Safety of telephone triage in out-of-hours care: A systematic review

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Abstract
Objective. Telephone triage in patients requesting help may compromise patient safety, particularly if urgency is underestimated and the patient is not seen by a physician. The aim was to assess the research evidence on safety of telephone triage in out-of-hours primary care.

Methods. A systematic review was performed of published research on telephone triage in out-of-hours care, searching in PubMed and EMBASE up to March 2010. Studies were included if they concerned out-of-hours medical care and focused on telephone triage in patients with a first request for help. Study inclusion and data extraction were performed by two researchers independently. Post-hoc two types of studies were distinguished: observational studies in contacts with real patients (unselected and highly urgent contacts), and prospective observational studies using high-risk simulated patients (with a highly urgent health problem).

Results. Thirteen observational studies showed that on average triage was safe in 97% (95% CI 96.5–97.4%) of all patients contacting out-of-hours care and in 89% (95% CI 86.7–90.2%) of patients with high urgency. Ten studies that used high-risk simulated patients showed that on average 46% (95% CI 42.7–49.8%) were safe. Adverse events described in the studies included mortality (n = 6 studies), hospitalisations (n = 5), attendance at emergency department (n = 1), and medical errors (n = 6).

Conclusions. There is room for improvement in safety of telephone triage in patients who present symptoms that are high risk. As these have a low incidence, recognition of these calls poses a challenge to health care providers in daily practice.

Key Words: After-hours care, emergency medical services, primary health care, safety, telephone, triage

Introduction
The organisation of out-of-hours primary care has changed in many developed countries during the last decade. In an increasing number of developed countries it is now provided by physicians who work in large-scale organisations [1–4], with an important role for telephone triage in the initial contact with the patient. Triage is the process of determining the level of urgency and type of health care required in requests for help. Different choices have been made regarding the utilisation of telephone triage across countries. In some countries telephone triage is performed by physicians [3,5], in other countries by nurses or other non-clinicians [2]. In addition, triage may be supported by computerised decision support systems [2].

Telephone triage may compromise patient safety, particularly if urgency is underestimated and the patient is not seen by a physician or with a delay in time. Identification of medical urgency during telephone contacts with out-of-hours primary care settings has proven to be suboptimal [6,7]. This may result in delayed treatment and thus suboptimal outcomes [8–10], but evidence on this is not consistent [11,12].

An older review of studies concluded that patient safety of telephone triage in out-of-hours care may be compromised [13], but a more recent Cochrane review [14] did not examine patient safety in detail [11,15,16]. Furthermore, the organisation and delivery of out-of-hours care has changed substantially in recent years, which may have influenced telephone triage [17,18]. In recent years a number of studies on telephone triage have been conducted, which is why we decided to perform a review of published research on telephone triage in out-of-hours care. The aim of this review was to assess the research evidence on patient safety of telephone triage in out-of-hours care.
How safe is telephone triage in out-of-hours care?

- Concerns have been expressed regarding the safety of telephone triage in out-of-hours care.
- We found that safety may be suboptimal in patients who present highly urgent symptoms. Improving safety poses a challenge given the low incidence of these patients.

Material and methods

Search strategy

We performed systematic searches in PubMed and EMBASE databases up to March 2010. The search strategy was designed to retrieve studies on telephone triage in out-of-hours care in relation to patient safety. As “telephone triage” is a relatively new term, we also used “telephone consultation” and “telephone hotline”, as suggested in previous reviews on telephone triage [14]. To identify research on clinical performance and patient safety, we searched for outcome measures concerning urgency estimation, advice, referral, and health outcomes. Our search included the following text words and MeSH/EMTREE terms: (telephone AND (triage OR consultation OR hotlines)) AND (harm* OR safe*) OR mortality OR hospitalisation OR accuracy OR appropriateness OR sensitivity OR specificity OR (patient simulation) OR incident OR (adverse outcome) OR (adverse event) OR error).

Furthermore, we checked the reviews of Bunn and Crouch [13,14,19]. Finally, we made a list of known relevant studies and we checked that our search strategy included all these studies.

