

Oncology/Haematology Telephone Triage Tool Kit for Children and Young People The Tool Kit Manual



This manual belongs to:

Hospital:

Developed by the Children and Young People's Cancer Nurses Group of the Royal College of Nursing and the Children's Cancer and Leukaemia Group.

Supported by the United Kingdom Oncology Nursing Society and the Royal College of Nursing.

Contents

1.0	Introduction and background	3
1.1	Quality of assessment and advice	3
1.2	National guidelines and recommendations	4
2.0	Aims and objectives	5
3.0	Quality and safety	6
4.0	The Tool Kit - content, application and implementation	7
4.1	Instructions for use	7
4.2	The Alert Card	8
4.3	The Triage Pathway Algorithm and Clinical Governance	8
4.4	The Triage Assessment Process and Tool	10
4.4.1	Key points	10
4.4.2	Risk assessment	11
4.4.3	The assessment process step by step	11
5.0	The Triage Log sheet	15
6.0	Training and competency	17
6.1	Target users and competency	17
6.2	The competency assessment	18
6.2.1	Summary	18
6.2.2	Conduct and responsibility	18
6.2.3	Maintaining Triage competency	19
6.2.4	Scope of the competency assessment	19
6.2.5	Competency assessment record	20
	References	23
	Appendix 1 - Alert Card example	25
	Appendix 2 - Skills for Health information	26-27

This publication contains information, advice and guidance, it is intended for use within the United Kingdom (UK) but readers are advised that practices may vary in each country and outside the UK.

The information in this manual has been compiled from professional sources. It provides a guideline for practice and is dependent on the clinical expertise and professional judgement of the registered practitioner who uses it. Whilst every effort has been made to ensure the provision of accurate and expert information and guidance, it is impossible to predict all the circumstances in which it may be used. Accordingly, the authors shall not be liable to any person or entity with respect to any loss or damage caused or alleged to be caused directly or indirectly by what is contained in or left out of this information and guidance.

1.0 Introduction and background

The Oncology/Haematology Telephone Triage Tool Kit for Children and Young People has been developed as a guideline for the provision of triage assessment and advice for staff answering telephone advice line calls.

This guideline provides recommendations for best practice for the appropriate treatment and management of children and young people (CYP) with cancer and serious blood disorders; it should be used in conjunction with the triage practitioners' judgment.

The development group recognised that there was a lack of relevant guidelines and training to support members of the clinical team who were undertaking telephone assessment of patients and providing clinical advice.

There is little published evidence regarding CYP oncology/haematology triage, though there is anecdotal evidence regarding the provision of 24-hour telephone advice line support for parents and carers in CYP Principal Treatment Centres (**PTC**) and CYP Paediatric Oncology Shared Care units (**POSCU**).

The group found that the advice and support provided at present was reliant on the experience and knowledge of the nurse or doctor answering the call and that although there were local models of good practice they had not generally been validated. There were no tested assessment or decision-making tools in use at present. Furthermore documentation and record keeping differed from trust to trust.

The group supported by the Royal College of Nursing (**RCN**) and the United Kingdom Oncology Nursing Society (**UKONS**) has adapted the UKONS adult triage tool for use in CYP services. The adapted tool was subject to a pilot in 5 PTCs and 2 POSCUs, which resulted in a very positive evaluation. The pilot was funded by the RCN.

UKONS successfully launched the original version of the tool for the triage of adults in 2010; this is now used widely in the United Kingdom and internationally for the telephone assessment and triage of patients who may be suffering from problems associated with systemic anti-cancer therapy, radiotherapy or immunosuppression (UKONS, 2010).

1.1 Quality of assessment and advice

The assessment and advice given regarding a potentially ill patient is crucial in ensuring the best possible outcome. Patient safety is an essential part of quality care; each and every situation should be managed appropriately.

The function of telephone triage is to determine the severity of the callers' symptoms or problem and direct the caller to the appropriate emergency assessment area if required or initiate appropriate medical or clinical follow up (Courson, 2005).

Telephone triage is an important and growing component of current oncology practice; we must ensure that patients receive timely and appropriate responses to their calls (Towle, 2009).

Telephone triage enables the call handler to have a positive impact on the standards of care. Successful triage will consistently recognise emergencies and potential emergencies, ensuring that immediate assessment and required interventions are arranged. Sujan (2014) found that the most frequent recommendation for improving communication was standardisation through procedures checklists or mnemonics, and appropriate training in their use; all of the above elements are used within the Tool Kit. Triage will also provide ongoing emotional support and care advice (Johnson and Yarbo, 2000).

1.2 National guidelines and recommendations

At the outset of this project there were no national guidelines in place to support training and standardisation of CYP oncology/haematology triage.

There are however, national recommendations regarding the provision of a telephone triage service:

