UKONS
Oncology Nursing Society

Oncology/Haemato-oncology
24-Hour Triage

TOOLKIT

INFORMATION AND INSTRUCTION MANUAL

The UKONS triage toolkit has been developed for use by all members of staff managing calls to the 24 triage lines for patients who:

- Have received or are receiving systemic anti-cancer therapy
- Have received any other type of anti-cancer treatment, including radiotherapy and bone marrow graft

N.B. Teenage and young adults are included in this pathway

3rd Edition | December 2024

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This publication contains information, advice and guidance; it has been developed for use within the UK, and 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 practitioner who uses it. Whilst every effort has been made to ensure the provision of accurate and expert information and guidance, it is not possible 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

The UK Oncology Nurses Society (UKONS) 24-Hour Triage Toolkit is a risk assessment tool that uses a Red, Amber and Green (RAG) scoring system to identify and prioritise the presenting problems of patients contacting the 24-hour triage lines for assessment and guidance.

It is a toolkit for use by all staff who are trained in the use of the toolkit and required to manage a 24-hour triage line for patients who:

- Have received or are receiving systemic anti-cancer therapy (SACT)
- Have received any other type of anti-cancer treatment, including radiotherapy and bone marrow cancer patients that have undergone transplant treatment

This guidance provides recommendations for best practice for the appropriate management of patients who contact the 24-hour triage line; it should be used in conjunction with the triage practitioner's scope of practice.

The original UKONS Toolkit was developed by the Central West Chemotherapy Nurses Group, a sub-group of UKONS, and was reviewed and endorsed by:

- UKONS
- The National Patient Safety Agency (NPSA)
- Macmillan Cancer Support
- The Society and College of Radiographers participated in the review and update of the tool in 2016

The first edition of the UKONS Toolkit was subject to a multicentre pilot, which resulted in an extremely positive evaluation.[1]

The original version of the tool for the triage of adults was successfully launched in 2010; it is now widely used across the UK and internationally for the telephone assessment and triage of patients who may be suffering from side effects associated with systemic anti-cancer therapy, radiotherapy and immunosuppression.[1]

This is version 3, the toolkit was also updated in 2016, following a multi-disciplinary review. These reviews have taken place to ensure that it remains fit for purpose. We would advise all organisations to ensure that you are using the most up to date version.

The triage and assessment process remains unchanged. A number of amendments and additions have been made to the assessment tool and log sheet.

The original development group recognised that there was commonly a lack of relevant guidelines and training to support members of the clinical team who were undertaking telephone assessment of patients, and often no consistent approach to triage either across or within organisations.

The group found that the advice and support provided 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 assessments or decision-making tools in use. Furthermore, documentation and record keeping differed from trust to trust.

There was little published evidence regarding oncology/haematology triage.

This Information and Instruction Manual provides:

- Rationale for use
- A brief description of the development and review history
- Examples of The Toolkit contents
- Instructions for use
- Governance and user responsibilities
- Competency framework

This information and instruction manual is essential reading for anyone wishing to use or implement the UKONS Toolkit in practice.

For the purposes of this document, oncology and haemato-oncology services will be referred to as ONCOLOGY.

Systemic anti-cancer therapy is an overarching term encompassing all systemic anti-cancer therapies including chemotherapy, immunotherapy and targeted therapies.

1.1 Quality of assessment and guidance

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

The function of telephone emergency/urgent triage is to determine the severity of the caller's symptoms and direct the caller if appropriate to an emergency assessment or initiate planned clinical follow up.[2] Telephone triage is an important component of current oncology and haematology practice; we must ensure that patients receive timely and appropriate responses to their calls.[3]

Successful triage will consistently recognise emergencies and potential emergencies, ensuring that immediate assessment and required interventions are arranged. Sujan[4] found that the most frequent recommendation for improving communication was standardisation through procedure checklists and appropriate training in their use. By using this tool appropriately and having received the correct training, this tool will improve communication and provide standardised patient triage, resulting in safer practice.