Study selection

Inclusion criteria were formulated in relation to the research aim (Table I). First, papers were included only if they referred to settings open out-of-hours and focused on telephone triage in patients with a first presentation of a medical complaint. Telephone triage was defined as a telephone contact in which the caregiver asked questions to estimate urgency and necessary care level, in order to give advice or refer the patient. Second, studies were included only if outcomes were related to safe performance or subsequent adverse events. We excluded studies that were not written in English, did not have an abstract or a full text article available, as well as letters to the editor or comments. Also, we excluded studies that focused on telephone consultation for one medical complaint (e.g. poison centre) and studies on helplines (e.g. tobacco cessation). All search results were independently checked by two of the three researchers (LH, VR, MS), using the criteria mentioned in Table I. In case of disagreement on inclusion, the researchers discussed the abstract and, if necessary, retrieved the full-text article for detailed information. If the two researchers could not gain consensus on inclusion, a third researcher was consulted.

Data extraction and analysis

Two researchers (LH, VR) independently extracted study characteristics and safety outcomes from the studies included, using an extraction form. The researchers compared all extracted data and discussed cases of disagreement until consensus was reached or consulted a third researcher (MS). All information presented in the final tables was checked by a third researcher (MS).

We considered unsafe performance as triage which could harm patients because of under-triage, under-estimation of urgency, or under-referral. These triage outcomes could lead to delay in treatment and thus pose risks to patients. For each included study we calculated the percentage of safe performance with a 95% confidence interval, using the Wilson Binomial Proportion Confidence Interval [20]. If the percentage of safe performance was not reported explicitly by the authors, it was deduced from other reported figures. Sometimes only a subset of contacts was relevant for our research aim. Summary estimates of safety were calculated using weighted averages, corrected for the size of the study. Post hoc we distinguished two types of studies: observational studies of real contacts, which included both urgent and less urgent health problems, and prospective observational studies, which used high-risk simulated patients. For real contacts we presented figures on safe performance (including over-triage and over-referral) for studies presenting unselected patients and for studies defining highly urgent patients. High-risk simulated patients (i.e. highly urgent patients) were patients with urgent health problems who needed direct referral, and we calculated the actual safe performance. So, three figures of safe performance were presented. Finally, we described outcomes related to adverse events, such as deaths, hospitalisations, and errors.

Results

Study selection

The searches in PubMed and EMBASE resulted in 790 and 690 hits, respectively. Many studies were excluded because they were not related to actual
telephone triage or did not report outcomes related to patient safety. We included an additional four studies from the reviews of Bunn and Crouch, which were not identified by our search in databases. We included 34 studies on the safety of telephone triage (Supplementary Table I to be found online at http://www.informahealthcare.com/pri/abs/10.3109/02813432.2011.629150). Of these, 23 reported on safe triage, 11 on adverse events, and two on both. The year of publication varied from 1989 to 2009. Most of the studies were performed in the United States (n = 11009) or the United Kingdom (n = 181).

**Observational studies**

Thirteen observational studies with real patients were identified, presenting figures on safe performance of both unselected and high-risk patients (Table II) [21–33]. For one study it was not possible to report an exact figure of performance, because it presented a graph rather than figures [30]. Ten studies presented safe performance in unselected patients (n = 4934), with a weighted mean of 97% (95% CI 96.5–97.4%). One study examined calls that were not forwarded to a physician for confirmation and found this was unsafe in 50% of the cases [27]. Exclusion of this outlier resulted in a weighted mean of 98% (95% CI 97.7–98.4%). Also, five studies (n = 1266) presented safe performance in a high-risk population (weighted mean of 89%; 95% CI 86.7–90.2%). One study of Fourny et al. (2009) found that 70% of contacts were unsafe (n = 245); exclusion resulted in a weighted mean of 93% (95% CI 91.4–94.5%) [26]. Two studies reported specifically on performance in patients with a proven acute coronary syndrome (respectively 87% and 79%) [22,26].

