Oncology/Haematology Telephone Triage Tool Kit for Children's Cancer Services: 2nd Edition 2020

The Tool Kit Manual

The Toolkit (RCN, CCLG, UKONS, CLIC Sargent 2020) has been developed for use by all members of staff who may be required to man 24-hour advice lines for patients who:

- Have received or are receiving systemic anticancer therapy
- Have received any other type of anticancer treatment, including immunotherapy, radiotherapy and haematopoietic stem cell transplant
- May be suffering from related immunosuppression (i.e. acute leukaemia, corticosteroids)

N.B. Adolescent patients treated within paediatric units ARE included in this pathway. Adolescent patients treated in adult units are included in the Adult UKONS Triage Tool. Systemic anticancer therapy is an overarching term encompassing all systemic anti cancer therapies including chemotherapy, immunotherapy and supportive therapies

This manual belongs to:

Hospital:

Royal College of Nursing

Children's Cancer and Leukaemia Group
Working together to beat childhood cancer

UKONS
Oncology Nursing Society

YOUNG LIVES vs CANCER
CLIC SARGENT

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Contents

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. Patients with non-malignant haematological conditions are not covered under the governance of this tool.

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).

Prior to the introduction of the Triage Tool, advice and support provided was reliant on the experience and knowledge of the nurse or doctor answering the call and 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. Furthermore documentation and record keeping differed from Trust to Trust.

The original CYP working group supported by the Royal College of Nursing (RCN) and the United Kingdom Oncology Nursing Society (UKONS) 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.

Version 2 of the CYP Toolkit was introduced in 2020 following review and update. This scheduled review includes the use of new systemic anticancer therapies including immunotherapies, to ensure it remains fit for purpose as treatments advance.

The Triage assessment process remains unchanged. A small number of amendments and additions have been made to the assessment tool and log sheet. These additions cover some of the new toxicities / problems that may occur with immunotherapies and take into account the lengthened side effect profile of these drugs. The review group also took the opportunity to add additional questions and prompts to both the assessment tool and log sheet to assist the practitioner in his / her decision making.

The information and instruction manual includes:

- Rationale for use.
- Brief description of the development and review of the toolkit.
- Examples of the Toolkit contents
- Instructions for use
- Governance and user responsibilities
- Competency Framework

The information and instruction manual is essential reading for anyone wishing to use or implement the UKONS Tool CYP 2nd edition in practice.

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 of 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 haematopoietic stem cell transplant
- 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:

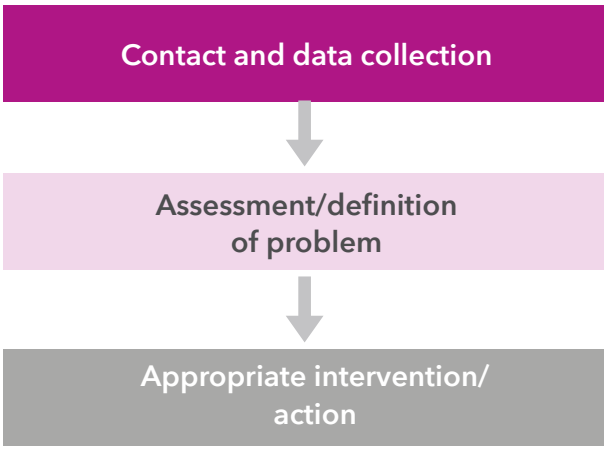
- Capacity and demand
- Common concerns and problems that CYP present with

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

Version 2 (2020) also includes learning from practice after 3 years of implementation across the UK

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.

The 2020 RCN / CCLG review group are aware of the tool being used by children's community nurses as an assessment tool during home visits, and are pleased to recommend this as a good practice tip.

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.28).

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 Triage 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 Triage 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 2020 RCN / CCLG review group are aware of good practice tips from sites where the tool has been successfully implemented. Some PTCs report that reducing from multiple numbers on a ward, clinic and day care unit to a single number mobile telephone held by a designated Triage practitioner, has improved quality and consistency of triage.

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 encourage the triage practitioner to expedite face-to-face assessment 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 must be advised to attend for urgent assessment as soon as possible

Amber – if a patient has two or more toxicities graded amber they must be escalated to red action and advised to attend for urgent assessment as soon as possible

Amber – one toxicity in the amber area must 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. Scheduling a less urgent face to face assessment may also be considered

Green – callers must be advised to call back if they continue to have concerns or their condition deteriorates or symptoms worsen

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. does the child have any difficulty breathing? 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 must 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?