1.2 National guidelines, recommendations and reports

The UKONS triage tool kit is the only national guideline in place to support training, standardisation and consistency of oncology/ haematology triage. Implementation of the tool kit meets widely recognised national recommendations regarding the provision of a telephone triage service.[5] The Manual for Cancer Services recommends that all cancer patients receiving systemic anti-cancer therapy should have access to a 24-hour telephone advice/traige service.[5] The World Health Organisation (WHO) recommends that organisations use a standardised approach to handover and implement the use of the Situation, Background, Assessment and Recommendation process (SBAR).[6,7] This recommendation stresses in particular consideration of the out-of-hours handover process, and emphasises the need to monitor compliance. Standardisation may simplify and structure the communication, and create shared expectations about the content of communication between information provider and receiver.[4] The National Chemotherapy Clinical Reference Group[5] identified winning principles that should be applied in the care of cancer patients:

- Unscheduled (emergency) patients should be assessed prior to the decision to admit. Emergency admission should be the exception, not the norm
- 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 an approved or registered organisation that meets required levels of safety and quality.

The UKONS Triage tool uses the SBAR principles, which offer a structured method for communicating critical information that requires immediate attention and action contributing to effective escalation and increased patient safety[7].

2.0 Purpose and scope

The UKONS Triage Toolkit provides guidance that can be adopted as standard practice; it will deliver:

- Guidance and support to the practitioner at all stages of the triage and assessment process
- A simple but reliable assessment process
- Safe and understandable guidance for the patient for the practitioner and the caller
- High quality communication and record keeping
- Competency-based training
- Provides standards that can be used for auditing purposes

Teenagers and Young Adults (TYA) with cancer should be cared for within a dedicated TYA unit, which may be associated with a either a service for children, or for adults. If they are treated in a TYA unit associated with a children's service, the Children and Young Peoples (CYP) version of the triage tool should be used. Where they are treated within an associated adult service this version of the tool should be used.[19]

The UKONS Triage Toolkit is an educational tool and includes a competency assessment framework that all disciplines of staff would need to complete prior to undertaking advice line triage.

The UKONS Triage Toolkit is a risk assessment tool that does not address patient management post admission, nor does it contain admission pathways. It does, however, support recommendation for acute assessment by the practitioner who has carried out the triage.

Primary care guidelines for the provision of telephone advice in primary care stressed the importance of risk management/mitigation and clinical governance in the provision of safe and high quality telephone care.

Key factors to consider when developing such a service are:

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

The UKONS Triage Toolkit addresses all key factors above. If correctly used, the Toolkit 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 competency.

Standardised elearning training modules are now available for all staff to complete https://www.e-lfh.org.uk/programmes/ukons-telephone-triage-training/.

Along with quality and safety data, regular audit of the tool provides data regarding:

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

The UKONS acute oncology initial management guidelines are useful to use as an adjunct with the UKONS triage toolkit when providing care advice following telephone triage assessment https://www.ukons.org/site/assets/files/1067/ukons_ao_initial_management_guidelines_final_version_2

3.0 The UKONS Toolkit – content, application and implementation

The triage process can be broken down into three steps:

- Contact and data collection
- Assessment/definition of problem
- Appropriate intervention/action

The UKONS Triage Toolkit 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 UKONS Triage Toolkit consists of:

- The Toolkit information and instruction 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 NCI-CTCAE common toxicity criteria V5

3.1 Instructions for use

This section of the manual explains: how it should be used; who should use it; what training they require; and the competency assessment framework that should be completed. It also contains the Triage Assessment Tool and the Log Sheet, which should be used to carry out the assessment and to document the outcome following assessment.

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

3.2 The Alert Card

The National Institute for Health and Care Excellence (NICE) neutropenic sepsis clinical guideline,[11] National Chemotherapy Advisory Group (NCAG) report,[12] and NHS England Chemotherapy Peer Review Measures[13] recommend that all patients and/or carers who are receiving or have received systemic anti-cancer therapy should be given a 24-hour contact number for specialist advice along with information about how and when to use the contact number. This information should also include the at-risk timeframe for the treatment received, as this can vary.