- The *Manual for Cancer Services, Children's Cancer Measures* (2014) states that a 24-hour telephone advice service should be provided for children and young adults with malignancy and their carers. The measures also recommend that there should be agreed levels of training and qualification for those staff expected to manage advice line calls (NHS England 2013/14)
 - *NHS Standard Service Specification Template for Cancer: Chemotherapy (Children, Teenagers and Young Adults)* states that patients during chemotherapy must be given access to a 24-hour helpline (24 hours a day, 7 days a week) for urgent advice about side effects or symptoms of infection from chemotherapy (NHS England 2013/14)
 - Recommendations for telephone triage services contained in the Department for Health (DH) report *The Acutely or Critically Sick or Injured Child in the District General Hospital: A Team Response* (DH 2006) include: Development and implementation of algorithms such as those used by NHS Direct or ambulance services, specific training in the use of these tools and regular audits for compliance. The same report also states that it is essential that there are clear lines of communication to access appropriate emergency care teams, clinicians and advice, both within an individual hospital and the network
 - The World Health Organisation (WHO) *Collaborating Centre for Patient Safety Solutions* (WHO 2007) recommends that organisations use a standardised approach to handover and implement the use of the Situation, Background, Assessment And Recommendation protocol (SBAR). The Tool Kit that has been developed adopts this approach and guides the user through the process.
- This recommendation stresses in particular consideration of the out-of-hours handover process, and emphasises the need for monitoring of compliance. Standardisation may simplify and structure the communication, and create shared expectations about the content of communication between information provider and receiver (Sujan 2013)
- The NHS *Litigation Authority Risk Management Standards 2013-14* require an approved documented process for handing over patients. This requirement stresses in particular consideration of the out-of-hours handover process, and emphasises the need for monitoring of compliance (NHS England)
 - *Cancer Reform Strategy, Achieving local implementation - second annual report* (DH, 2009) identified the following winning principles that should be applied in the care of cancer patients:
 - **Winning Principle 1** - Unscheduled (emergency) patients should be assessed prior to the decision to admit. Emergency admission should be the exception, not the norm
 - **Winning Principle 4** - Patients and carers need to know about their condition and symptoms to encourage self-management and to know who to contact when needed
 - Patients have the right to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety and quality (The NHS Constitution for England, 2014)
- The tool that has been developed meets good communication recommendations, ensuring that contact assessment and action taken is recorded in a standard format, using an agreed process with a common language. The developed pathway ensures that the treating team is made aware of the parent/carer contact and can see clearly what occurred, thereby meeting all elements of the SBAR protocol.

2.0 Aims and objectives

The aim of the Triage Tool Kit is to provide guidelines that can be adopted as a standard and will:

- a. Improve patient safety and care by ensuring that they receive a robust, reliable assessment every time they or their carers contact a helpline for advice
- b. Ensure assessments are of a consistent quality and that advice is determined based on the use of an evidence based assessment tool
- c. Provide management and advice appropriate to the patient's level of risk. To ensure that those patients who require urgent assessment in an acute area are identified and that appropriate action is taken, but also to identify and reassure those patients who are at lower risk and may be safely managed by the primary care team or a planned clinical review and avoid unnecessary attendance
- d. Form the basis of triage training and competency assessment for practitioners
- e. Help to maintain accurate records of the assessment and decision-making process in order to monitor quality, safety and activity

The Tool Kit has been developed for use by all members of staff who may be required to answer 24-hour advice lines for CYP patients who:

- Have received chemotherapy/systemic anticancer therapy
- Have received any other type of anticancer treatment, including radiotherapy and bone marrow graft
- May be suffering from disease/treatment related immunosuppression (ie. acute leukaemia, corticosteroids)

Teenagers and Young Adults (TYA) with cancer should be cared for in a dedicated TYA unit, which may be part of a service for children, or for adults. Where they are treated in a children's service, this triage tool should be used. Where they are managed within an adult service, the corresponding adult tool should be used.

For the purpose of the Tool Kit, both oncology and haemato-oncology services are considered as one service and referred to as oncology.

This Tool Kit provides:

- Guidance and support to the practitioner at all stages of the triage and assessment process
- A simple but reliable assessment process
- Safe and understandable advice for the practitioner and the caller
- High quality communication and record keeping
- Competency-based training
- An audit tool

This tool does not address patient management post admission, nor does it contain admission pathways. It does, however, give the right of admission for assessment to the practitioner manning the helpline.

The level of oncology/chemotherapy knowledge and training required to manage a 24-hour advice line is variable nationally, and many practitioners feel unsure and ill equipped to make advanced care decisions. This Tool Kit is also an educational tool and includes a competency assessment framework that all disciplines of staff would need to complete prior to undertaking advice line triage.

3.0 Quality and safety

Males (2007) produced guidelines for the provision of telephone advice in primary care and stressed the importance of risk management/ mitigation and clinical governance in the provision of safe and high quality telephone care.

Males identified key factors to consider when developing such a service:

- Training
- Triage
- Documentation
- Appropriateness and safety
- Confidentiality
- Communication

On review, the Tool Kit was found to address all of the key issues above. If correctly used, the tool will contribute to the governance process, providing an accurate record of triage and assessment.

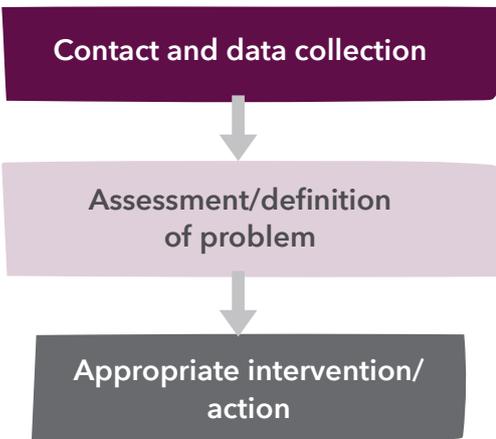
Regular review of triage records is recommended for assessment of quality and of practice. Along with quality and safety data, regular audit of the tool provides data regarding:

- Capacity and demand
- Common concerns and problems that CYP present with

The Tool Kit has been subject to a multi centre pilot, which resulted in an extremely positive evaluation.

4.0 The Tool Kit - content, application and implementation

The triage process can be broken down into three steps:



The Tool Kit supports and guides the practitioner through each of the three steps leading to the early recognition of potential emergencies and side effects of treatment, and provision of appropriate and consistent advice.