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Patients may present with problems other than those listed below, these would be captured as "other" on the log sheet checklist. Practitioners are advised to refer to the NCI-CTCAE common toxicity criteria V5.0 to assess the severity of the problem and/or seek further clinical advice regarding management.

Caution! Please note patients who are receiving or have received IMMUNOTHERAPY may present with treatment related problems at anytime during treatment or up to 12 months afterwards. If you are unsure about the patient's regimen, be cautious and follow triage symptom assessment.

TOXICITY / SYMPTOM	All green = self care advice		1 Amber = review within 24hrs	2 or more Amber = Escalate to red	Red = Attend for assessment as soon as possible / consider 999	
	0	1		2	3	4
Fever Receiving or has received Systemic Anti Cancer Treatment (SACT) within the last 8 weeks or immunocompromised? Recent Blood count known? On G-CSF? Use Sepsis Six © principles	36°C – 37.4°C			37.5°C-37.9°C Remain alert and advise to call back if not settling, worsening or additional symptoms	38°C or above.	
	Please note that hypothermia (<36°C) is a significant indicator of sepsis.					
	ALERT- Patients on steroids/analgesia or dehydrated may not present with pyrexia but may still have infection. (If there are signs of sepsis through combination of symptoms in the Tool arrange urgent assessment and review / consider 999)					
Infection Site/ sign of infection? Shivering, chills or shaking episodes- rigor?	None	Site of infection / inflamation, e.g. access device or line, lower abdominal pain. Otherwise generally well. Arrange planned review		Signs of infection e.g. access device or line, abdominal pain, and generally unwell. Arrange for review	Severe symptomatic infection. Arrange urgent assessment and review. Follow sepsis pathway. Consider emergency paramedic support / 999	Potential life threatening sepsis (severe symptoms e.g. difficulty breathing, floppy, altered consciousness, clammy / sweaty skin, extreme discomfort) Arrange paramedic support and emergency care. Discontinue further triage questions
Shortness of breath / difficulty breathing Is it a new symptom? Change in respiratory rate? Accompanied with being pale, ashen, or mottled? Chest pain? Affecting activity level? Cough / wheeze? Choking?	None or no change from normal.			Short of breath on exertion. Arrange for review	Short of breath on normal level of activity. Arrange urgent assessment and review.	Short of breath at rest, aggitation, struggling, change of colour, choking, noisy breathing, grunting. Emergency assessment and review. Consider paramedic support.
Bleeding and Bruising Is it a new problem? Is it continuous? Where is it from? Is there any trauma involved? Is the patient on anticoagulants? Blood in urine or stools?	None	Mild, self limiting bleeding controlled by conservative measures. New localised petechiae / bruising. Monitor and arrange planned blood count if on treatment. Escalate to rapid review / blood count if ongoing or less localised.		Non-severe bleeding, but not self limiting or keeps restarting. Less localised petechiae / bruising.	Uncontrolled bleeding. Moderate to severe petechiae / purpura / bruising and / or non-blanching spots. Urgent assessment to ward or emergency admissions unit as local policy directs. Consider paramedic support.	
Neurosensory / neuromotor When did the problem start? Is it continuous? Is it getting worse? Is it affecting ability to function? Any constipation or faecal / urinary incontinence? Consider AVPU scoring (Alert, responds to Voice, Responds to Painful Stimulus, Unresponsive)	None	Any new or increased signs of sensory loss, parasthesia (abnormal sensation, pins & needles), or weakness and / or loss of function, altered gait, or level of consciousness. Any new problems noted with the child's vision. Arrange urgent assessment and review.				
Activity Recent change in activity?Appear or feel generally unwell? Paralysis (consider cord compression) Consider usual levels of activity in assessment, and normal for personal response to stage of current treatment. Consider treatment related fatigue	No change from normal	New mild symptoms. No impact on usual activity. Ensure planned review is scheduled		Symptomatic. Greater restriction on play or normal activities, and less time spent active. Arrange for review	Lying around much of the day. Minimal active play or normal activities. Sleepy, lethargic, floppy. Arrange urgent assessment and review	
Pain Is it a new or worsening problem? Location (consider devices and tumour site)? Intensity? Onset? Triggered by? How long? Patterns, e.g. morning? Pins & Needles? Child's words. Analgesia given and effect? Does patient have shunt, Ommaya Reservoir or other medical devices? Consider with Mucositis symptoms	None or no change from normal. Pain score 0	Mild pain. Not interfering with function or activity. Pain score 1-3 Arrange for review - consider phone review by CNS, ANP or Doctor or next scheduled appt.		Has pain. Pain interfering with function but not activity. Pain score 4-5 Arrange analgesia and review	Severe pain. Pain interfering with function and activity and / or disabling. Repeated Headaches (often worse in the morning) which may or may not affect functioning. Pain score 6-10 Arrange urgent assessment and review. Consider liaising with neuro teams.	