The UKONS Triage Toolkit group supports these recommendations and would also recommend that a card containing key information about the treatment they are receiving and the triage line contact details should be provided for each patient/carer. These cards act as an aide memoire for the patient and carer and as an alert for other healthcare teams that may be involved in the patient's care.

The card should include at least the following:

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

Services may consider collaborating to produce a standard Alert Card and provide education regarding its significance.

3.3 The Triage Pathway Algorithm and Clinical Governance

Written protocols and agreed standards can be useful to describe and standardise the triage process, which is data collection, planning, intervention and evaluation, They can also help reduce the risk of liability.[9]

The algorithm below details each step of the pathway and describes the roles and responsibilities of the triage practitioner, this should be agreed and approved locally. Triage line service 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 practitioner for a period of duty. On completion of this period the responsibility for triage line 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 UKONS Triage Toolkit is a guideline and should be approved for use for each service provider by the appropriate organisational governance group prior to implementation. The governance responsibility for the provision of the triage line service and the use of the UKONS Triage Toolkit triage guidelines rests wholly with the service provider.

Triage Process Algorithm

Patient/carer contacts triage line

↓

Call directed to trained triage practitioner

↓

Information collected and recorded on the triage log sheet

↓

All toxicities/symptoms assessed and graded according to the assessment tool guidelines
The toxicity scoring the highest grading takes priority
Guidance and action should be according to the assessment tool;
this should be recorded on the triage log sheet

↓

Toxicity/problem may be managed at home. Self care advice and warning statement for the caller, asking them to call back immediately if they notice any change or deterioration	1 Amber requires follow up/ review within 24 hours. Self-care advice and warning statement for the caller, asking them to call back immediately if they notice any change or deterioration **2 or more ambers = RED**	Red toxicity or problem requires URGENT assessment. Inform assessment team, providing as much information as possible

↓

Triage log sheet completed with a record of the action taken and a copy placed in the patient record.
Treating team should be informed of the patient's attendance and/or admission

↓

Within 24 hours, the completed triage log sheets should be reviewed, patient's outcomes followed up and a record of the triage assessment and action taken should be entered on to a database with copy entered into the patients medical record

3.4 The Triage Assessment Process and Tool

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

3.4.1 Key points

Organisations should consider the location and provision of triage services and provide dedicated time in a suitable area for the telephone consultation to take place. This will enable the practitioner to pay appropriate attention to the caller without being interrupted and facilitate real time record keeping of the interaction. This ensures safe practice and aligns with similar organisational pathways such as 111 and 999. This standard should be consistent and maintained 24/7.

The triage practitioner should consider the level of concern of the patient/carer as well as the data collected using the assessment tool to decide on the appropriate action to initiate. If the patient's presenting problem is an acute emergency, such as collapse, airway compromise, severe haemorrhage or severe chest pain, then the following action should be taken:

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

Wherever possible the practitioner should speak directly to the patient as this will enable a more complete and accurate assessment. If a patient is too unwell to come to the phone this is always a significant concern.

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.

If there is any doubt about the patient's or the carer's ability to provide information accurately or understand questions or instructions provided then a face-to-face consultation assessment should be arranged.

Ideally the telephone practitioner should speak directly to the patient; a lot can be gained from this in relation to how unwell the patient may be – e.g. likely to be an unwell patient if they cannot come to the phone.

If, in the triage practitioner's clinical judgment, the guideline is not appropriate to that individual situation, for example previous knowledge about the patient's personal circumstances or disease that would either encourage the practitioner to expedite face-to-face assessment, or conversely leave the patient at home despite the recommendation in the UKONS Toolkit, then the rationale for that decision should be clearly documented. Escalation may provide inconvenience for the patient but no additional risk.

There are triage line calls/queries that will not be addressed by the assessment tool; for example, a medication query or central line problems. Advice in these circumstances should be given according to local policy. A log sheet should still be completed in these circumstances so that there is a record of the call and of the advice given.

3.4.2 Risk assessment

The assessment tool is based on the NCI-CTCAE common toxicity criteria.[10] It should be 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.