The Tool Kit consists of:

- The Tool Kit manual with competency assessment
- Alert Card recommendations
- The Triage Pathway Algorithm and Clinical Governance recommendations
- The Triage Log Sheet
- The Assessment Tool based on the WHO/NCRI-CTCAE common toxicity criteria with individual guidelines

4.1 Instructions for use

This section of the manual, sets out the way in which the Tool Kit itself should be used; who it should be used by; what training they require, and the competency assessment framework that should be used. It also contains the Triage Tool and the Log Sheet, which should be used to carry out the assessment, and to document the outcome of that assessment.

It is clinically focused and covers the triage and assessment process in detail and the clinical governance pathway:

1. Initial contact and data collection
2. Triage assessment and decision making
3. Giving interim clinical advice and information to patients or others who might be with them regarding further action, treatment and care
4. Referring a patient for further assessment

The Tool Kit has been designed to support telephone triage, but it could also be used as part of a face-to-face assessment in a health care environment.

4.2 The Alert Card

The group supports the recommendations of *National Chemotherapy Advisory Group* (2008) and the *Children's Chemotherapy Peer Review Measures* (2014) that each CYP and/or carer must be provided with information about when they may need to contact the advice line for help and clear contact details. The group suggests that a card containing key information about the treatment they are receiving and the advice line contact details should be provided for each CYP/ carer. These cards act as an *aide memoir* for the CYP and carer and as an alert for other healthcare teams that may be involved in the patient's care. Such cards are now widely used in the adult setting in the UK.

The card contains:

- Patient identification details
- Regimen details
- Information about symptom recognition/ warning signs
- Emergency contact numbers
- Information about treatment delivery area

CYP services may consider collaborating to produce a standard Alert Card and provide national education regarding its significance (appendix 1. p.25).

4.3 The Triage Pathway Algorithm and Clinical Governance

Written protocols and agreed standards can be useful to describe and standardise the process of data collection, planning, intervention and evaluation. They can also help reduce risk of liability (Males 2007).

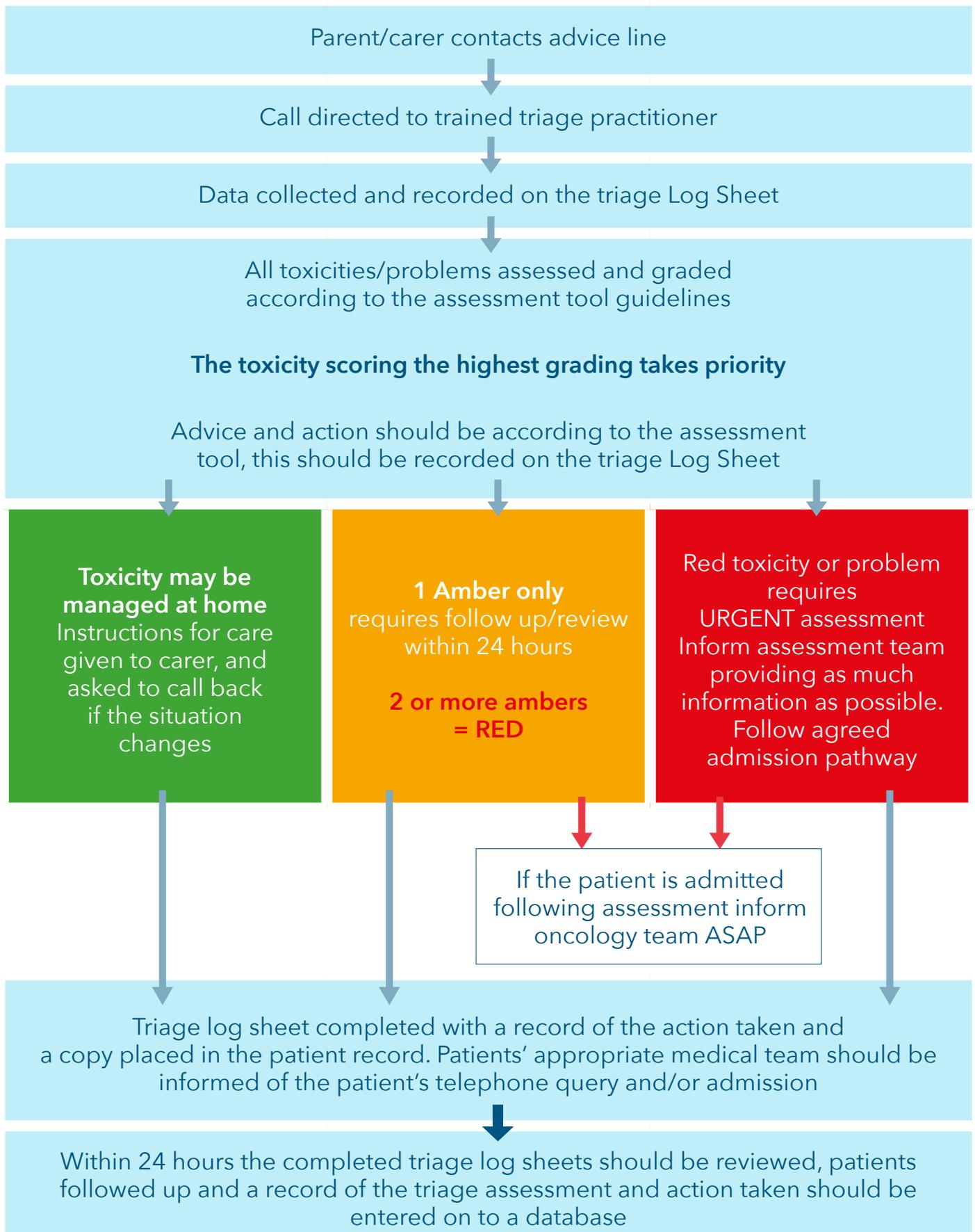
The group has developed a process map that details each step of the pathway and describes the role and responsibilities of the advice line practitioner, which should be agreed and approved locally. Advice line providers should have agreed assessment, communication and admission pathways. Assessment areas and routes of entry should be clearly defined.