**Simulated patients**

Eleven studies that used simulated patients were identified, but one was excluded because of unclear results (Table III) [6–8,10,34–39]. The estimated proportion of safe triage contacts varied from 9% to 100%, for a subset of high-risk cases. The weighted mean was 46% (95% CI 42.7–49.8%). The setting and telephone triage process varied for these studies. Six studies were performed at emergency department (ED) and urgent care settings [10,34–38]. The three most recent studies were performed in out-of-hours primary care settings [6–8].

**Adverse events**

Adverse events described in the studies included mortality (n = 6 studies) [11,16,26,40–42], unplanned hospitalisations (n = 5) [40,41,43–45], unplanned attendance at ED (n = 1) [42], and medical errors
<table>
<thead>
<tr>
<th>First author</th>
<th>Year</th>
<th>Design</th>
<th>Setting</th>
<th>Number (unselected/high risk)</th>
<th>Triage</th>
<th>% Safe performance (95% confidence interval)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Egleston</td>
<td>1994</td>
<td>Retrospective follow-up study</td>
<td>Emergency care ED</td>
<td>104</td>
<td>Appropriate advice in 102 of 104 cases at review; 2 calls inappropriate (= unnecessary referral to ED)</td>
<td>100 (96.4–100)</td>
</tr>
<tr>
<td>Srinivas</td>
<td>1996</td>
<td>Retrospective observational study</td>
<td>Telephone helpline and ED</td>
<td>300</td>
<td>97% of callers received appropriate advice as per protocol, while in 3% the advice given was considered to be either insufficient or inappropriate</td>
<td>97 (94.4–98.4)</td>
</tr>
<tr>
<td>Fatovich</td>
<td>1998</td>
<td>Prospective observational study</td>
<td>ED</td>
<td>1,682</td>
<td>Inappropriate advice in 1.4% of calls (= 23 calls); of which 11 (48%) were assessed as potentially life-threatening and 4 (17%) as a possible risk of serious sequelae</td>
<td>99 (97.9–99.1)</td>
</tr>
<tr>
<td>Sramek</td>
<td>1994</td>
<td>Prospective follow-up study</td>
<td>Ambulance care Ambulance dispatch centres</td>
<td>398/136</td>
<td>132 of 136 true urgent calls were detected</td>
<td>99 (97.5–99.6)</td>
</tr>
<tr>
<td>Farand</td>
<td>1995</td>
<td>Retrospective observational study</td>
<td>Emergency Medical Services</td>
<td>1,006/444</td>
<td>18 contacts were under-triaged; 426 of 444 urgent calls were triaged accordingly</td>
<td>98 (97.2–98.9)</td>
</tr>
<tr>
<td>Dale</td>
<td>2004</td>
<td>Retrospective follow-up study</td>
<td>Ambulance services</td>
<td>239</td>
<td>For 231 calls (96.7%) the majority of the panel agreed with the non-ambulance triage decision; in 35 calls at least one member of the panel thought an ambulance was needed; secondary review showed that only 2 calls needed an emergency ambulance (0.8%) and appropriateness was 99.2%</td>
<td>99 (97.1–99.8)</td>
</tr>
<tr>
<td>Deakin</td>
<td>2006</td>
<td>Retrospective observational cohort study</td>
<td>Ambulance service call centre</td>
<td>263</td>
<td>87% of patients with a confirmed acute coronary syndrome were classified as requiring a category A response (urgent)</td>
<td>87 (82.4–90.5)</td>
</tr>
</tbody>
</table>

