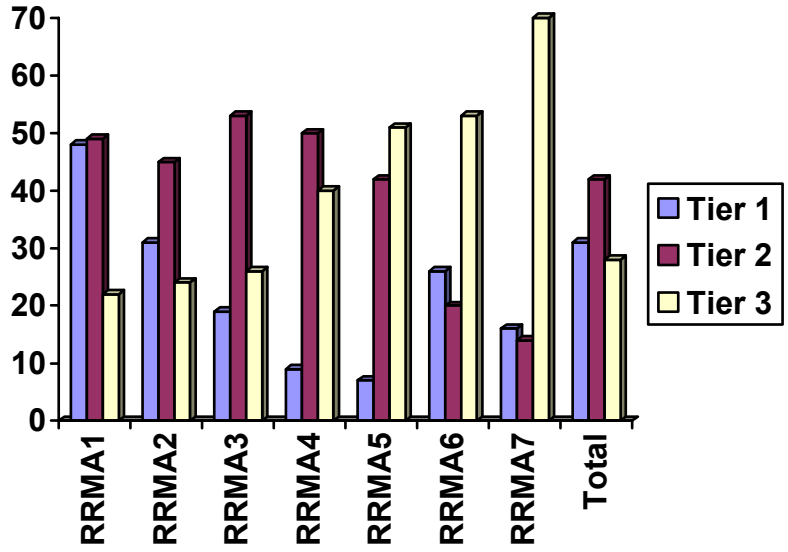


Figure 9: PIP After hours Participation by region.
(Source:Pegram, 2000)

2. Aims & Objectives of the Trial

The overall aim of phase 2 of the Central Grampians After Hours Trial remains consistent with the aims of the initial phase. Phase two of the trial aims to establish and assess the feasibility and acceptance of a nurse triage after hours service in a rural area. The trial aims to show that nurse triaging can reduce the number of phone calls to doctors on duty by 20% or more whilst maintaining professional after-hours advice to the consumer.
As part of the Division's multifaceted approach to improve recruitment and retention of rural GPs, this trial seeks to reduce the workload of doctors responsible for after hours care.

The Division has identified that the after hours work, on top of a busy day practice is a major disincentive to attracting and retaining doctors in the country.

Specifically, the objectives of the trial are:

- Improved after hours services from a GP, consumer and hospital perspective.
- Better understanding of the issues involved in rural after hours care
- 20% reduction in calls to GP after-hours
- Assessment of groups/zones of after-hours care by GPs
- Assessment of the acceptance of regional call centres for after-hours care.
- Assessment of nurse triage services in rural areas
- Education of Supervising nurses in trial areas
- Ensure a sustainable model

3. Quality Service Outcomes

3.1.1. How the Central Grampians After Hours Model Functions

The primary objectives of the Central Grampians Model is to offer the public a confidential, reliable and consistent source of professional advice on health care, between the hours of 6:00pm and 8:30am.

The Central Grampians After Hours trial involves GPs switching their practice phones through to a dedicated 1800 after hours telephone. When a patient calls their practice after hours the call is automatically diverted to a trained triage nurse who answers "Grampian's After Hours Medical Service". The nurse takes the patients details and via a set of GP approved protocols, assesses whether the patient requires nursing advice and reassurance, a medical appointment the next day or advice/treatment from the doctor on call.

The telephone system permits calls to be transferred from the triage nurse to the on call doctor in the appropriate area for the patient or for the nurse to put the patient on hold, speak to the doctor and then relay the doctor's advice to the patient. Should a patient require assessment they are initially directed to their local hospital. A policy has been established that the triage nurse informs the satellite hospital of the patient referral.

3.2. Management Committee

From inception the trial has been managed by committee, which meets monthly. The committee consists of representatives for relevant organisations involved in the trial including West Vic Division of General Practice, Stawell Regional Health, and Stawell Medical Centre. To ensure that all facets of the trial were represented the committee consisted of the following representatives:

- GP Representative and Chair of the Committee
- Executive Director Stawell District Hospital
- Director of Nursing Stawell District Hospital
- Consumer Representative
- Local Evaluators
- Trial Project Officer
- West Vic Division Project Manager
- Triage nurses
- Practice managers
- Department of Human Services

Committee requirements have varied over the life of a program. Initially the emphasis was developmental, identifying the key requirements for testing and designing a model that met the needs of key stakeholders. However, as the trial has expanded to include new regions and has progressed to the establishment of a sustainable service, the existing committee presented above has been disbanded with a new more representative committee to be implemented.

The new committee will include representation from a General Practitioner, Hospital Service Providers, a Satellite Hospital, a Triage Nurse, a Consumer Representative and the West Vic Division of General Practice. Specific details of the committee structure and roles and responsibilities are outlined in the After Hours Kit attached to this report.

3.3. Dedicated triage nurses appointed

In order to progress from a trial to the establishment of successful service that can be offered to GP's and their patients in the West Vic Division of General Practice geographical region it was deemed necessary to have dedicated triage nurses.

The initial model was to upskill supervising nurses at Stawell Regional Health who managed the triage phone as part of their role as the nurse supervisor. The advantages of this model were that there was a team of trained triage personal who were able to cover the after hours period. The nurses were known and respected by the GP's and they had been taking calls from the public who phone the hospital directly

The disadvantages of this model became apparent when the triage model became more established and was rolled out to other towns. In rural areas there is a shortage of nurses especially those with qualifications in midwifery etc and the growing demands of triage at times conflicted with the demands of nursing. Also it was difficult to implement quality assurance or reflect on activity with a workforce of 10 who replaced each other on shifts.

Through the trial it was established that it is necessary to have dedicated triage nurses to fill the evening shift between the hours of 6-11pm seven days a week. To cover the shifts and holidays ectera it was decided that a staff of three would meet the required resources.

The current trial site, Stawell Regional Health, experienced difficulties in recruiting three dedicated triage nurses due to nurse shortages, the time of the triage shift and the existing demands on experienced staff to maintain current services.

Taking the acknowledged shortage of suitably qualified nurses, the West Vic Division was keen to explore models of triage capacity building in a rural area in order for the trial to make the transition to a service. It was therefore determined to pursue the option of seeking dedicated nurses from surrounding hospitals.

Three dedicated triage nurses have been appointed from Stawell Regional Health, Wimmera Health Care Group and East Grampians Health Service. The dedicated triage nurses are Lauryn Matheson (Stawell), Amanda Kelly (Horsham) and Jodie Saunders (Ararat). All have received specialised training in telephone triage and will provide triage services in a rotating roster between the hours of 6pm and 11pm seven nights a week. The nurses' work out of their employing hospital and the 1800 number is diverted at appropriate times to the correct location. After 11pm, when calls significantly decrease, calls will continue to be answered by supervising nurses at Stawell Regional Health Service.

The dedicated triage nurses have received training in phone triage and copies of the local protocols and details of the one page documentation to be completed for each telephone triage. The triage nurses are paid at Div 1 level and ANF insurance is covered.