Rash and / or Infectious Disease Contacts Is it localised or generalised? Onset? Duration? Type? Signs of infection? Is it itchy? Close contact with infectious diseases (Chicken Pox, Measles, other) > 15 minutes? Consider post transplant GVHD. Consider increasing petechial rash with low platelets or non-blanching. Consider Burns rule of 9 to assess localised versus widespread as % of body surface area.	No rash or no change from normal. No known infectious contacts or no direct close contact.	Localised rash covering <10% BSA. Otherwise well. **Macular:** Small, flat spots or blemishes **Papular:** Small solid bumps rising above the skin. **Petechial:** flat, pin-prick spots often appearing in clusters. Close contact with infectious disease longer than 15 minutes, but not symptomatic. Arrange planned review, check immune status and consider prophylaxis	Macular or Papular rash covering 10-30% BSA with additional signs and symptoms, e.g. **Vesicular:** fluid-filled papules often associated with chicken pox **Erythema:** redness of the skin or mucous membranes **Pruritus:** severe itching Arrange assessment and review	Generally unwell. Localised or widespread rash >30% BSA and / or sudden onset that does not disappear under pressure i.e. non-blanching. GVHD flare up. Direct Infectious disease contact with symptoms. Arrange urgent assessment and review
Nausea, Eating & Drinking Onset of nausea? Appetite? Duration? Weight loss? Fluid intake in last 48hrs? Thirst? Taking anti-emetics? Impact on wellbeing and activites? Consider against pain grading	No change from normal	Some loss of appetite / mild nausea – still able to eat and drink to near normal intake. Review anti-emetics and dietary advice	Can eat & drink but intake significantly decreased from normal. Moderate nausea impacting activities. Review anti-emetics according to CCLG National Guidelines. Arrange planned review (could include telephone review).	Oral intake significantly decreased, with or without debilitating nausea. Excessive thirst. Prolonged nausea with other concerns from parents e.g. behaviour change, weaknesses, headache. Arrange urgent assessment and review.
Vomiting Caution in the case of infants. How many episodes over how many days? Impact on wellbeing and activity? Oral intake? Any particular triggers or patterns, e.g. every morning on waking? Possible infectious causes?	No change from normal	1 episode in 24hs Review anti-emetics as prescribed	2-5 episodes in 24hrs. No change or limited impact on normal activity levels. Normal urinary output. Review anti-emetics according to CCLG National Guidelines for CINV and / or explore infectious causes	Over 6 episodes in 24 hrs. Repeated early morning vomiting; may only be one episode a day. Arrange urgent assessment and review
Mucositis Onset? Duration? Severity? Mouth ulcers, white patches on mucosa? Coated tongue? Red inflamed gums? Consider mixed symptoms & potential for systemic fungal infections, esp. post haematopoietic stem cell transplantation (HSCT). Consider personal history of post-treatment mucositis.	None	Painless ulcers, mild redness, mild soreness. Patient able to eat, drink and talk as normal. Discuss mild analgesics and mouthcare. Personal history of pattern of severe post-treatment mucositis - escalate to amber	Painful ulcers, redness, sore mouth. Able to maintain some fluids and soft diet. Arrange planned review. Discuss analgesia and mouthcare until reviewed.	Painful, sore mouth. White patches and / or multiple ulcers. Significant decrease in fluids and diet, and / or difficulty talking and swallowing. Arrange urgent assessment and review
Urinary output Passing urine / nappies wet? Colour of urine? Are they drinking normally? Pain / discomfort? Consider urinary obstruction in certain tumour types. Consider infection.	No change from normal Normal urine output. Clear light straw coloured urine		Reduced urine output / nappies less wet. Urine colour dark. Discomfort Arrange planned review. Advise increasing fluid intake.	Poor or absent urine output / dry nappies. Dark urine. Sunken fontanelle in babies. Few or no tears when crying. Dry mouth. Drowsy. Pain. Arrange urgent assessment and review
Diarrhoea Caution in the case of infants. Onset? Duration? Severity? Abdonimal pain / discomfort? Any medication to relieve? Consider post haematopoietic stem cell transplantation (HSCT) N.B. Patients receiving imunotherapy should be managed according to the drug specific pathway and assessment arranged as required.	None or no change from normal	2-3 bowel movements a day above normal 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 bowel movements and / or moderate cramping. Drink plenty of clear fluids. Consider stool sample in line with local policy. Consider regimen specific anti-diarrhoeal. If diarrhoea persists after taking regimen specific antidiarrhoeal escalate to red. If patient is or has been on immunotherapy escalate to red	7 episodes or more a day above normal pattern or severe cramping and / or bloody diarrhoea. Patient is or has been on immunotherapy. 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 constipation - no bowel movement in the last 24hrs and different from normal pattern. Dietary advice. Increase fluid intake. Review medication.	Moderate - no bowel movement for 48-72 hrs above normal pattern despite active intervention (Medication). If associated with pain / vomiting escalate to red If not, review fluid and dietry intake. Recommend laxatives	Severe- 72 hours or more of no bowel movement with associated symptoms, e.g. Pain and / or nausea / vomiting / headache. Arrange urgent assessment and review.
Other:	None or no change from normal	Mild self limiting concerns able to be managed by non-triage related advice or reminder of existing advice and adherence to advice / medicines	Concerns not otherwise listed above which require non urgent planned review. This could include further telephone review with CNS, ANP or Doctor	Major concern not otherwise covered above. 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