(Continued)
<table>
<thead>
<tr>
<th>First author</th>
<th>Year</th>
<th>Design</th>
<th>Setting</th>
<th>Number (unselected/high risk)</th>
<th>Triage</th>
<th>% Safe performance (95% confidence interval)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fourny</td>
<td>2009</td>
<td>Prospective observational cohort study</td>
<td>University hospital-affiliated Emergency Medical Service call centre</td>
<td>245</td>
<td>Initial EMS dispatcher’s decision was appropriate for 171 (70%) patients with ST-elevation myocardial infarction</td>
<td>70 (64.0–75.4)</td>
</tr>
<tr>
<td>Jackson</td>
<td>1997</td>
<td>Retrospective observational study</td>
<td>Primary care Primary Care Clinic and Pediatric Health Information Line</td>
<td>19 vs. 50</td>
<td>Evaluators concurred that advice was appropriate in 95% of resident calls and 98% of nurse calls</td>
<td>Residents: 95 (75.3–99.1)</td>
</tr>
<tr>
<td>Hildebrandt†</td>
<td>2003</td>
<td>Retrospective follow-up study</td>
<td>Primary care physicians and answering services</td>
<td>119</td>
<td>50% (range 22–77%) of calls not forwarded to the on-call physician represented an emergency needing immediate contact with the physician</td>
<td>Nurses: 98 (89.5–99.6)</td>
</tr>
<tr>
<td>Scarfone</td>
<td>2004</td>
<td>Retrospective observational cohort study</td>
<td>Out-of-hours call centre of a tertiary care hospital</td>
<td>927/178</td>
<td>Compared with children referred immediately to the ED, the proportion instructed to go to the ED within 4 hours of the telephone call received significantly lower ED triage classifications (93% vs. 77%); 91.6% of non-urgent referrals were correct</td>
<td>98 (97.4–99.0) 92 (86.6–94.8)</td>
</tr>
<tr>
<td>St George‡</td>
<td>2005</td>
<td>Retrospective observational cohort study</td>
<td>Healthline</td>
<td>90</td>
<td>For 82.2% there were no safety concerns</td>
<td>82 (73.0–88.7)</td>
</tr>
<tr>
<td>Sprivulis</td>
<td>2004</td>
<td>Comparative study with concurrent controls</td>
<td>Health Direct and ED</td>
<td>842</td>
<td>Triage distribution at the ED of patients who complied with urgent telephone triage disposition was very similar to the triage distribution of patients triaged to non-urgent care who presented to the ED despite a non-urgent disposition (by telephone); same for hospital admissions</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

Total weighted mean 4,934/1,266 97 (96.5–97.4) 89 (86.7–90.2)

Notes: *Wilson Binominal proportion confidence interval; †Hildebrandt: self-triage of patients who have to decide whether or not their problem is an emergency; ‡Exact figures were not available in the article; ‡St George: stratified selection of contacts.
Safety of out-of-hours telephone triage

Eleven studies reported solely on adverse events, but St George et al. (2005) and Fourny et al. also reported on appropriate performance.

### Mortality

Six studies reported on mortality. Labradorre et al. reported one death after a call with a non-urgent disposition [42]. Kempe et al. found no deaths in two studies [40,41]. Lattimer et al. found a significant difference in mortality between triaged patients (0.9%) and control patients (0.8%) [11], whereas Thompson et al. did not find differences between these groups [16]. Fourny et al. stated that in-hospital mortality did not differ according to the appropriateness of the initial dispatcher’s decision [26].

### Unplanned hospitalisations

Five studies reported on hospitalisations related to under-referral. Stewart et al. found that 21% of patients who were not referred by the telephone triage centre NHS Direct were admitted to hospital compared with 12% of referred patients [45]. The under-referral rate with subsequent hospitalisation ranged from 0.2% to 5.2% [40,41,43,44].

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### Table III. Safe performance in telephone triage in simulated patient studies (high-risk patients; n = 10 studies).