There should be a clearly identified advice line practitioner for each span of duty. The process should allow for allocation of responsibility to a nominated triage nurse/doctor for a period of duty. On completion of this period the responsibility for advice line/triage management and follow up of patients is clearly passed to the next member of suitably qualified staff. This should provide a consistent, high quality service.

The Tool Kit is a guideline and should be approved for use in each service provider by the appropriate organisational governance group prior to implementation.

The governance responsibility for the provision of the advice line service and the use of the triage guidelines to support the service rests wholly with the service provider.

Triage Pathway



4.4 The Triage Assessment Process and Tool

The triage practitioner's assessment of the presenting symptoms is key to the process.

4.4.1 Key points

Dedicated time in a suitable area for the consultation will enable the clinician to pay appropriate attention to the caller, without being interrupted.

The practitioner needs to be aware of the caller's ability to communicate the current situation accurately, and should use appropriate questioning and prompts until all necessary information has been gathered. They should ensure that the parent/carer understands the questions asked and instructions provided, and that they should feel free to ask questions, clarifying information as required.

The triage practitioner should assess if telephone management is appropriate in the present situation. If the patient's presenting problem is an acute emergency, such as collapse, airway compromise, haemorrhage or severe chest pain, then the following action should be taken:

- The assessment process should be shortened, contact details and essential information collected
- Emergency services should be contacted and immediate care facilitated.

If there is any doubt about the parent or carers ability to provide information accurately or understand questions or instructions provided then a face-to-face consultation should be arranged.

The triage practitioner should consider the data collected along with the parent/carer level of concern in order to perform a clinical assessment and decide on the appropriate action to initiate.

The toxicity assessment triage tool is used as a guideline, highlighting the questions to ask and leading the practitioner through the decision-making process. This leads to appropriate action by giving structure, consistency and reassurance to the practitioner.

If, in the triage practitioner's clinical judgment the guideline is not appropriate to that individual situation, for example previous knowledge about the CYPs personal circumstances or disease that would either encourage the call manager to expedite face-to-face assessment, or conversely leave the child at home despite the recommendation in the Tool Kit, then the rationale for that decision should be clearly documented.

There are advice line calls/queries that will not be addressed by the assessment tool for example: a medication query or nasogastric tube misplaced. Advice in these circumstances should be given according to local policy.

A Log Sheet should be completed in these circumstances so that there is a record of the call and of the advice given.

4.4.2 Risk assessment

The triage tool is based on the WHO/NCRI-CTCAE common toxicity criteria.

It is a risk assessment tool used to grade the patient's symptoms and establish the level of risk the patient is currently under, and will enable practitioners to provide a consistent standard of advice. It is a cautious tool and will advise assessment at a point that will allow early intervention for those at risk.

The presenting symptoms have been red, amber, green (**RAG**) rated according to the grade and significance. The tool not only recognises high-grade symptoms such as pyrexia, but also recognises that a significant number of CYPs and carers who contact triage advice lines may not report a single overwhelming problem, but will have a number of low grade problems. The cumulative significance of these problems was demonstrated during the pilot with 67% of those asked to attend requiring either intervention or admission.

Action selection is based upon the triage practitioner's grading of the presenting symptoms/toxicity following interview, data collection and triage:

Red - any toxicity graded here takes priority and action should follow immediately. Patient should be advised to attend for urgent assessment as soon as possible

Amber - if a patient has two or more toxicities graded amber they should be escalated to red action and advised to attend for urgent assessment

Amber - one toxicity in the amber area should be followed up within 24 hours and the caller should be instructed to call back if they continue to have concerns or their condition deteriorates

Green - callers should be instructed to call back if they continue to have concerns or their condition deteriorates

If a CYP is required to attend for assessment then transport should be arranged for them if indicated either due to a deteriorating or potentially dangerous condition or lack of personal transport.

If the CYP is deemed safe to remain at home then the parent/carer should receive sufficient information to allow them to manage the situation and understand when further advice needs to be sought (Males, 2007).

4.4.3 The assessment process step by step

Step one – Perform a rapid initial assessment of the situation: “is this an emergency?” do you need to contact the emergency services?

Do you have any doubt about the parent/carers ability to provide information accurately or understand questions or instructions provided if so then a face-to-face consultation should be arranged.

Record name and current contact details in case the call is interrupted and you need to get back to the caller.

Step two – what is the parent/carers initial concern, why are they calling?

You should assess and grade this problem first, ensuring that you record this on the log sheet. If this score is **RED** then you may decide to stop at this point and proceed to organising urgent face-to-face assessment.

If the patient is stable you may decide to complete the assessment process in order to gather further information for the face-to-face assessment.

Step three – if the parent/carers initial concern scores amber, record this on the log sheet and proceed with further assessment.

Move methodically down the triage assessment tool, asking appropriate questions. e.g. do you have any nausea? If **NO** tick the green box on the log sheet and move on.

If **YES** use the questions provided to help you grade the problem and note either amber or red and initiate action (tick the log sheet).

If the CYPs symptoms score red or another amber at any time they should be asked to attend for assessment

Step four – look back at your log sheet: -

- Have you fully completed the assessment?
- Have you arranged assessment for all patients who have scored **RED**?
- Have you arranged assessment for all patients who have scored more than one **AMBER**?
- Have you fully assessed all the patients who have one **AMBER**, is there a tick in all the other green boxes of the log sheet?
- Have you fully assessed all the patients who have one **GREEN**, is there a tick in all the other green boxes of the log sheet?
- Have you recorded the action taken and advice given?
- Have you documented any decision you have taken or advice you have given that falls outside this guideline, and recorded the rationale for your actions?