It is a risk assessment tool used to grade the patient's symptoms and establish the level of risk to the patient, and will enable practitioners to provide a consistent robust triage. It is a cautious tool and will advise assessment at a point that will allow early intervention for those at risk. It is NOT a diagnostic tool and any advice given to the patients must follow locally agreed pathways or be within the scope of practice of the practitioner.

The presenting symptoms have been Red, Amber and Green (RAG) rated, according to their significance. The tool not only recognises high-grade symptoms, but also recognises that a significant number of patients and carers who contact triage lines may not report a single overwhelming symptom, but will have a number of low grade symptons. The cumulative significance of these problems was demonstrated during the pilot, with 67% (70 of 101) 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:

Red – any toxicity graded red takes priority and action should follow immediately. The practitioner should arrange for an appropriate face-to-face assessment. Assessment pathways should be agreed locally.

Amber + – if a patient has two or more toxicities graded amber they should be escalated to red action and advised to attend for an urgent face-to-face assessment. Assessment pathways should be agreed locally.

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. No significant problems were identified.

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

If the patient is deemed safe to remain at home, the patient/carer should receive sufficient information to allow them to manage the situation and understand when further advice needs to be sought.[9]

Remember all advice given must be within the scope of practice of the practitioner or following local agreed pathways/guidelines.

Please Note patients may present with problems other than those listed on the assessment tool and log sheet, these would be captured as "other" on the log sheet checklist. Practitioners are advised to refer to the latest NCI-CTCAE common toxicity criteria to assess the severity of the symptom and discuss further assessment and management with a senior clinical colleague.

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ONCOLOGY/HAEMATO-ONCOLOGY TRIAGE LINE
TRIAGE ASSESSMENT TOOL, VERSION 3

CAUTION! Please note patients who are receiving or have received **IMMUNE CHECK POINT INHIBITORS** may present with treatment related problems at anytime during treatment or even months to years after treatment has been completed. If you are unsure about the patient's regimen, be cautious and follow triage symptom assessment.

All Green = self care advice **1 Amber = review within 24 hours** **2 or more amber = escalate to red** **Red = arrange for a face to face assessment as soon as possible**

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 latest version of NCI-CTCAE common toxicity criteria to assess the severity of the problem and seek further clinical advice regarding management.