<table>
<thead>
<tr>
<th>First author</th>
<th>Year</th>
<th>Setting</th>
<th>Number (high-risk cases)</th>
<th>Triage</th>
<th>% Safe performance (95% confidence interval)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verdile</td>
<td>1989</td>
<td>ED</td>
<td>46 (1 case)</td>
<td>In 9% appropriate advice to go to ED by ambulance; 61% gave advice to visit ED</td>
<td>70 (55.6–81.3)</td>
</tr>
<tr>
<td>O’Brien</td>
<td>1990</td>
<td>Urgent care centres</td>
<td>100 (1 case)</td>
<td>In 17 of 100 calls adequate advice to consult urgent care centre or ED</td>
<td>17 (10.9–25.5)</td>
</tr>
<tr>
<td>Isaacman</td>
<td>1992</td>
<td>ED</td>
<td>61 (1 case)</td>
<td>60.4% advised same-day evaluation (= implicit “gold standard”); 71.7% advised to see a physician; no statistical differences between the advice of physicians vs. nurses</td>
<td>60 (47.9–71.7)</td>
</tr>
<tr>
<td>Evans</td>
<td>1993</td>
<td>ED</td>
<td>30 calls (none of 3 cases)</td>
<td>Correct telephone advice was given to 74% of all calls</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Kunkler</td>
<td>1994</td>
<td>ED</td>
<td>72 (1 case)</td>
<td>In 75% appropriate advice (n = 54) to go to ED by ambulance/car/taxi</td>
<td>75 (63.9–83.6)</td>
</tr>
<tr>
<td>Aitken</td>
<td>1995</td>
<td>ED and private ED clinics</td>
<td>36 (1 case)</td>
<td>In 20 of 36 institutions that gave telephone advice, the advice was adequate (56%)</td>
<td>56 (40.0–70.8)</td>
</tr>
<tr>
<td>Yanovski</td>
<td>1992</td>
<td>Primary care Pediatric and family medicine (private practices and hospital)</td>
<td>117 (1 of 3 cases)</td>
<td>Appropriate advice for scenario on diarrhoea and dehydration: first-year residents 52%, third-year residents 59%, private practitioners 44%, and faculty physicians 100%. More than one third of all residents and private practitioners reached inappropriate management decisions</td>
<td>60 (50.9–68.4)</td>
</tr>
<tr>
<td>Moriarty</td>
<td>2003</td>
<td>Primary care telephone triage system</td>
<td>85 (all 4 cases)</td>
<td>51% of calls were under-triaged (not referred)</td>
<td>49 (38.6–59.4)</td>
</tr>
<tr>
<td>Giesen</td>
<td>2007</td>
<td>Primary care physician cooperatives</td>
<td>83 (5 of 20 cases)</td>
<td>Correct urgency estimation by triage nurses in 69%; overestimation in 12.5%; underestimation in 19% of contacts</td>
<td>76 (65.8–83.9)</td>
</tr>
<tr>
<td>Derkx</td>
<td>2008</td>
<td>Primary care physician cooperatives</td>
<td>153 (3 of 7 cases)</td>
<td>Triagists achieved the appropriate triage outcome in 58% of all calls; advice was underestimated in 41% of all calls and overestimated in 1% of calls</td>
<td>9 (5.0–14.0)</td>
</tr>
</tbody>
</table>

Total weighted mean | 753 | 46 (42.7–49.8) |

Note: *Wilson Binominal proportion confidence interval.
Table IV. Overview of adverse events in telephone triage (n = 13).

<table>
<thead>
<tr>
<th>First author</th>
<th>Year</th>
<th>Setting</th>
<th>Design</th>
<th>Adverse events</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sher</td>
<td>1994</td>
<td>Telephone helpline</td>
<td>Follow-up study (n = 317)</td>
<td>-</td>
</tr>
<tr>
<td>Lattimer</td>
<td>1998</td>
<td>Primary care physician cooperatives</td>
<td>Randomised controlled trial (nurse telephone consultation vs. normal primary care physician cooperative practice) (n = 7308 vs. 7184)</td>
<td>Within 7 days: 0.9% in control and 0.8% in nurse triage</td>
</tr>
<tr>
<td>Thompson</td>
<td>1999</td>
<td>Primary care physician cooperatives</td>
<td>Randomised controlled trial (n = 100 vs. 123)</td>
<td>Within 7 days: no significant differences found (control vs. nurse triage)</td>
</tr>
<tr>
<td>Kempe (outcomes)</td>
<td>2003</td>
<td>After-hours call centre of children’s hospital</td>
<td>Retrospective study (n = 1561)</td>
<td>No reported deaths</td>
</tr>
<tr>
<td>Labarere</td>
<td>2003</td>
<td>After-hours primary care call centre</td>
<td>Follow-up study (n = 409)</td>
<td>Death after call with non-urgent disposition: (0.2%)</td>
</tr>
</tbody>
</table>
Table IV. (Continued).