Children and Young People Oncology/Haematology Triage Tool

TOXICITY	GRADE				
	0	1	2	3	4
Fever Has a recent full blood count been done? Result:	36°C - 37.4°C		37.5°C - 37.9°C Repeat in an hour and patient call back.	38°C or above	
Please note that hypothermia (<36°C) is a significant indicator of sepsis					
ALERT - Patients on steroids/analgesics or dehydrated may not present with pyrexia but may still have infection (if there are signs of sepsis arrange urgent assessment and review)					
Infection Site/sign of infection? Has the patient experienced any shivering, chills or shaking episodes - rigor? Has a recent full blood count been done? Result:	None	Site of infection/ inflammation, e.g. access device or line. Otherwise generally well. Arrange for review.	Signs of infection and generally unwell. Arrange for review.	Severe symptomatic Infection. Arrange urgent assessment and review.	Possible life threatening sepsis. Arrange urgent assessment and review.
Consider emergency paramedic support					
Activity Has there been a recent change in the child's activity? Do they appear or feel generally unwell? Please consider usual levels of activity in assessment.	No Change	Mild symptoms. No impact on usual activity. Arrange for review.	Symptomatic. Greater restriction of play and less time spent in play activity (Lansky score 70) Arrange for review.	Lying around much of the day. Minimal active play. (Lansky score 50-60) Arrange urgent assessment and review.	
Pain Is it a new problem? Where is it? How long has the patient had it? Has patient received any analgesia?	None	Mild Pain. Not interfering with function or activity. Advise/discuss analgesia.	Has Pain. Pain interfering with function but not activity. Arrange analgesia and review.	Severe pain. Pain interfering with function and activity and/or disabling. Arrange urgent assessment and review.	
Bleeding and Bruising Is it a new problem? Is it continuous? Where from? Is there any trauma involved? Is the patient on anticoagulants?	None	Mild, self limited bleeding controlled by conservative measures. Localised petechiae/ bruising	Uncontrolled bleeding. Moderate to severe petechiae/purpura/bruising. Urgent assessment to ward or emergency admissions unit as local policy directs. Consider emergency paramedic support.		
Dyspnoea/ shortness of breath Is it a new symptom? Is there a change in respiratory rate? Is there any chest pain? Impacting on patient activity?	None	No new symptoms	Dyspnoea on exertion. Arrange review.	Dyspnoea at normal level of Activity. Arrange urgent assessment and review.	Dyspnoea at rest, agitation, struggling, change in colour Arrange assessment and review. Consider emergency paramedic support.
Rash Is it localised or generalised? How long has it been there? Any signs of infection? Is it itchy? Consider post-BMT/SCT rash. Consider increasing petechial rash with low platelets	None	Macular or papular eruption or erythema without associated symptoms. Localised rash. Otherwise well.	Macular or papular eruption or erythema with pruritis or other associated symptoms. Arrange review.	Generally unwell with localised or widespread rash and/ or sudden onset. Arrange urgent assessment and review.	
Nausea, eating and drinking How long has the patient had nausea? What is the patient's oral intake? Is the patient taking anti-emetics as prescribed? What is appetite like?	No nausea. No change in normal eating and drinking habits.	Some loss of appetite, able to eat/drink reasonable intake. Review anti emetics and dietary advice.	Can eat/drink but intake significantly decreased. Normal urinary output. Review anti emetics according to local policy and arrange review.	Fluid intake significantly decreased. Poor urinary output. Arrange urgent assessment and review.	
Vomiting (Caution in the case of infants!) How many days/episodes? What is the patient's oral intake?	None	1 episode in 24 hours Review anti emetics as prescribed.	2-5 episodes in 24 hours. No change in activity levels. Normal urinary output. Review anti emetics according to local policy.	Over 6 episodes in 24 hours Arrange urgent assessment and review.	

TOXICITY	GRADE				
	 0	 1	 2	 3	 4
Mucositis How many days? Is there evidence of mouth ulcers? Is there evidence of infection? Are they able to eat/drink? Assess patients urinary output	None	Painless ulcers, erythema, mild soreness. Patient is able to eat, drink and talk as normal. No decrease in urinary output. Discuss mild analgesia and mouth care.	Painful ulcers, erythema, sore mouth. Patient is able to eat soft diet and take oral fluids. Arrange review. Discuss analgesia and mouth care.	Painful, sore mouth. Significantly decreased intake of diet and fluids, and/or difficulty talking. Arrange urgent assessment and review	
Diarrhoea (Caution in the case of infants!) Consider infection! How many days has this occurred for? How many times in a 24hr period? Does the patient have any abdominal pain/discomfort and for how long? Has the patient taken any medication? Consider post-BMT/SCT complication	None	2-3 movements a day above usual pattern. Drink more fluids. Consider stool sample in line with local policy. Consider regimen specific anti-diarrhoeal	4-6 episodes a day over usual pattern or nocturnal movement /moderate cramping. Drink plenty of fluids Consider stool sample in line with local policy. Consider regimen specific anti-diarrhoeal	7 episodes or more a day above normal patten or severe cramping and/or bloody diarrhoea. Arrange urgent assessment and review	
Constipation Is the patient on regular laxatives? Assess change from normal bowel pattern. How long since bowels opened? Does the patient have any abdominal pain/vomiting? Is the patient eating/drinking normally? Note: Bristol stool chart can be used to assess bowel movement	None	Mild - no bowel movement in last 24 hours over normal pattern. Dietary advice, increase fluid intake, review supportive medication.	Moderate - no bowel movement for 48-72 hours above normal pattern despite active intervention (medication). If associated with pain/vomiting move to Red. If not, review fluid and dietary intake. Recommend laxative	Severe - 72 hours or more over normal pattern with associated symptoms, e.g. pain and/or nausea/vomiting. Arrange urgent assessment and review	
Neurosensory/motor When did the problem start? Is it continuous? Is it getting worse? Is it affecting mobility/function? Any constipation or urinary incontinence?	None	Any new or increased signs of sensory loss, paraesthesia or weakness and/or loss of function. Arrange urgent assessment and review.			
Extravasation Any problems immediately after administration? What was injected/infused? When did the problem start? Is the problem around the injection site? Explain the reaction/appearance?	N/A	Non vesicant. Review next day		Vesicant. Arrange urgent assessment and review	
Infectious disease contact Has the patient had contact with infectious diseases such as chicken pox or measles or other?	None	Indirect contact. No symptoms.	Direct contact. No symptoms. Consider immunity status and prophylaxis.	Direct contact. Symptomatic. Arrange urgent assessment and review	
Other	None				Arrange urgent assessment and review