The triage nurses also have the opportunity to be involved in the development of telephone triage protocols and quality assurance processes for telephone triage.

3.4. Satellite Hospital Nurse Triage Training

Triage training sessions have been developed and run for those supervising nurses who may have a patient referred to attend A&E for assessment as a result of a Telephone Triage decision (ie. Edenhope Supervising Nurses). This training has been implemented due to the recognition of local GPs of the significant role the supervising nurses.

This has also increased the capacity of small rural hospitals and promoted community ownership of the service. The training offered will be further reviewed and evaluated in the provision of the service.

3.5. Regions involved

The regions involved in the project initially commenced with Stawell and surrounds before rolling out to Ararat, Beaufort, Skipton, Casterton, Coleraine and Edenhope. The distance form the furthermost regions is approximately 200kms.

The number of GPs in each centre also varied, this is evident from the following table showing the number of GPs in participating towns. These different elements create different attitudes, consumer patterns and political issues in trying to roll the trial out to each centre. Community infrastructure and the range primary health care services also vary greatly between these centres.

Table 1: Number of GPs in participating and proposed towns

Towns participating in Trial	*Number of GP's*
Ararat	8 GP's , one GP registrar and one surgeon
Stawell	9 GP's , one GP registrar and one surgeon
Beaufort	One GPs
Edenhope	Two GPs
Casterton/ Coleraine	Four GPs

Two of the regions involved in Phase 2 of the trial have also featured in the local press in relation to the profile. These articles are presented in Appendix 1 and give a good overview of the community and what the community views as important.

3.5.1. Stawell

Prior to the trial the GPs in Stawell shared the after hours roster (co-operative after hours model). This arrangement included the solo GP in the town and selected GPs from the 9 GPs at the Stawell Group practice. GPs also shared other after hour rosters such as anaesthetic and obstetrics rosters. The hospital is the towns only 24 hour, 7 day a week medical service although a doctor is not present at all times.

Consumers in Stawell had a tendency and were directed to ring their GP after hours as the first point of call. This pattern may have arisen due to hospital/GP policy or due to the fact that the group practice was in such high demand that it was too difficult to consult a GP during the day.

In order to alleviate some of the after hour demand, the group practice began to open on Saturday mornings and public holidays. The clinics also introduced an answering machine message informing consumers that the clinic was closed and directing consumers to the suitable services, including a mobile phone number for the on-call GP should the situation warrant. Changes in after hours billing were also introduced to deter patients.

The trial entered the live phase in Stawell on Monday 4th October 1999. Both clinics diverted their phones after hours to the 1800-triage phone number. The trial has therefore run for over 2 years covering the after hour calls of the ten GPs in Stawell.

3.5.2. Ararat

Prior to the after hours trial rollout to Ararat, the Ararat Medical Clinic classified after hours as between 6:30pm and 7:30am. The on call GP started at 6pm, however, was likely still to be at the clinic. Once after hours started clinic phones were either diverted directly to the GP's home phone or a mobile phone. Alternatively the answering machine was switched on and patients were instructed to either call the hospital or call the mobile phone number. Also of note is that the practice manager, was often answering calls until 8pm, triaging calls.

The Ararat Practices also operated on a co-operative arrangement on weekends, while the solo GP did his own after hours during weekdays. GP's are on a 1 in 8 weekend roster, with most GPs rostered one night a week and charging after hours rates. It was indicated that by charging after hours rates the number of non serious cases is reduced.

As a result of 10-12 years of training and promotion the Ararat community largely call the hospital, where an informal arrangement sees the nurses triage the patients and the GPs consult patients at the hospital after hours.

Of specific interest is that GP's in Ararat are on a set after hours roster. Specific consumers have established which doctor will be on, which night and therefore, which preferred night to call seeking medical assistance.

Despite little support for the trial in the early stages, the trial extended coverage to Ararat (eight GPs) on the 29th May 2000. Roll out has been successfully implemented with all stakeholders (clinic, hospital, doctors and consumers) reporting that they are happy with the service being offered. The stakeholders further realise the importance in being involved in the project to ensure the Commonwealth is aware of the after hours work undertaken by rural GPs, the number of calls for whom the hospital staff already deal with and the recruitment and retention issues that surround the provision of after hours services.

The trial sponsors believe it is important to note of one Ararat GP's role in influencing the clinic's participation. He indicated that the Ararat GPs prior to the triage service had a fairly good after hour's roster and relationship with local supervising nurses, however, he felt the current arrangement with the triage nurse was a superior service. His main rationale for involvement was that he had previously spent 5 years in a small community and for a percentage of this time had been the only GP and thus was on a 24/7 roster. Having changed to a larger practice as a result of fatigue, he felt it was important that an initiative such as the Central Grampians After Hours Primary Medical Care Trial, was available and promoted to all rural GPs. He indicated that should a service be available that it may be the difference between GPs leaving and staying in smaller populations.

3.5.3. Beaufort & Skipton

The Beaufort Health Service began participation in the trial on January 2nd 2001. At present the service is only operating on weeknights, as the clinic is yet to establish remote access diversion.

Prior to the service being implemented no after hours services were offered and the community was required to ring a major hospital 30-40 minutes from the clinic to receive any advice after hours. This had predominantly been promoted as GPs working in Beaufort and Skipton have resided in Ballarat a 30-40 minute drive from the clinic. The communities' pattern of seeking medical assistance after hours has resulted in few calls being received by the triage nurse. It is anticipated that with the trial moving to a service and advertising, the call rate will increase.

Whilst Skipton initially trialed the service, they have stopped participating as a result of infrastructure and management issues between the Beaufort and Skipton Clinics, not as a result of the triage service. The circumstances around this situation have been previously reported.

3.5.4. Casterton & Coleraine

Casterton and Coleraine Clinics until recently operated independently, however, with the possibility of the Casterton Clinic closing the GP owner of the Coleraine Clinic purchased the clinic. The purpose of this was to ensure that more GPs were recruited to the area thereby reducing his workload and in particular reducing his after hours commitments.

Casterton and Coleraine also work in a co-operative after hours arrangement with a 1 in 4 roster. Clinic phones are diverted to the GP after hours or an answering service

message instruct patients to either call the on-call GP or the hospital. In the Coleraine community a large percentage of consumers call the GP, where as, in the Casterton community they are more likely to phone the hospital. The Casterton hospital has an informal triage arrangement currently in place and collects very detailed records of triage calls and presentations.

Coleraine Clinic entered the trial on December 23rd 2000, whilst Casterton commenced on the 11th January 2001. They delay in Casterton's commencement related to the introduction of a new commander telephone system that can handle diversions.

A Coleraine GP and Practice Manager have agreed to participate in the Central Grampians After Hours Primary Medical Care Service Steering Committee. This is an excellent progression as it ensures that the trial has the insight of regions involved outside of the Stawell zone. It is also believed that the experience of these representatives as long standing members of a small rural practice is vital to ensuring that a complete after hours rural perspective is presented to the Commonwealth.