<table>
<thead>
<tr>
<th>First author</th>
<th>Year</th>
<th>Setting</th>
<th>Design</th>
<th>Adverse events</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mortality (after call)</td>
<td>Hospitalisations (after non-urgent disposition)</td>
</tr>
<tr>
<td>St George</td>
<td>2005</td>
<td>Healthline</td>
<td>Retrospective observational cohort study (n = 90)</td>
<td></td>
</tr>
<tr>
<td>Hildebrandt</td>
<td>2006</td>
<td>Private family medicine call handling</td>
<td>Retrospective observational study (N = 119)</td>
<td>-</td>
</tr>
<tr>
<td>Kempe (safe)</td>
<td>2006</td>
<td>Pediatric after-hours call centre</td>
<td>Retrospective follow-up study (n = 32,968)</td>
<td>No deaths within 1 week;</td>
</tr>
<tr>
<td>Stewart</td>
<td>2006</td>
<td>NHS Direct and ED</td>
<td>Follow-up study (n = 3,312)</td>
<td>-</td>
</tr>
<tr>
<td>Hirsh</td>
<td>2007</td>
<td>Tertiary care paediatric hospital with call centre for paediatricians</td>
<td>Retrospective follow-up study (n = 83)</td>
<td>-</td>
</tr>
<tr>
<td>Killip</td>
<td>2007</td>
<td>After-hours telephone service for family medicine clinic</td>
<td>Retrospective observational study (n = 63)</td>
<td>-</td>
</tr>
</tbody>
</table>

(Continued)
One study reported on unplanned ED attendance. One study reported on errors. A study of St George et al. reported that 0.023% of all calls to a nurse telephone line involved risk incidents, although none had critical outcomes [48]. Killip et al. reported that 22% of calls to an out-of-hours telephone service could have threatened patient safety; 3% involved errors with potentially serious consequences to patient safety [46]. Finally, Fourny et al. reported that in 1.1% of cases the lower endpoint for triage advice posed some risk to the patient [33]. Studies using simulated patients reported higher rates of unsafe contacts than studies using real patients. Therefore, the results of studies using simulated patients may be more valid than data extraction from medical records of real patients, because of the objectivity of the measurements. As both designs have advantages as well as disadvantages, making a choice is also a matter of feasibility.

<table>
<thead>
<tr>
<th>First author</th>
<th>Year</th>
<th>Setting</th>
<th>Design</th>
<th>Adverse events</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fourny</td>
<td>2009</td>
<td>University hospital-affiliated Emergency Medical Service call centre</td>
<td>Prospective observational cohort study (n = 245)</td>
<td>In-hospital mortality did not differ according to the appropriateness of the initial dispatcher's decision</td>
</tr>
<tr>
<td>St George</td>
<td>2009</td>
<td>Nurse-on-call: telephone triage line</td>
<td>Retrospective observational study (N = 173 189)</td>
<td>-</td>
</tr>
</tbody>
</table>

Note: 1 Hildebrandt: self-triage of patients who have to decide whether or not their problem is an emergency (calls not forwarded).
Furthermore, simulated patient studies had lower scores on safe performance compared with real patient studies. This most likely is partly due to the focus on high-risk cases in the simulated patient studies. These cases were carefully designed to allow a straightforward interpretation of the decisions taken. Also, appropriate decisions have been predefined, so that deviations from optimal decisions are more easily detected. Real patient studies often use expert review to assess appropriateness after the actual contact. These contacts may include many aspects that make a range of decisions legitimate. As a medical condition can change over time, decisions could be influenced by the timing of expert review. Even an estimated highly urgent contact is often less urgent afterwards, particularly in primary care. So, there could be hindsight bias in expert review studies.