5.0 The Triage Log Sheet

It is vitally important that the data collection process is methodical and thorough in order for it to be useful and provide an accurate record of the triage assessment. A standardised format for recording telephone consultations will support the triage process in the following ways:

- A guide and check list for the practitioner, to remind them about the important information they should collect and reassure them that they have completed the process
- A communication tool that will relay an accurate picture of the problem, and action taken at the time of assessment, to the other members of the healthcare team
- A record of the process for quality, safety and governance purposes

We recommend that all advice line practitioners record verbatim what the parent/carer calls for (Males, 2007). This information may be important if the call should require review at any time. Assessment and advice can only be based on the information provided at the time of interview and an accurate record of what the practitioner was told and what they asked is vital.

A Log Sheet should be completed for **all** calls and unscheduled patient visits. This provides an accurate record of triage and decision-making and will support audit of the helpline service.

The data collected should be:

- **C**omplete
- **A**ccurate
- **L**egible
- **C**oncise
- **U**seful
- **T**raceable
- **A**uditable

There should be a robust local system of record keeping, with log sheets available for audit purposes.

24 Hour Triage Rapid Assessment and Access Tool Kit for Children and Young People - Log Sheet

Hospital name and department:

Patient details	Patient history	Enquiry details
Name:	Diagnosis:	Date: Time:
NHS no:	Who is calling?:
Hospital no:
DoB:	Male <input type="radio"/> Female <input type="radio"/>	Current contact no:
Age:	Consultant team:	Call <input type="radio"/> Drop in <input type="radio"/>
Phone no:

Reason for the call (in caller's own words):

What treatment is the patient receiving?

Chemotherapy (incl. oral maintenance) Radiotherapy Post BMT or Stem Cell Rescue Surgery Supportive None

State regimen:

When did the patient last receive treatment?:

What is the patient's temperature?: °C *please note that hypothermia is a significant indicator of sepsis*

Last full blood count?

Date:

Result:

Does the patient have a central line?

Yes No

Advise Follow up/review Assess
REMEMBER two or more amber = RED

Please document significant medical history/medication:

Fever	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Infection	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Activity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bleeding and/or bruising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dyspnoea/shortness of breath	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rash	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nausea, eating and drinking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vomiting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mucositis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diarrhoea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Constipation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Neurosensory/motor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Extravasation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Infectious disease contact	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other (please state)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Action taken:

Triage practitioner details

Signature:

Print name:

Designation:

Date:

Follow up action taken

Signature:

Print name:

Designation:

Date:

6.0 Training and competency

It is vital when introducing any defined process such as this that the team involved receives training and support and is assessed as proficient prior to participating (Males, 2007).

The Tool Kit Manual should be read in detail at the start of training, followed by a process of formal classroom based training with scenario practice, and then observed clinical practice and competency assessment. This approach was used in the pilot process.

The manual contains a competency assessment document linked to the national key skills framework that should be completed for all those who answer the advice line and undertake triage and assessment. It is recommended that this assessment be repeated regularly to ensure that competence is maintained; assessment could be linked to the chemotherapy annual competency assessment.

The set of training slides used during the pilot are available at www.cclg.org.uk/triagetool and can be adapted to include local detail, such as advice line numbers and service leads.

The training slides cover the following key points of the process:

- Development of the tool and rationale for use
- The triage process, pathway and decision making
- Clinical governance and professional responsibility
- The importance of accurate documentation, data recording and audit
- Telephone consultation skills, including active listening and detailed history taking

It is important that the wider healthcare team is made fully aware of the plan and implementation of the triage process and the strict requirements for specific training and competency assessment before providing this service.

It should be made clear that if they have not received training and competency assessment they should NOT be providing telephone healthcare advice and should refer these calls to a trained member of staff.

6.1 Target users and competency

All staff working within CYP oncology services and who are expected to manage advice lines should be appropriately trained as follows:

- Successfully complete the 24-hour triage training and competency assessment
- Nurses should have achieved a minimum of foundation competencies as recommended within the Improving Outcomes Guidance for Children and Young People with Cancer (NICE 2005)

N.B. Children and young people's medical staff should be made aware of the triage tool and, if expected to provide advice by telephone, should achieve triage competencies.

6.2 The Competency assessment

All staff expected to manage 24-hour triage advice lines should undertake this assessment.