3.5.5. Warracknabeal

Initial discussions were held with the two practices in Warracknabeal and the Director of Nursing of the Warracknabeal hospital. Those discussion indicated that all parties were very keen to be involved in the trial, however, since this time there has been conflict between one practice and the hospital, thus one practice is not prepared to be involvement in the trial at this stage.

Since initial discussion, these difficulties have commenced being resolved and a new GP has started work in the area. There have also been changes in senior management within the hospital. Discussion has occurred with the new GP who was going to take the idea to a meeting of GPs in the area, feedback on the results of this meeting are yet to be heard.

The lessons learnt with engaging Warracknabeal include acknowledging the importance of the relationship between GP's and the hospital and that After Hours is only a small part of the complex relationship in General Practice.

3.5.6. Edenhope

Initial discussions were been held with the Edenhope GP and with key hospital Managers. All parties indicated that they were happy to commence. The Edenhope practice has purchasing a new commander system to allow diversion and commenced diversion to the service on September 25th, 2001.

A new GP has also commenced in Edenhope, thus the region has two GPs providing 24/7 coverage in a co-operative system. The trial and its progression to a service is viewed as a means of retaining the newly appointed GP.

3.5.7. Barriers and Common themes throughout regions

While negotiating with each community there are a number of barriers to implementation and common issues raised.

- Concern over loss of local service delivery. Rural hospitals have faced many changes over the last ten years. Amalgamations to create health services have meant that some services have been rationalised or shared across campuses. Any service that by-passes a rural hospital can be seen to impact on a rural hospitals sustainability
- Local health service providers' perceptions of consumer acceptance of an out of town service (ie. In rolling out the trial, it was important to health service providers that the name of the after hours service and how triage nurses answered the phone was acceptable to the local consumers in the region.)
- Local health service providers' concern over the importance of local knowledge of patients and environs.
- Outdated telephone technology that does not allow transfer and divert functions.
- GP s and practices maintaining positive relationship with hospital
- Small rural hospitals do not have the capacity to staff dedicated triage nurses from existing staff.
- Triage nurses require infrastructure (i.e. computers, portable phones, support structures)

These barriers have been addressed. Through detailed consultation with key players reassurance was given that the after hours service would not interfere with hospital service provision but value add to current service delivery. Local perceptions and knowledge was and will be addressed through focus groups held in the region. In relation to the out of date telephone technology the trial has agreed to assist these clinics in purchasing or leasing systems which allow diversion.

Common themes through discussion with key players in each location were:

- GPs have after hour commitments, which significantly impact on their own wellbeing, their family life and restrict their freedom. This includes being on call, VMO responsibilities and often being involved in anesthetics, obstetrics etc.
- The rural GP and the local hospital care often share the provision of after hours care.
- GPs will participate, however, they do not wish to jeopardize the very important relationships they have with their local hospital.
- The relationship between the local GP and the local hospital is often complex.
- Local GPs and hospitals do not wish to promote a service to the community, which is not sustainable.
- Local hospitals do not wish to be by-passed. They view that as a significant removal of their role and feel threatened that it is yet another way to remove a service and in turn down size their hospital.
- Local hospital supervising nurses feel that their existing triage skills are not recognised.
- Supervising nurses at various locations would welcome further training to ensure triage sustainability post trial.
- Consumers have a right to and want access to quality after hour servicces
- The feeling in the community is that should a regional after hours number be provided, a large proportion of the population would still follow traditional patterns of contact such as contacting their local hospital for local support by a known and respected health professional.
- Consumers accept a triage nurse as the first point of contact and often feel more comfortable with this approach.

- Consumers do not like the concept of centralisation of after-hours and feel local knowledge and in particular having a contact that has access to your medical history is critical.
- There is concern by health professionals on the management of local high dependency patients or regular users by a central after hours system.
- Out of data technology is a burden to overcoming after hour issues.
- Rural after hours services are significantly different to urban services both in current delivery and in conceptual implementation plans.

3.6. Service utilisation

During the trial period of Phase 2 (October 2000 to December, 2001) the triage nurses registered 3780 calls. Whilst the average number of calls per night was 5, there were also peak nights.

The large percentage of calls occurred in the early evening, 67% of the calls were received between 6pm and 11pm.

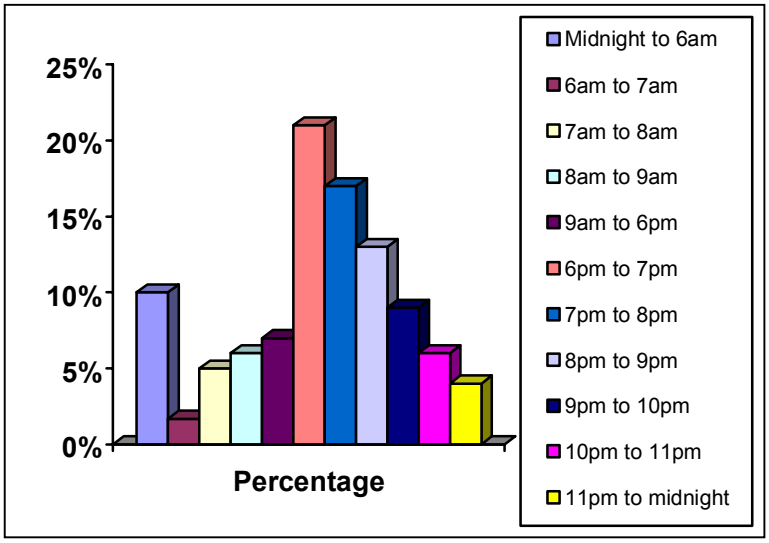
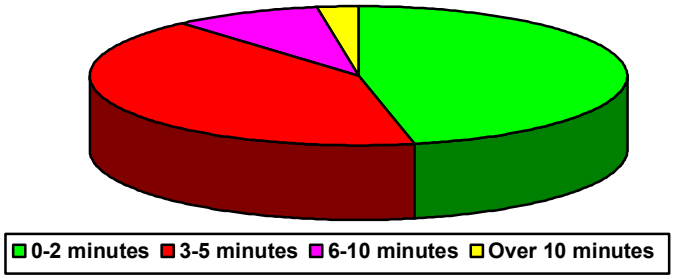


Figure 1: Time of call



The majority of calls were up to 5 minutes in duration (82%).

Figure 2: Duration of calls

The majority of consumers who called the after hours service only called once (93%) regarding their problem. Five percent of callers called the service twice.

Of the calls that came into the triage service 71% came through on the triage phone, which is the line directed from the medical practices.