Since out-of-hours care involves large numbers of contacts, the accumulated effects of unsafe telephone triage are substantial at population level and in patients with many contacts over time. Many developed countries have examined the rate of adverse events in hospital care. A systematic review reported that one or more adverse events occurred in 9.2% of all patients admitted to hospital [49]. Relatively little is known about patient safety in primary care settings, and even less in out-of-hours care. A retrospective patient record review study in Dutch out-of-hours primary care physician cooperatives in 2009 found patient safety incidents in 2.4% of all contacts; a third of these were related to telephone triage [50]. This study was based on medical records, so these figures are best compared with studies in real patients. The lower figure may show the benefits of recent reforms in out-of-hours care in the Netherlands, such as the introduction of a primary care physician who approves all telephone triage decisions.

Unsafe telephone triage does not always result in harm to patients. A considerable number of patients who visited an out-of-hours service will have a return or follow-up consultation. Patients may act upon feelings of non-safety and therefore receive appropriate care within a reasonable timeframe and without serious consequences, even when they were initially inappropriately managed [26,41]. Moreover, in most cases patients’ conditions will not deteriorate quickly, so there is often time to correct the initial health care decision [40].

**Strengths and limitations**

This review of observational research in telephone triage provided robust estimates of the safety of telephone triage at out-of-hours care. Nevertheless, some limitations have to be mentioned. Despite our systematic searches we may have missed relevant studies, because of inconsistent use of key words or a differential presentation of studies. For instance, we missed four studies from the reviews of Bunn and Crouch. Second, it is important to stress that our post-hoc distinction between research in real patients and research in simulated patients is associated with a number of differences, including clinical cases presented, measures of safety, and denominator for the calculations. The calculation of percentages for actual performance was made partly after interpretation of the study results and depended on the information available in the articles. Moreover, we focused on under-triage, under-estimation, and under-referral as triage outcomes that might compromise patient safety. However, over-triage could also compromise patient safety, if it results in an overload with insufficient resources and delay in treatment. Furthermore, it could result in other problems, such as overtreatment and medicalisation. Moreover, the articles included represent a range of settings, cases, and triage professionals, which limits the generalisability. We were not able to analyse differences concerning settings and triage professionals, because the number of included studies was limited. Finally, not all included studies reported figures on adverse events, and the studies on adverse events often did not have enough power to detect differences in clinical outcomes, given their relatively small sample sizes [16,26]. Also, these adverse events were probably not all preventable/avoidable by improving the quality of telephone triage.

**Implications for clinical practice**

In many countries telephone triage has a crucial role in the organisation and delivery of out-of-hours care [5,14,51]. It is expected to control workload and costs, while maintaining high safety of patient care [14,51]. An obvious question is how telephone triage can be improved. Computerised decision support systems have been tested, but it seems important to improve their clinical relevance substantially concerning safety and efficiency. Another approach is better training of nurses who are responsible for telephone triage. The quality of history-taking is essential for an appropriate triage decision [6,52]. The use of triage protocols can prompt nursing staff to ask appropriate questions [36] and identify accurately the patients at highest medical risk [41]. Education of triage nurses and physicians might contribute, as well as supervision and counselling by physicians [6,7,21]. Because of the low incidence of patients with urgent medical complaints [33], education should focus on the recognition of urgent calls and an adequate response to them.
Implications for future research

Studies on safety of triage are relatively old, especially when taking into account recent reforms of out-of-hours care. New studies on safety of telephone triage are needed to inform health policy. As different models for organising and providing telephone triage exist, comparative studies on effectiveness are recommended, considering different triage professionals and models [41]. Furthermore, evaluation of the cost-effectiveness of the involvement of primary care physicians for supervision of telephone triage is recommended.

Declaration of interest

The author report no conflicts of interest. The author alone is responsible for the content and writing of the paper.

References


Supplementary material available online
Supplementary Table I to be found online at http://www.informahealthcare.com/pri/abs/10.3109/02813432.2011.629150.