6.2.1 Summary

This workforce competency covers the assessment of patients who:

- Have received chemotherapy/systemic anticancer therapy
- Have received any other type of anticancer treatment, including radiotherapy and bone marrow graft
- May be suffering from disease/treatment related immunosuppression (e.g. acute leukaemia, corticosteroids)

It is clinically focused and covers:

- Referring a patient for further assessment
- Giving interim clinical advice and information to CYP, parents/carers or others who might be with them regarding further action, treatment and care.
- It may involve talking via the telephone to an individual in a variety of locations or talking face to face in a healthcare environment.

The aim of the communication process is to assess the patient's condition and:

- Identify patients who require urgent/rapid clinical review
- Give advice to limit deterioration until appropriate treatment is available
- Provide homecare advice and support

Advice and information will usually be given to a parent or carer, unless the caller is an older teenager, in which case it may be given directly to the patient if they are of sufficient age to both understand, and to act on it.

Users of this competence will need to ensure that practice reflects up to date information and policies.

6.2.2 Conduct and responsibility

This workforce competence has indicative links with the following dimensions within the NHS Knowledge and Skills Framework (October 2004);

- Core dimension 1: Communication
- Core dimension 5: Quality
- HWB6 - Assessment and treatment planning
- HWB7 - Interventions and treatments.

Nursing and Midwifery Council (2015) The Code: Professional standards of practice and behaviour for nurses and midwives - further detail can be found at appendix 2.

6.2.3 Maintaining Triage competency

- Named assessors will assess triage practitioners on a 12 monthly basis
- Assessment will include observed practice, scenario assessment and discussion
- Assessment sheet will be signed by a nominated assessor and also by practitioner to confirm competence.

6.2.4 Scope of the competency assessment

This section provides guidance on required areas to be covered in this framework. Areas covered:

- Giving clinical advice which will include:
 - Managing emergency situations
 - Monitoring for and reporting apparent changes in the individual's condition
 - Calming and reassuring the individual or their parent/carer
- The importance of identifying the capacity of the parent/carer, or young person where applicable to take forward advice, treatment or care
- The importance of ensuring the caller contacts the helpline again if condition worsens or persists
- The importance of completing the assessment pathway and ensuring that decisions are documented and reviewed.
- The importance of documenting any decisions taken or advice given which falls outside this guideline and recording the rationale for the advice given and action taken

6.2.5 Competency assessment record

Following completion of training and assessment process the assessor and the practitioner must agree on and confirm competency.

Practitioner name: _____

Practitioner signature: _____

Assessor name: _____

Assessor signature: _____

Date: _____

This is to deem that: _____

Organisation: _____

has been assessed as competent in the use and application of the *24 Hour Rapid Assessment and Access Tool Kit*

To be signed and dated by the student and assessor to confirm competency

1. Knowledge and Understanding

You need to be able to explain your understanding of the following to your assessor:

		Date	Signature
1a	Your own role and its scope, responsibilities and accountability in relation to the provision of clinical advice.		
1b	The types of information that need to be gathered and passed on and why each is necessary.		
1c	How communication styles may be modified to ensure it is appropriate to the individual and their level of understanding, culture and background, preferred ways of communicating and needs.		
1d	Barriers to communication and responses needed to manage them in a constructive manner.		
1e	The application of the triage tool kit guidelines available for use as tools for decision making in relation to different types of request and symptoms, illnesses, conditions and injuries.		
1f	The importance of recording all information obtained in relation to requests for assistance, treatment, care or other services on the tool kit log sheet.		
1g	The process to be followed in directing requests for onward action to different care pathways and related organisations.		
1h	Why it is important that you advise the individual making the request of the course of action you will take and what will happen next.		
1i	The circumstances in which a request for assistance, treatment, care or other services may be inappropriate/beyond your remit and the actions you should take to inform the person making the request of alternatives open to them.		

2. Performance Criteria:

You need to demonstrate that you can:

To be signed and dated by the student and assessor to confirm competency

		Date	Signature
2a	Explain to the individual what your role is and the process you will go through in order to direct their request.		
2b	Select and apply the Tool Kit triage process appropriate to the individual, and the context and circumstances in which the request is being made.		
2c	Adhere to the sequence of questions within the protocols and guidelines. Phrase questions in line with the requirements of the protocols and guidelines, adjusting your phrasing within permitted limits to enable the individual to understand and answer you better.		
2d	Demonstrate competent use of the assessment tool and completion of the tool kit log sheet.		
2e	Explain clearly: <ul style="list-style-type: none"> • Any clinical advice to be followed and its intended outcome • Anything they should be monitoring and how to react to any changes • Any expected side effects of the advice • Any actions to be taken if these occur 		
2f	Clarify and confirm that the individual understands the advice being given and has the capacity to follow required actions.		
2g	Provide information that: <ul style="list-style-type: none"> • Is current best practice • Can be safely put into practice by people who have no clinical knowledge or experience • Acknowledges the complexity of any decisions that the individual has to make • Is in accordance with patient consent and rights 		
2h	Communicate with the individual, in a manner that is appropriate to their level of understanding, culture and background, preferred ways of communicating and which meets their needs. The ability to communicate in a caring and compassionate manner.		
2i	Communicate with the individual in a manner that is mindful of: <ul style="list-style-type: none"> • How well they know the patient • The accuracy and detail that they can give you regarding the situation and the patient's medical history, medication etc. • Patient confidentiality, rights and consent 		

2. Performance Criteria (continued):

To be signed and dated by the student and assessor to confirm competency

You need to demonstrate that you can:

		Date	Signature
2j	Manage any obstacles to effective communication and check that your advice has been understood.		
2k	Provide reassurance and support to the individual or third party who will be implementing your advice, pending further assistance.		
2l	Ensure that you are kept up to date regarding the patient's condition so that you can modify the advice you give if required.		
2m	Ensure that full details of the situation and the actions already taken are provided to the person or team who take over the responsibility for the patient's care.		
2n	Recognise the boundary of your role and responsibility and the situations that are beyond your competence and authority.		
2o	Seek advice and support from an appropriate source when the needs of the patient and the complexity of the case are beyond your competence and capability.		
2p	Ensure you have sufficient time to complete the assessment.		
2q	Provide information on how to obtain help at any time.		
2r	Record any modifications, which are made to the agreed assessment process and documentation and the reasons for the variance.		
2s	Record and report your findings, recommendations, patient and/or carers response and issues to be addressed according to local guidelines.		
2t	Inform the patient's medical team on the outcome of the assessment as per the assessment pathway.		