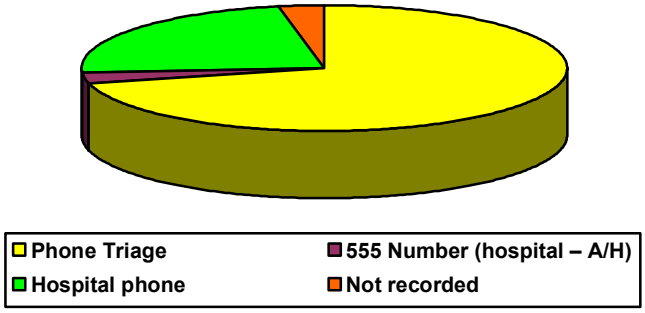


Figure 3: Phone call received on

Caller profile

The majority of those calling were female (73% of those whom gender was recorded). Those calling were largely the patient themselves (26%) or a parent (23%). Note that details were not collected for 29% of cases.

Patient details

Patients were largely female (55%) and/or between the age of 0-9 years (27%). It is important to recall that a large percentage of people contacting the service were parents.

As expected, patients were also largely residents of the Stawell District, as 77% indicated a residential postcode of 3380 (note percentage derived on when postcode was recorded). It is also of interest to indicate that 10% of patients were from the Ararat postcode region entered into the database. It appears that per month the triage services received 94 calls from Stawell (3380) residents and 18 calls from Ararat (3377) residents. The only explanation for this is different treatment seeking patterns in different towns (ie. Ararat consumers are more likely to call directly to the hospital after hours). The primary diagnosis made has been classified in Table 2.

Diagnostic Assessment	Percentage
A97 Absence of disease	27.7%
D10 Emesis	4.3%
A03 Feeling feverish	3.3%
D01 Colic, Abdominal	2.8%
A29 Clumsiness	2.1%
N01 Headache	2.1%
A98 Counselling	2.1%
S18 Cut	2.0%
D06 Cramps, abdominal	1.9%
K01 Pain Cardiovascular	1.5%
R05 Cough	1.3%
R02 Breathing difficulty	1.2%
S12 Bite	1.2%
A16 Unwell infant	1.0%
A05 General feeling unwell	0.9%

Table 2: Primary diagnosis of patients

The following patient outcomes were reported (note: missing values have been included in calculating percentage).

Outcome	Frequency	Percentage
Reassurance or information only	1727	45.6%
Managed entirely / symptomatic treatment	1366	36.0%
Admitted to hospital	72	1.9%
Referred	1859	49.0%

Table 3: Outcome of after hours call

Of data reported, most cases were referred to the emergency department (46%), 24% required consultation with a GP, 14% were asked to consult their GP in the morning and only 1% of cases required after hours primary medical care.

Responses to the completion of the section relating to who made the triage decision (ie. GP, nurse or both) outlined that of cases where data was collected, the nurse was responsible for making triage decision in 72% of cases. The GP made the triage decisions in 23% of cases and both were responsible in the remaining 5% of cases (based on information recorded).

3.6.1. New Phone Message

As per the recommendation of the Local Evaluators an automatic message has been placed on the 1800 Nurse Triage Number.

The process is that the patients ring their usual Medical Practice after hours, the call is automatically diverted to triage phone. On diversion a recorded message automatically cuts in telling the caller:

"Your call is being transferred to the After Hours Medical Service. If an emergency hang up and call '000', if you need medical advice please hold the line, if you are seeking an appointment or test results please call back during clinic hours"

The triage nurse then answers the phone. The purpose of this message was to reduce the large number of administrative calls (almost 50%) being received by the service. It is also important to note that these calls were previously received by the on call GP.

The new message was posted on Triage phone on 1/8/2001. As a result the number of A&E attendance for one month previously and one month after remained fairly consistent. Of telephone triage calls there has been a 36% reduction in calls to the triage phone post new message implementation. Triage Nurses have also reported that there has been a considerable decrease in 'nuisance ' calls ie administration and wrong numbers although these have not been alleviated. The trial sponsors therefore believe the phone message is having the desired effect.

3.6.2. Outcomes of those requested to attend A&E

Concern was raised in relation to the level that patients followed the triage nurse's advice. In order to ascertain if advice was being followed the dedicated triage nurse audited triage files between 11/04/99 and the 04/02/00 against A&E entries in the Stawell District Hospital outpatient log book.

Within this time frame the data was collated according to postal code of 3380, which is not completely representative of the triage/catchment area for the trial, however, identified Stawell cases. A total of 545 files were examined.

135 no report in A&E log book found
46 not applicable – were not asked to present to A&E (2 were from Ararat)
234 Seen by Doctor
50 Seen by Nurse only
48 Phone orders administered by nursing staff
56 Admitted
1 Transferred from A&E to another hospital

The large amount of reports not found may be attributed to various factors.

1. Some patients were taken straight to the ward, particularly chest pains or after hour ambulance arrivals
2. The time of day that patients arrived at A&E ie. Handover times or late at night meant that records may not have been done by staff, for attendances.
3. Some attendances to A&E were triaged by the Supervisor who also assessed them and their findings/treatments were entered into the triage book not the outpatient records.
4. Some A&E records have been taken with the doctor who attended and, therefore, record of attendance is not available.
5. At times data entry is out of order (date wise) in the log book and the entry may be located on a different page to the date of attendance. This was discovered on some occasions, but was very time consuming and may account for some files not found.

This audit highlighted some of the discrepancies with data entry, but showed that patients were compliant with recommendations given to them by the triage nurse. The notes added to triage files clearly showed that patients were willing and keen to present to A&E for further care when it was recommended, even if the record of their attendance may not have been found.

In all of the 545 files audited, only one had the comment that they did not report to A&E when requested.

This review outlines that triage nurse requests to attend A&E are being followed and that those presenting appear to require attendance.

3.6.3. Acuity of those presenting to A&E

Other After Hour Trials had reported an increase in A&E attendances as a result of the after hours service being offered and that these attendances were in many cases not warranted. In order to establish the Nurse Telephone Triage Service referrals to A&E

and the acuity of those referred, the dedicated triage at Stawell auditing triage files against A&E entries in the Stawell District Hospital outpatient log book. The files were taken from the beginning of the project ie 01/10/2001 to the 31/12/2001. The documented patient referrals to attend A&E for this period were **122.**
There is no record found for **19** people
Of these **3** were bought in by ambulance and went Straight to ward
3 were pregnancy check not recorded.
Those seen by a Doctor **60** including **17** admitted.
Phone treatment by Dr **17** (nursing staff administering recommendations)
Those seen by Nursing staff **25**

Presentations were also investigated in terms of A&E triage coding.

13 pts – triage code **3** (urgent, within 30mins)
57 – triage code **4** (semi – urgent, within 60mins)
32 – triage code **5** (non-urgent, within 120mins)

As the A&E log book is not detailed enough to check the acuity of signs and symptoms against those recorded in the triage record book the National A&E Triage Scale has been used to categorise the severity of signs and symptoms that presented.
It should be noted that the coding only allows for a 1–5 scale (5 being least urgent). There is no coding for presentations not requiring attention in an outpatient facility (i.e. could wait for a GP clinic to be opened), there is no ability to accurately assess those presenting with a '5' coding and how this relates to the acuity of their symptoms.