Toxicity/Symptom ↓ Grade →	0	1	2	3	4
1. Shortness of breath Is there any chest pain or tightness? - If yes refer to chest pain. Is this a new symptom? How long for? Is it getting worse? Do you have a cough? How long for? Is it productive? If yes, what colour is your phlegm/spit? **Consider:** SVCO/Anaemia/Pulmonary embolism/Pneumonitis/Infection.	None or no change from normal.	New onset shortness of breath with moderate exertion.	New onset shortness of breath with minimal exertion.	Shortness of breath at rest.	Life threatening symptoms. Advise 999 - Urgent assessment in ED.
2. Chest pain STOP oral and intravenous Systemic Anti-Cancer Treatment (SACT) until reviewed by oncology or haematology team.	None.	Advise URGENT ED for medical assessment- 999. NB if infusional SACT in place arrange for disconnection.			
3. Bleeding/Bruising Are you actively bleeding? Site of active bleeding? Injury, trauma related or spontaneous? Is the bleeding spraying, pouring or enough to make a puddle? Are you taking anticoagulants? Have you any new bruises? Localised or generalised? Related to any trauma? NB For Haematology patients please follow local policy.	None or no change from normal.	Mild, self limited controlled by conservative measures. Consider arranging a full blood count. Localised - single bruise in only one area.	Bleeding that is not self limiting and/or multiple sites of bruising or one large site. Advise 999 - Urgent assessment in ED.		
4. Consciousness/Cognitive disturbance Establish the patients level of consciousness. This may indicate the need for urgent action. **Consider:** Immune effector cell-associated neurotoxicty syndrome (ICANS).	None or no change from normal.	Mild disorientation not interfering with activities of daily living. Slight decrease in level of alertness.	Moderate cognitive disability and/or disorientation limiting activities of daily living.	Severe cognitive disability and/or severe confusion; severely limiting activities of daily living. Altered level of consciousness. Advise 999 - Urgent assessment in ED.	Life threatening consequences. Loss of consciousness/ unrousable. Advise 999 - Urgent assessment in ED.
5. Fever on SACT Within the last 6-8 weeks or immunocompromised. What time was temp last taken? Have you taken any antipyretic medication?	Normal 36.0 - 37.4 C.	IF TEMPERATURE 37.5˚C OR ABOVE OR BELOW 36.0˚C OR GENERALLY UNWELL - URGENT ASSESSMENT AND CLINICAL REVIEW - FOLLOW NEUTROPENIA PATHWAY. ALERT - patients who have taken analgesia or steroids or who may be dehydrated may not present with an abnormal temperature but may still have an infection and be at risk of sepsis - if in doubt do a count.			
6. Infection Have you taken your temperature? If so when? What is it? - if pyrexial see fever toxicity. Are there any specific symptoms, such as: pain, burning / stinging or difficulty passing urine? cough, any sputum, if so what colour? Any shivering, chills or shaking episodes? Localised signs of infection? e.g. redness, swelling, inflammation.	None.	Localised signs of infection otherwise generally well.	Signs of infection and generally unwell.	Signs of severe symptomatic infection.	Life threatening sepsis. Advise 999 - Urgent assessment in ED.
7. Fever NOT ON SACT **NOT** receiving Systemic Anti Cancer Treatment (SACT) and **NOT** at risk of immunosuppression. What time was temp last taken? Have you taken any antipyretic medication?	Normal 36.0 -37.4 C.		< 36.0˚c or > 37.5˚c - 38.0˚c.	> 38.0˚c - 40.0˚c.	> 40.0˚c.
8. Fatigue/Performance status Has there been a recent change in activity levels and ability to work or carry out self care? Is this a new problem? Is it getting worse? How many days? Any other associated symptoms? Do you feel exhausted?	No change from normal.	Fatigue relieved by rest; restricted in strenuous activity but ambulatory and able to carry out work of light nature.	Fatigue not relieved by rest; ambulatory and capable of self care but unable to carry out any work activities. **If patient is or has been on Immune Checkpoint Inhibitors, escalate to RED.**	Fatigue not relieved by rest, capable of only limited selfcare, confined to bed or chair more than 50% of waking hours.	Completely disabled. Cannot carry out any self care. Totally confined to bed or chair.
9. Ocular/Eye problems Is this a new problem? Any associated pain? Any visual disturbance? Any discharge/sticky eyes?	None or no change from normal.	Mild symptoms not interfering with function.	Moderate to severe symptoms interfering with function and/or any visual disturbance.		