The 2020 revised version of the Log Sheet includes asking about shunts or Omyer reservoirs, a positive response to this should be taken into account when considering symptoms. The Log also asks you to enquire if the caller has called any other health professional in the last 48hrs, and to record why. This is to help you assess if this is an ongoing problem and connect with previous assessments.

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 may be used for 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 Toolkit for Children and Young People V2 (2020) Log Sheet

Hospital name and department:

Patient details	Patient history	Enquiry details
Name: NHS no: Hospital no: DoB: Age: Phone no:	Diagnosis (Inc. other diagnoses / co-morbidities): Male ◯ Female ◯ Consultant team:	Date: Call start time: Who is calling? What phone number do you want us to call back on? Reason for the call (in caller's own words):

What treatment is the patient receiving? *(Please tick below)*

Chemotherapy (incl. oral maintenance) ◯ Immunotherapy ◯ Car-T ◯ Radiotherapy ◯ Post Stem Cell Transplant ◯ Surgery ◯ None ◯

When did the patient last receive treatment?:

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

When was the patient last discharged / reviewed? Have you called any other healthcare professional in the last 48 hours? Yes* ◯ No ◯

Does the patient have a central line? Yes ◯ N ◯ Does the patient have a shunt / Ommayer Reservoir / other medical device? Yes ◯ N ◯

Advise 🟢 Follow up/review 🟠 Assess 🔴 REMEMBER two or more amber = RED		Please document current medication	Please document significant medical history: (Include last FBC if known and date taken, and *detail of any recent calls)
Fever	🟢🟠🔴		
Infection	🟢🟠🔴		
Shortness of breath / difficulty breathing	🟢🟠🔴		
Bleeding and / or bruising	🟢🔴🔴		
Neurosensory / Neuromotor	🟢🔴🔴		
Activity	🟢🟠🔴		
Pain	🟢🟠🔴		
Rash and / or infectious disease contacts	🟢🟠🔴		
Nausea, eating, drinking	🟢🟠🔴		
Vomiting	🟢🟠🔴		
Mucositis	🟢🟠🔴	Action taken / advice given:	
Urinary output	🟢🟠🔴		
Diarrhoea	🟢🟠🔴		
Constipation	🟢🟠🔴		
Other (please state)	🟢🟠🔴	Attending for assessment at:	Receiving team notified: Yes ◯ N ◯ Call end time:

Triage practitioner details

Signature:	Designation:
Print name:	Date:

Review of actions taken: (Review no later than 24 hours after call. Single Ambers require earlier call back)

Signature:	Designation:
Print name:	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; re-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 a member of staff has 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) and current Children'e Cancer Service Specifications for each country in the UK.