For example of the 33 presentations under code 5, five were one patient with repeated medication needs who has a standard order. This person, without the order, would ordinarily require some Dr contact (either phone or in person) and therefore, *may* score a higher code.

This review again indicates that those referred to A&E have required referral.

3.7. Complaint process

The complaint process for phase 2 of the trial is outlined in phase 1. Should there be any complaints regarding the service, they are to be directed to Alicia McGrath as project manager, who would in turn direct them to the relevant person, namely the DON or CEO of the hospital. Should a complaint be raised information is directed to those whom the complaint has been made and recommended changes to administrative and/or clinical protocols implemented. Those making the complaint also receive of acknowledgement of their concern.

Consumers can also contact the Ombudsman. However, as the service has not been advertised, the complaint process has not been widely dispersed.

There have been no reported adverse outcomes for phase 2 of the trial.

3.8. After Hour Kits for service replication

In recognition of the significant lessons learnt and processes for the establishment of a after hours nurse telephone triage service a roll-out kit has been produced.

The purpose of this kit is to succinctly outline issues, which must be considered, and the best means for dealing with these issues. The kit includes details relating to initiation, governance, protocols for involvement, clinical protocols, phone diversion, quality assurance, training, medico legal issues, referral services, and contracts between parties.

This kit will be of interest to the large number of organisations seeking further information of telephone triage.

This is a comprehensive kit is attached.

3.9. Quality Review

3.9.1. Local evaluators

Local evaluators will continue to evaluate the quality of the triage service in phase 2. The evaluation of the trial will continue as indicated until the 31st December 2001. This will include the local evaluation of the following trial objectives:

1. That the provision of the CGAHPMCT nurse triage after hours program will result in improved services from a consumer, GP and hospital perspective.
2. In conducting the CGAHPMCT the major issues involved in rural after hours care will be identified.
3. That implementation of the CGAHPHCT will maintain a 20% reduction in calls to GPs after hours.
4. That the implementation of the CGAHPMCT will support the development of effective groups or zones of GPs offering after hours care.
5. That the implementation of call centers by the CGAHPMCT will meet with widespread acceptance by key stakeholders
6. The implementation of the CGAHPMCT will identify the significant elements of nurse triage services

The Local Evaluators have undertaken telephone and face to face consultations with GPs receiving service in new areas and those who could potentially use the Trial. GP's consistently reported that there is a broad range of skill levels and practices of nurses carrying out the triage role in their local hospitals. They saw the Trial as a vehicle for defining the role, of having more comprehensive protocols, and ultimately of having a more consistent after hours service. GP's in newly participating service areas were satisfied with the Trial. Although recognizing that most calls went straight to the local hospital, they appreciated the convenience of having an arrangement in place for the small number of after hours calls that would otherwise come through to them.

Further consultations were carried out with consumer groups in Casterton and Coleraine during early July 2001. Groups were chosen to represent older consumers, parents of young children, and the general community. It was reported that most people in

Casterton and Coleraine rang their local hospital as the first point of contact after hours, and felt that this gave them access to medical advice, support and access to the GP if required. Younger consumers recognised that a specific triage nurse may provide a more consistent and comprehensive after hours medical service, particularly if the technology was developed to allow linking and transfer of calls to a broad range of other health and welfare services, ie lifeline, poisons information. Older consumers were more likely to see the Trial arrangements as a loss of services from the local community. Some consumers felt that there was some advantage in the call centre being located in a rural centre, arguing that triage nurses would be more likely to understand a rural context.

The Local Evaluators acknowledge that the trial sponsor have taken on board their recommendations by moving towards the employment of dedicated triage nurses and arranging formal quality assurance meetings. Whilst movement has been made in this direction, both have been difficult to implement.

3.9.2. Central Grampians After Hours Forum

Key players involved in the After Hours Trial were invited to attend a forum held in March 2001. Approximately 25 representatives covering Stawell, Ararat, Casterton and Coleraine attended the forum. These representatives ranged from GPs, Supervising Nurses, Triage Nurses, CEO's and Practice Mangers. The forum provided the opportunity to showcase the lessons learnt and to plan for the future of after hours care in the rural setting.

The Forum allowed positive discussion around a number of issues. This particularly related to the desire that GPs outside of the Stawell region needed to know that their patients were being managed well and were positive about the service being provided. There was also discussion around the positive impact the trial has had on the GPs lifestyles. GPs present indicated commitment to the trial.

As a result of the Forum, Ararat GPs have been provided with both focus group and 72 hours follow up feedback from Ararat consumers. A request has also been made that all triage records relating to Ararat consumers are faxed to the clinic the morning after the contact.

Also as a result of this Forum a meeting was held with the CEO and DON of the East Grampians Health Service (Ararat). Discussion arose around the benefits of the trial, rurality, a voice to Canberra, commitment for their involvement and the involvement of a Supervising Nurse in protocol development. East Grampians Health Service indicated in this meeting that they were committed to their involvement in the trial.

3.9.3. Nurses satisfaction with telephone triage and/or requirements

The West Vic Division of General Practice surveyed supervising nurses in order to inform the Commonwealth of rural nurses' experience of telephone triage, willingness and context in which to undertake such activity. In total 24 surveys where returned from 6 hospitals.

Those surveyed largely reported being Charge or Supervising Nurses. The majority were also qualified registered nurses, whilst some had additional qualifications. Almost all (92%) supervising nurses identified themselves as having a Divisional 1 rating. Only two nurses stated otherwise (3B/3B7 and RN). Those surveyed had worked as a qualified nurse for 9 to 40 years. The average number of years worked was 23 years, indicating potential future workforce issue.

All nurses reported undertaking face to face triage for people presenting to the hospital. All nurses also reported that they currently give advice to people seeking medical advice over the telephone

On average nurses reported that they would receive 2.2 calls during the day (8am-6pm) and 3.3 calls after hours (6pm-8am) which required assessment and/or advice. The number of calls reported during the day ranged from 0 to 6, while after hours the number of calls ranged from 0 to 12.

Only 5 (21%) of the 24 nurses reported that they had received specific telephone triage training. Of these nurses three reported that their training had been provided through the Central Grampians After Hours Medical Care Trial, whilst one reported attending a triage conference.

Only 54% of nurses reported having guidelines for the process of answering the call (ie. who takes the call, arrangements with GP, etc.) However, when actually investigated the type of guidelines, many were not appropriate. Results as follows.