10. Mucositis/Oral Are you able to eat or drink? Do you have any mouth ulcers and/or pain swallowing? If yes, How many days? Is there evidence of infection? Assess patient's urinary output and colour.	None or no change from normal.	Painless ulcers and/or erythema, mild soreness but able to eat and drink normally.	Painful ulcers and/or erythema, mild soreness but able to eat and drink normally.	Painful erythema, difficulty eating and drinking.	Significant pain, minimal intake and/or reduced urinary output.
11. Anorexia What is your appetite like? Has this recently changed? Do you feel hungry? Do you have difficulty eating or swallowing? Any recent weight loss? Any contributory factors, such as dehydration, nausea, vomiting, mucositis, diarrhoea or constipation - If yes refer to specific problem/symptom.	None or no change from normal.	Loss of appetite without alteration in eating habits.	Oral intake altered without significant weight loss or malnutrition.	Oral intake altered in association with significant weight loss/malnutrition.	Life threatening Symptoms. Advise 999 - Urgent assessment in ED.
12. Nausea How many days? What is your oral intake? Are you taking antiemetics as prescribed? Assess patient's urinary output and colour.	None.	Able to eat/drink reasonable intake.	Able to eat/drink but intake is significantly decreased.	No significant intake.	
13. Vomiting How many days? How many episodes? What is your oral intake? Is there any constipation or diarrhoea? - if yes see specific toxicity. Assess patient's urinary output and colour.	None.	1-2 episodes in 24 hours.	3-5 episodes in 24 hours.	6-10 episodes in 24 hours.	>10 episodes in 24 hours.
14. Diarrhoea How many days has this occurred for? How many times in a 24 hour period? Has there been an increase in ostomy output? How frequently are you emptying your bag? Is there any abdominal pain or discomfort? Is there any blood or mucus in the stool? Have you taken any antidiarrhoeal medication? Is there any change in urine output? Are you eating and drinking normally? Has there been any recent contact with anyone suffering with diarrhoea? **Consider:** Infection / Colitis / Constipation. N.B Patients receiving Immune check point inhibitors or Capecitabine should be managed according to the drug specific pathway and assessment arranged as required.	No change from normal.	Increase of up to 3 bowel movements a day over pre-treatment normal or mild increase in patients usual ostomy output.	Increase of up to 4-6 episodes a day or moderate increase in patients usual ostomy output or nocturnal movement or moderate cramping. **If diarrhoea persists after taking regimen specific antidiarrhoeal escalate to red.** → **If patient is or has been on Immune check point inhibitors escalate to RED.** →	Increase of up to 7-9 episodes a day or severe increase in patients usual ostomy output OR incontinence/severe cramping/ mucus/bloody diarrhoea.	Increase>10 episodes a day or grossly bloody diarrhoea.
15. Constipation How long since bowels opened? What is normal? Is there any abdominal pain and/or vomiting? Have you taken any medication? Are you passing wind? Is there any nausea? Have you taken any antidiarrhoeal medication? Assess the patients urinary output and colour.	None or no change from normal.	Mild - no bowel movement for 24 hours over pre-treatment normal.	Moderate - no bowel movement for 48 hours over pre-treatment normal.	Severe - no bowel movement for 72 hours over pre-treatment normal.	No bowel movement for >96 hours - consider paralytic ileus.
16. Urinary Is there an odour? Is there any incontinence, frequency or urgency? How long have you had the symptoms? Is there any pain or difficulty passing urine? Are you drinking normally, are you thristy? Are you a diabetic? Have you checked your blood sugar? Has it changed from normal output? If so, How? Is it a new or worsening symptom? Do you have a catheter? **Consider:** Infection / Diabetes - existing or new onset.	None or no change from normal.	Mild symptoms. Minimal increase in frequency, urgency, dysuria or nocturia. Slight reduction in output.	Moderate symptoms. Moderate increase in frequency, urgency, dysuria nocturia. moderate reduction in output.	Severe symptoms. Possible obstruction/retention new incontinence, new or increasing haematuria, severe reduction in output.	Little or no urine output.
17. Skin Where is the problem? How much of the body is affected? How long have you had it? Is it getting worse? Is the area associated with a recent infusion/injection site? Are there any of the following symptoms - rash, pain, feeling generally unwell, broken or cracked skin, problems with nails, dry or itchy skin, weeping, swelling or warm to touch? Use the rule of 9's to assess the body service area affected. RULE OF 9's. **Consider:** Redness in white skin tones and subtle darkness, maroon/yellow/purple/grey appearance or darker than surrounding area in brown and black skin tones. Please follow local drug toxicity specific pathways.	None or no change from normal.	Rash/skin changes covering <10% of BSA with or without itching, redness, no pain	Rash/skin changes covering 10-30% BSA. Rash/skin changes limiting normal ADL's. With or without painful redness or swelling	Rash covering >30% BSA with or without associated symptoms; limiting self care activities. spontaneous bleeding or signs of associated infection, moist desquamation, ulceration, blistering and severe pain.	
18. Pain Is it a new problem? Where is it? How long have you had it? Have you taken any pain killers? Is there any swelling or redness? If pain associated with swelling or redness consider thrombosis or cellulitis. Back pain consider metastatic spinal cord compression (MSCC). Is the pain around or along an injection site? If yes, consider extravasation. Do you have a headache? consider ICANS/CRS	None or no change from normal.	Mild pain not interfering with daily activities.	Moderate pain interfering with daily activities.	Severe pain interfering with daily activities.	Severe disabling pain.
19. Neurosensory/Motor When did the problem start? Is it continuous? Is it getting worse? Is it affecting mobility/function? Any perineal or buttock numbness (saddle paresthesia)? Any constipation? Any urinary or faecal incontinence? Any visual disturbances? Is there any pain? If yes refer to specific problem/ symptom. **Consider:** metastatic spinal cord compression, cerebral metastases or cerebral event.	None or no change from normal.	Mild paresthesia, subjective weakness. No loss of function.	Mild or moderate sensory loss, moderate paresthesia, mild weakness with no loss of function.	Severe sensory loss, paresthesia or weakness that interferes with function.	Paralysis.