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Appendix 1. Alert Card example

<p>Always carry this card with you and show it to anyone who treats you!</p> <p>If you:</p> <ul style="list-style-type: none">○ Have a temperature of 37.5 or above○ Feel shivery or flu like○ Feel generally unwell <p>You must contact the 24-hour helpline immediately!</p>	<p> <i>(Insert 24-hour helpline contact number here)</i></p> <p></p> <p>24-HOUR HELPLINE CONTACT NUMBER</p> <p> <i>Somebody will always be there to help you.</i></p>
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<p>Greater Midlands Cancer Network</p> <p>CHEMOTHERAPY ALERT CARD!</p> <p>The complications of chemotherapy are potentially life threatening, they include Neutropenic sepsis which is a medical emergency and must be treated urgently!</p>	<p> Name:</p> <p> Hospital number:</p> <p> Treatment area:</p> <p> Regimen:</p> <p style="writing-mode: vertical-rl; transform: rotate(180deg);">Adapted by permission of UKONS</p>
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Appendix 2. Skills for Health and NMC Information

Please see below indicative links with the following dimensions within the NHS Knowledge and Skills Framework (October 2004);

- Core dimension 1: Communication
- Core dimension 5: Quality
- HWB6 - Assessment and treatment planning
- HWB7 - Interventions and treatments

Core dimension 1: Communication

Level 3: Develop and maintain communication with people about difficult matters and/or in difficult situations.

Core dimension 5: Quality

Level 2: Maintain quality in own work and encourage others to do so.

HWB6

Assessment and treatment planning: Assess physiological and/or psychological functioning when there are complex and/or undifferentiated abnormalities, diseases and disorders and develop, monitor and review related treatment plans.

HWB7

Interventions and treatments: Plan, deliver and evaluate interventions and/or treatments when there are complex issues and/or serious illness

Nursing and Midwifery Council (2015) The Code: Professional standards of practice and behaviour for nurses and midwives.

The practitioner is reminded that they are accountable for practice as detailed on the NMC (2015).

The code details the following guidelines for practise that are relevant to the advice line practitioner:

Ensure that you assess need and deliver or advise on treatment, or give help (including preventative or rehabilitative care) without too much delay and to the best of your abilities, on the basis of the best evidence available and best practice. You communicate effectively, keeping clear and accurate records and sharing skills, knowledge and experience where appropriate. You reflect and act on any feedback you receive to improve your practice.

Always practise in line with the best available evidence

- Make sure that any information or advice given is evidence- based, including information relating to using any healthcare products or services
- Maintain the knowledge and skills you need for safe and effective practice.

Communicate clearly

- Use terms that people in your care, colleagues and the public can understand
- Take reasonable steps to meet people's language and communication needs, providing, wherever possible, assistance to those who need help to communicate their own or other people's needs
- Use a range of verbal and non-verbal communication methods, and consider cultural sensitivities, to better understand and respond to people's personal and health needs
- Check people's understanding from time to time to keep misunderstanding or mistakes to a minimum

Work cooperatively

- Respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate
- Maintain effective communication with colleagues
- Keep colleagues informed when you are sharing the care of individuals with other healthcare professionals and staff
- Work with colleagues to evaluate the quality of your work and that of the team
- Work with colleagues to preserve the safety of those receiving care
- Share information to identify and reduce risk.

Keep clear and accurate records relevant to your practice

This includes but is not limited to patient records. It includes all records that are relevant to your scope of practice.

- Complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event
- Identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need
- Complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements
- Attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation

Ensure that you make sure that patient and public safety is protected. You work within the limits of your competence, exercising your professional 'duty of candour' and raising concerns immediately whenever you come across situations that put patients or public safety at risk. You take necessary action to deal with any concerns where appropriate.

Recognise and work within the limits of your competence

- Accurately assess signs of normal or worsening physical and mental health in the person receiving care
- Make a timely and appropriate referral to another practitioner when it is in the best interests of the individual needing any action, care or treatment
- Ask for help from a suitably qualified and experienced healthcare professional to carry out any action or procedure that is beyond the limits of your competence
- Complete the necessary training before carrying out a new role.

Always offer help if an emergency arises in your practice setting or anywhere else

- Arrange, wherever possible, for emergency care to be accessed and provided promptly.

Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

- Prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs
- Make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines.

Oncology/Haematology Telephone Triage Tool Kit for Children and Young People The Tool Kit Manual

This Oncology/Haematology Telephone Triage Tool Kit for Children and Young People has been developed by the RCN Children and Young People Cancer Nurses Group and the CCLG Nurses Discipline Group. It is based on the original work of UKONS, who created the first adult cancer Telephone Triage Tool Kit.

CLIC Sargent is pleased to support this work for the benefit of children and young people with cancer and their families, and has worked on the design and dissemination of the Tool Kit documents. This training manual and associated documents have been developed collaboratively by UKONS, RCN, CCLG and CLIC Sargent. There are options within associated documents for local NHS Trusts to apply their own logo to endorse local implementation.

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