- Verbal understanding 1. GP to be called on other phone, 2. Call put through to GP. 3 Ambulance called or told to come to A&E. 4. General illness advice given and documented
- After hours - refer to Ballarat or Ararat if medical care required
- Allocated book to record conversation. One copy forwarded to medical practice next day
- Supervisor takes calls. Notifies on call GP if necessary
- Written guidelines on triage clip board
- Nursing supervisor only takes calls
- Dedicate Phone Triage Nurse Takes all Hospital and Patient calls. Clinical Co-ord takes calls at other times. Guidelines developed by After Hours Trial
- Can speed dial GP if nursing staff need guiding
- Very limited. Still to be/being developed
- Nurse triage guidelines in green folder
- Job description mentions looking after and assessment of clients presenting to A&E (And answering phone)
- Assoc Charge nurse takes calls (grade 5) documents evidence of call and calls GP if necessary
- We have a list of guidelines to follow in conjunction with an emergency advice log book
- Not in writing - it is understood that all enquires are given to a Division nurse no formal in policy

Only 6 (25%) on nurses reported that they followed formal medical protocols for assessing patients over the phone. Again those indicating that protocols were being

followed were either following vague guidelines or using the guidelines developed through the Central Grampians After Hours Primary Medical Care Trial.

- All enquires are usually transferred through to the GP unless purely asking for information
- Follow phone report sheet
- Nursing training
- Limited basic protocols written by GP & RN1 prior to phone triaging formally commencing
- Phone triage guidelines
- Fairly vague format of questions being asked
- The ones in the guidelines

Results relating to documentation of calls was more favorable with 18 (75%) of nurses reporting that they documented calls. Further the indication on what documentation was completed was also positive.

- emergency department log
- Name of caller, address complaint advice , time, signature of staff date
- Yes if not put through to the GP, We have a book we record information given out to the public
- Phone report sheet
- Allocated book
- Notebook near phone, write date, time, name and address of caller, phone No. reason for call, advice, by whom
- Telephone advice log book
- In a telephone advice log book - recording patients particulars, clinical features and advice given
- Telephone triage log, however, if busy with ill patients in outpatients, will give phone telephone advice
- Formal document sheet
- Any that require attention documentation on sheet. Don't always record clinic appointment phone calls
- Have a phone documentation form
- Only sometimes, sign. Details written on OP card if caller identifies self and likely to present; or if sit
- Form
- Fill in the log book and place the original in the drawer for the doctor to see the next day
- Emergency department log

Only 2 nurses reported that there was a formal Quality Assurance Process in place for reviewing advice given. One reported that there was a follow up call, while another indicated that a GP reviewed records.

The responses to the following questions are outline below as percentages.

	Yes	No	Don't know
Do you enjoy your situation as a telephone advisor?	37.5	37.5	25.0
Do you feel that the patients are satisfied with the advice given?	83.3	4.2	12.5
Do you feel that as a telephone adviser you have support from local GPs?	79.2	4.2	16.7
Do you feel confident giving medical advice?	66.7	25.0	8.3
Do you feel there is a general agreement between nurses and GPs with respect to the advice given by nurses?	70.8	4.2	25.0
Is the working relationship between the GP and triage nurse good?	83.3	-	16.7
Do you feel that your role as a telephone adviser is well defined with respect to responsibility, medical knowledge, and referral pathways?	33.3	45.8	20.9

In relation to telephone triage activities the nurses indicated that the best use of their time is presented below using the indicated scale.

	Very Useful	Useful	Unsure	Not Useful
Providing reassurance for patients	66.7	33.3	-	-
Preventing unnecessary appointments	4.2	29.2	16.7	12.5
Encouraging patients to seek early advice	62.5	29.2		
Keeping in contact with house bound and older patients	25.0	25.0	16.7	33.3
Referring patients to an appropriate health care professional	54.2	33.3	8.4	4.2
Giving test results	12.5	8.3	8.4	70.8
Resolving simple queries	70.8	16.7	8.4	4.2

Of nurses, 95.8% indicated that they would attend telephone triage education if it were free, 54.2% indicated they would attend it if it were at a financial cost.

The perspective of nurses in relation to the importance of the following components in training is presented below. Results indicated that all aspects of training were very important or important.

	Very important	Important	Unsure	Not important
Communication training	62.5	37.5	-	-
How to deal with difficult patients or patients with psychological problems	83.3	16.7	-	-
Legal Issues around telephone triage	91.7	8.3	-	-
How to follow protocols	45.8	54.2	-	-
How to advice patients	70.8	29.2	-	-
How to complete documentation	45.8	54.2	-	-

The opinion of nurses in on the following issues is presented below.

	Yes	No	Don't know
Do you believe it is important for the triage nurse to have A&E experience? On average the number of months' experience that triage nurse should have was 11 months. The range was however 1 to 24 months, with a mode of 12 months.	66.7	16.7	16.7
Should staff undergo formal triage training before dealing with calls?	79.2	8.3	12.5
Is it important to have an experienced medical staff member available as a back up to help with advice when needed?	87.5	8.3	4.2
Should telephone inquires be channeled through one extension?	70.8	-	29.2
Should a designated member of the staff be assigned to deal with the triaging calls?	66.7	29.2	4.2
Should callers telephone number, symptoms, and advice given be documented?	83.3	-	16.6
Should triage nurses also give out information about other health care services?	75.0	8.3	16.7

The Nurses perspective of attributes necessary to provide effective nurse triage are outlined below. Nurses believed all attributes were very important or important.

	Very important	Important	Unsure	Not important
Ability to extract the most important information from callers' descriptions of the problem	83.3	12.5	4.2	-
Good communication skills	70.8	25.0	4.2	-
Experience of working in A&E	29.2	45.8	25	-
Confidence in what you are saying	50.0	45.8	4.2	-
Patience with dealing with the caller	50.0	45.8	4.2	-
A caring approach	45.8	50.0	4.2	-
Err on the side of caution	45.8	41.7	8.4	4.2
Allow or suggest patient calls back if still concerned	66.7	29.2	4.2	-
Documentation of calls	70.8	16.7	8.4	4.2
Training for crisis intervention	41.7	33.3	20.9	4.2
Formal training	25.0	50.0	20.9	4.2
Use of formal guidelines for advice	41.7	41.7	8.4	8.3

The results of this survey support assumptions that many smaller town have solved their local problems and often provide an after hours service. The result of this survey, however, indicate that a large number of these arrangements are adhoc and without skilled training and protocols in place. This information should clearly raise concerns over the quality of services offered and medico-legal coverage for those providing the service. It is therefore evident that the formailisation of telephone triage needs to be implemented as soon as possible. This includes the further development of protocols, quality assurance and triage training. The survey indicated the nurses' importance of education, especially around communication and medico-legal issues.

3.9.4. Quality Assurance Process

One Quality Assurance activity has been undertaken and results previously reported. The trial sponsors have sought the involvement of a West Vic Division of General Practice GP and a local nurse with significant expertise in the area of Quality Assurance practices to redevelop a quality process, which will be inline with current quality assurance in rural hospitals. It is envisaged that the quality process will be formalised prior to transition to a service.

Committee structures and terms of reference, triage nurse reporting forms, GP reporting forms and consumer reporting forms have all been drafted for further comment by

experts in the field. These steps are significant in the movement to a service and a transferable model.

