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

The Tool Kit Pocket Flier

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

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Children and Young People Oncology/Haematology Triage Tool

TOXICITY	GRADE 0	GRADE 1	GRADE 2	GRADE 3	GRADE 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.	

INSTRUCTIONS FOR USE

The 24-Hour Telephone Triage Tool is a widely utilised recognised tool that is used to perform risk assessment for patients who have:

- Received systematic anti-cancer therapy including chemotherapy
- Radiotherapy
- Disease related immunosuppression.

It is a simple reliable evidence-based process that grades the toxicities according to the significance of presenting symptoms and advises action accordingly.

It is important that the effects of treatment are not underestimated and that the significance of the lower level amber toxicities are recognised.

Risk assessment process
There are a number of questions to ask and information that will need to be collected to make sure that the correct advice is given.

Step 1
Perform a rapid initial assessment of the situation: 'Is this an emergency?' Do you need to contact the emergency services? Assess urgent symptoms first.

Step 2
The user then moves methodically down the triage assessment tool, asking appropriate questions. e.g. do you have fever? 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** (tick the log sheet) and initiate action.

Step 3
Red and/or **Amber**:
If the child or young person's symptoms score one **red** or two **ambers** at any time they should be asked to attend for assessment. Patients may require urgent assessment in a suitable clinical area that provides access to investigation and treatment facilities.

One **Amber** only: Have you provided advice in accordance with local guidelines? Arrange follow-up and/or further monitoring for the patient.

Green:
If your patient scores **green** in all toxicities they should be reassured that the problem at present does not give cause for concern, but they should be vigilant and if the situation gets worse or does not improve they should call the **Helpline** immediately.

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TOXICITY	GRADE 0	GRADE 1	GRADE 2	GRADE 3	GRADE 4
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.	
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 pattern 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.	