N.B. Children and young people's medical staff should be made aware of the triage tool and, if expected to provide triage advice by telephone, should follow the training, assessment and recording process for Telephone Triage approved by the Trust Governance department.

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 and/or immunotherapy
- Have received any other type of anticancer treatment, including radiotherapy and haematopoietic stem cell transplant (HSCT)
- 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 (updated 2019);

- Core dimension 1: Communication
- Core dimension 5: Quality

Nursing and Midwifery Council (last updated 2018 or current version) 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 could 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 rational for the advice given and action taken

Re-assessment good practice tips:

- the local implementation protocol should include guidance on re-assessment agreed by the governance body for the Trust.
- Good practice might include an annual refresh and re-assessment tied in with annual chemotherapy updates.
- Re-assessment could include repeating the competency assessment or group sessions reviewing the Trust Telephone Triage Tool Audit findings, reflecting on practice and discussing improvements.
- Some teams review completed Log Sheets and reflect on learning from practice
- A sample re-assessment sheet has been included in the manual to allow for a flexible approach.

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*

1. Knowledge and Understanding You need to be able to explain your understanding of the following to your assessor:		To be signed and dated by the student and assessor to confirm competency	
		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: • 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: • 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: • 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.		

Re-Assessment Certificate

1. Personal Development

☐ I have, within the previous 12 months, demonstrated continual professional development in relation to Oncology/haematology Telephone Triage Toolkit, (e.g. attended workshops regarding the Telephone Triage Toolkit, reflective scenario-based session, conference presentations, re-read training materials)

2. Policies and Standards

I have read and understood the current legislation, literature and local Guidelines / SOPs regarding the requirement for a dedicated Oncology/Haematology Telephone Triage Helpline

☐ Cancer Service specifications
☐ Cancer services operational policy
☐ Out of hours management of an Oncology/haematology patient

3. Process

☐ I ensure the RAG system is followed when using the Telephone Triage Toolkit
☐ I ensure the 'log sheet' is appropriately completed and communication regarding patients is discussed with the relevant MDT
☐ I ensure when applicable 24 hour call backs occur through the agreed Hospital Designated Practitioner and / or myself

4.Communication Assessment Skills

☐ I conduct telephone consultations using the Oncology/haematology Telephone Triage Tool through application of good communication and information delivery skills
☐ I ensure patient/carers are aware of the Telephone Triage Tool and contact pathway pre discharge from Principal Treatment Centre or Paediatric Oncology Shared Care Unit.
☐ I have within the past year peer-reviewed log sheets within the service and participated in giving feedback to the wider team or Hospital trainer and / or engaged in learning from local TTT Audits.

5. Declarations

☐ I remain competent to use the Oncology/haematology Telephone Triage Toolkit
☐ I do/do not require any further training regarding the Oncology/haematology Telephone Triage Tool kit

Signed: _____ Date: _____

Name: _____

Position: _____ (Nurse/Clinician)

Assessor

I have observed _____ perform triage using the Oncology/haematology Telephone Triage Tool kit

Signed: _____ Date: _____

Name: _____ (Nurse/Clinician)

Position: _____

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Appendix 1. Alert Card example

Appendix 2. Skills for Health and NMC Information

Please see below indicative links with the following dimensions within the NHS Knowledge and Skills Framework (January 2019, https://www.nhsemployers.org/SimplifiedKSF);

- 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

- identifies the impact of contextual factors on communication
- adapts communication to take account of others' culture, background and preferred way of communicating
- provides feedback to others on their communication where appropriate
- shares and engages thinking with others
- maintains the highest standards of integrity when communicating with patients and the wider public

Core dimension 5: Quality

Level 2: Develop own skills and knowledge and provide information to others to help their development

- seeks feedback from others about work to help identify own development needs
- evaluates effectiveness of own learning/ development opportunities and relates this to others
- identifies development needs for own emerging work demands and future career aspiration
- offers help and guidance to others to support their development or to help them complete their work requirements effectively
- offers feedback promptly

Nursing and Midwifery Council (2018) 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 (2018).

The code details the following guidelines for practise that are relevant to the advice.

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's Cancer Services

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.

Version 2.0 May 2020

Royal College of Nursing

Children's Cancer and Leukaemia Group
Working together to beat childhood cancer

UKONS
Oncology Nursing Society

YOUNG LIVES vs CANCER
CLIC SARGENT