Through the trial, the trial sponsor has also established that it is necessary to have three dedicated triage nurses to fill the evening shift between the hours of 6-11pm seven days a week. This is necessary as workload increases as the trial expands, but more importantly to ensure consistent and quality advice is given. The trial has currently appointed three triage nurse and expressions of interest have been obtain from a further two nurses who will be interview by in early October. Supervising nurses in Stawell will continue to cover the service from 11pm to 8am, when call numbers are few.

Supervising nurses were also invited to attend a view and up-skill session with Robin Tchernomoroff, the triage nurse educator from the Collaborative Health, Education and Research Centre. This session was not well supported due to conflicting demands and another peer review event. The Trial Sponsors proposed additional meetings and to cover the cost of such meetings, however, the service provider had difficulty establishing suitable dates. The trial sponsors feel that the Service Providers as the employers of the trial nurses must give direction and support to ensure that these meetings occur.

4. Budget

At this stage, it is anticipated that the trial can be completed on budget.

EXPENSE REPORT AS AT December 31, 2001

ACCOUNT	BUDGET	ACTUAL
INSURANCE	$1,300.00	$100.00
PETTY ITEMS OF EXPENSE	$636.00	$610.48
TRAINING	$12,000.00	$2,000.00
TELEPHONES	$1,400.00	$1,848.19
TRAVEL	$6,000.00	$5,108.21
GP PROGRAMME INVOLVEMENT	$5,250.00	$10,295.00
EVALUATION	$32,000.00	$32,000.00
NURSE WAGES	$97,500.00	$78,317.67
PROJECT OFFICER	$55,000.00	$51,424.00
ADMIN WAGES	$6,770.00	$6,770.00
CONSUMERS	$650.00	$625.00
PROJECT MANAGEMENT	$14,400.00	$18,567.00
STAFFING ONCOSTS	$10,000.00	$8,817.55
EQUIPMENT	$3,500.00	$2,120.55
PRINTING & STATIONERY	$1,500.00	$2,342.00
POSTAGE	$2,475.00	$2,698.00
Total	**$249,881.00**	**$223,643.65**

4.1. Expenditure report

Phase two expenditure to date is less than anticipated as the account for nurse training has not been received. The amount indicated above therefore actually represents an estimated cost to December 31, 2001, based on previous accounts. Due to the appointment of a specific triage nurse to answer calls between 6.00pm and 11.00pm, the cost associated with nurse wages is approximately $2,000.00 less per month.

The anticipated unspent fund at Dec 31 is $26,237.35. It is however anticipated that accounts to be paid will include additional training costs and auditing accounting costs. An audited financial statement will be prepared in February 2002 and provided by the end of that month.

5. Consumer Perspective of After Hours and Trial

5.1. Consumer Representative Feedback

The Consumer Representative in this role will highlight and expand on the following:

- A parent's perspective

- Concerns/expectations of parents in relation to the availability of services
- After hours care/when does this start and end
- Contact with Doctors after hours

The consumer report contains information and data that is sourced from the following areas:

- Contact with the major consumer group (mothers of young children) through holding the position of President of the Committee of Management for the Stawell & District Pre-School Association.
- Position: Planning & Future Developments
- Family Caseworker- Strengthening Families
- Experiences gained as a mother of three young boys five, four and two.

Throughout Phase 2 of the trial feedback has been coming through steadily to the consumer representative. Both Ararat and Stawell patients have provided information to contribute to the trial. All information has been gathered as patients told their stories to others and then later followed with a request for a formal interview in a confidential manner. After conducting several interviews it became obvious to the Consumer Representative that a standard proforma was needed to ensure all relevant information was collected at that time. This has been developed and is being used.

Consumer case studies

The Consumer Representative reported that a Stawell mother of a young child used the after hours triage system several times within a week. She was very happy with the service she received and indicated she would use the service again. She indicated “The Nurse was friendly and helpful”, “The Nurses encouraged us to ring back if we were worried or the condition became worse”, “We didn’t hesitate to use the Triage system as we knew it existed”.

A mother praised Triage Nurses who acted quickly and precisely in a situation when her 2-year-old child had a lump in his stomach. The child was brought to the hospital to see a GP and required surgery. The parents of the child reported that they would be happy to seek nurse triage advice in the future.

An Ararat mother of a young child visited the Ararat Medical Centre at 5:15pm to be told she needed to go to the hospital, as the clinic did not have any doctors available. She was told to go to outpatients. The hospital seemed confused as to why she would go to the hospital. She commented: “It appeared confusing to everyone when office hours commenced and finished:, “I was charged after hours rates which stinks when I attended the Medical Centre in office hours”, “Nurse was snappy”, “The whole experience was unclear”.

The Trial Sponsors believe these reports emphasis the need to advertise the trial as it progresses to a service.

In summary the Consumer Representative has reported that:

- Generally the Stawell Community are not aware of the Trial and how the Triage system operates

- A serious incident involving a child's life was handled well by the Triage Nurse
- Ararat Community continues to go to the hospital to be seen by a Doctor instead of phoning a Triage Nurse
- Ararat Community appear to be unaware of Triage Nurse extra training
- Semi Remote Rural area's (50kms from Stawell) see Triage system to be wonderful as it breaks down isolation barriers and the need to travel into town unnecessarily.
- Nurse was considered friendly
- Nurse information was accurate and precise
- GPs were reported to be taking to much time getting to the hospital after Triage Nurse called them to see the patient

6. Provider outcome

The steering committee for Phase 2 of the trial has remained essentially the same as for Phase 1. The steering committee is comprised of local GPs, local nurses, Division representatives, a hospital CEO a practice manager and a community representative. The trial sponsors are progressing towards new committee structures and members as the trial moves towards a service. Terms of reference for the new structure have been developed and are in the process of being endorsed by the West Vic Division of General Practice Board of Management. The new structure will ensure that there is strong involvement from all regions and involvement of representatives with significant experience in after hour services. The new structure will ensure the trial progresses to a sustainable and successful service, whilst presenting the Commonwealth with a complete after hours rural perspective.

Protocols have been developed in conjunction with local GPs, local nursing staff and the Division management committee for Phase 1 and continue to be used in Phase 2. Whilst these protocols have been sufficient for the current trial, it has been determined that as the trial moves towards a service these protocols need to be revisited. In this regard Triage Nurses and selected GPs involved in the service were given a range of established protocols. It was determined that the protocols developed by Julie Briggs were the superior to others. The top 20 reasons for contacting the service were established and Briggs protocols modified to be applicable to Regional Australia. GPs and Triage Nurses have endorsed the modified protocols.

The trial sponsors have also consulted with the Collaborative Health Education and Research Centre and specifically Robin Tchernomoroff a nurse educator with vast experience in the area of developing emergency nursing guidelines and nurse triage education to play a role in the development of training modules. Following an initial meeting a formal proposal has been put to this organisation seeking their involvement. The proposal requested involvement in "how to use the protocols" document as well as education module development. The trial sponsors expect to have a reply in the very near future, as they are aware that the organisation has meet to discuss the proposal.

Trials in live stage in Stawell, Ararat, Beaufort, Casterton, Coleraine and Edenhope. Further discussion has occurred with Warracknabeal

A number of significant personal experiences are being recorded.

A Forum has been held for all key players involved in the trial. The forum has provided the opportunity to showcase the lessons learnt and to plan for the future of after hours care in the rural setting.

Commonwealth Representatives visited the region on the 20th June. A series of brief meetings were arranged which allowed the Stawell CEO, a Stawell GP, a Ararat GP, a Triage Nurse, a Practice Manager, a Local Evaluator and the West Vic Division of General Practice to present their perspective of the trial. This was a highly successful event, with positive perspectives being presented from those involved in the trial. Below are some comments made on the day.

"Trial has made a big difference with recruitment and retention"
"Eager to consolidate and continue to cover other areas"
"On call is a cross we bare (GP), which we don't get paid for, we don't want to be heros at 2am and then start at 8am. PIP increase has been nice, but we don't want to see more patients, the less at night the better".
"Triage is a big incentive in recruitment"
"If didn't have triage it would be one reason why I (GP) would leave sooner, rather than later"
"Triage is viewed as a skill, it is becoming a specialised area"
"Triage is formalising a process"
"There is a psychological feeling of increased freedom being able to switch through to a triage nurse and thus a screening system"
"Trial important to be able to offer it to other small regions"
"Triage service is a great thing and well received"

The trial has moved towards the employment of three dedicated triage nurses between 6-11pm to ensure consistent and quality advice is given.

A formal quality assurance process which is comparable to rural hospital quality assurance process has been developed with the assistance of West Vic Division of General Practice GP and local nurse with significant experience in the area of Quality Assurance has.

7. Conclusion

The Central Grampians After Hours Medical Trial has been successfully implemented since October 1999 and continues to expand in coverage.

It can be stated that the Central Grampians After Hours Trial was highly successful in achieving the objectives of the trial. After hours services were improved from the GP, consumer and hospital perspective. The trial has provided the Commonwealth and decision-makers with a better understanding into the issues involved in the unique provision of quality rural after hours care. After hours calls to GPs have been reduced by over 50% and acceptance of regional call centers and nurse triage services in the rural area have been assessed.

Through Phase 2 of the trial, a number of significant findings have been identified which impact on the provision of after hour nurse telephone triage services. Firstly it is clearly evident that rural consumers have the right to access to and want quality after hour services. In a small rural community the provision of quality care is shared between the rural GP and the local hospital. Share service provision often leads to complex relationship issues, any after hours initiative must value add to the relationship not detract from future sustainability issues. The local politics of the small rural communities must never be under estimated. It is important to identify who are the key change agents and the strategic thinkers within the nursing and GP workforce.

Rural communities are often faced with GP shortages which in turn places increased clinical demands of the nursing workforce. These demands should not be transferred to the nursing workforce without training, support and professional recognition. Training around face to face triage for satellite hospital nurses can strengthen regionalised phone triage activity as the local nurses are part of the continuum of care after hours for those who need face to face assessment by a GP.

The triage model has identified that small rural hospitals do not have the capacity to staff dedicated triage nurses from existing staff. Finding the staff across three small hospitals can develop this capacity. In this regard the trial sponsors have successfully appointed three dedicated triage nurses who have received specialised training in telephone triage and will provide triage services in a rotating roster between the hours of 6pm and 11pm seven nights a week. After this time, calls will continue to be answered by supervising nurses at Stawell Regional Health Service. Besides having to address workforce capacity, infrastructure issues also required addressing the triage nurses need a computer, mobile phone and support from management and peers.

Any new role in rural nursing needs to be managed well. If not introduced effectively with clear support from management and role descriptions to nursing peers, the triage nurse can be perceived as not contributing effectively to the nursing workload. Introducing a different model may also mean that some experienced nurses may lose the task of answering community calls and resent the change. GP's who have had informal or adhoc after hours relationship with the hospital also can feel that they lose flexibility of pleasing themselves once they become part of formal arrangements and agreed rosters.

Existing systems have been refined to ensure quality service delivery. A significant amount of negotiation and consultation has occurred with widely recognised experts in the area of triage protocol development, education and quality assurance policy development.

In addition a kit has been produced outlining the key factors to consider when establishing and implementing a after hours nurse telephone triage service. This kit is of significant benefit to other organisations in their endeavors to develop such a service.

In concluding in can be indicated that substantial work has been undertaken to establish the trial as a service. The service has become entrenched as a valuable service to those involved, which they do not want to lose.

"The Service is the difference between me leaving the clinic and staying (GP)"

"Thank-you for providing peace of mind (Consumer)"

8. Reference

Campbell Research and Consulting. The General Practice Profile Study. A national survey of Australian General Practice. For the GP Branch, Department of Health and Family Services, Dec 1997.

Cragg DK, Campbell SM, Roland MO. Out of hours primary care centres: characteristics of those attending and declining to attend. BMJ 1994; 309:1627-1629.

Dale J, Shipman C, Locock L, Davies M. Creating a shared vision of out of hours care: using rapid appraisal methods to create an interagency, community orientated approach to service development. BMJ 1996; 312: 2106-1210.

Foster M, Kell A & Sprogis A. After Hours care Project. Final report. Hunter Urban Division of General Practice (1996).

Gallagher M, Huddart T & Henderson B. Telephone triage of acute illness by practice nurse in general practice: outcomes of care. British Journal of General Practice, 1998. 48(429): p1141-5.

Hallam L. Primary medical care outside normal working hours: review of published work. BMJ 1994; 308: 249-253.

Lattimer V et al. Safety and effectiveness of nurse telephone consultations in out of hours primary care: randomised controlled trial. The South Wiltshire Out of Hours Project (SWOOP) Group. BMJ, 1998. 317(7165): p.1054-9

Livingstone AE, Jewel JA, Robson J. Twenty four hour care in inner cities: two years' out of hours workload in east London general practice. BMJ 1989; 299: 368-370.

Karabatsos G. After Hours General Practice service: A guide for Divisions of General Practice. Access and Evaluation Resource Unit. 1999. Melbourne.

MacIsaac P. Rural Health services a changing system. West Vic Division of General Practice, 1996.

MacIsaac P, Snowdon T, Thompson R, Crossland L, Veitch C. (Undated) GPs leaving rural practice in Western Victoria. In Macisaac P et al., Rural GP Recuitment – The approach of the West Vic Division of General Practice.

Pegram R. (2000, draft) After Hours Primary Medical Care Services in Australia: An analysis of research, current data and activity. General Practice Branch-Health Service Division, Department of Health and Aged Care.

Pitts J, Whitby M. Out of hours workload of a suburban general practice: deprivation or expectation. BMJ 1990; 300:1113-1115.

Strasser R, Harvey D and Burley M "The Health Service Needs of Small Rural Communities The Australian Journal Of Rural Health Vol 2 Number 2 Feb 1994

APPENDICES NOT ATTACHED IN THIS REPORT, PLEASE CONTACT PROJECT MANAGER