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The Assessment Process Step By Step

Step 1. 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 patient/carer ability to provide information accurately or understand questions or instructions provided? If so then a face-to-face assessment 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 2. What is the patient/carer 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 organise 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 3. If the patient/carer 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 patient's symptoms score red or another amber at any time they should be asked to attend for assessment.

Step 4. Look back at your log sheet:

- Have you arranged assessment for patients who have scored RED?
- Have you arranged assessment for patients who have scored more than one AMBER?
- Have you fully assessed the patient who has scored one AMBER? Is there a tick in all the other green boxes of the log sheet?
- Have you fully assessed the patient who has scored 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?
- Have you fully completed the triage process?

4.0 The Triage SBAR 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. The log sheet does follow an SBAR process. A standardised format for recording telephone consultations will support the triage process in the following ways:

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

We recommend that all triage practitioners record verbatim what the patient/carer says. 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 assessment, 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 advice line service.

The data collected should be:

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

There should be a robust local system of record keeping, with log sheets available for audit purposes. This may be in an electronic format, linking with organisational systems and/or data bases, or as hard copies. An electronic or hard copy of the log sheet should be entered in the patient record.

Robust data capture processes will assist with the recommended regular audit and review of the triage line service. Information gained can be used to:

- Assess quality of triage and record keeping
- Monitor activity level
- Identify actual or potential service issues
- Support service improvement and innovation
- Analyse certain disease or treatment specific groups
- Support research and audit
- Contribute to national data collection and analysis

HOSPITAL NAME / DEPT: ..... **UKONS 24 HOUR TRIAGE LOG SHEET** (VERSION 3 2024)

Patient Details	Patient History	Enquiry Details
Name:	Diagnosis:	Date: .....
Hospital no:	.....	Time: .....
DOB:	Consultant:	Who is calling? .....
Tel no:	Has the caller called the triage line previously with the same concern/issue? Yes O No O	Contact no: .....
		Walk in? Yes O No O

Reason for call? (in patients own words)

Is the patient on active treatment? SACT O ICI O RT O OTHER O SUPPORTIVE O BISPECIFICS O NO O

Previous Immune checkpoint inhibitor - (ICI)? Yes O No O Don't Know O

State regimen: ..... Clinical trial? Yes O No O

When did the patient last receive treatment? Today O 1-7 days O 8-14 days O 15-28 days O Over 4 weeks O

Does the patient have a CVAD? Yes O No O Infusional pump in situ? Yes O No O Is the SACT treatment oral? Yes O No O

What is the patient's temperature?.....°C (Please note that hypothermia is a significant indicator of sepsis)

Anti-pyretic medication in the previous 4-6 hours? Yes O No O Are you a diabetic? Yes O No O

Do you monitor your blood glucose? Yes O No O Current blood glucose: .....

(If blood glucose above or below patients normal parameters, seek senior clinical opinion)

CAUTION! Please note patients who are receiving or have received ICI may present with treatment related problems at anytime during treatment or even months to years after treatment has been completed. If you are unsure about the patient's regimen, be cautious and follow triage symptom assessment.

Advice	24 hour follow up	Assess		
SYMPTOM	**0**	**1**	**2**	**3**	**4**
Shortness of breath					
Chest pain					
Bleeding/Bruising					
Consciousness/Cognitive disturbance					
Fever on SACT					
Infection					
Fever not on SACT					
Fatigue/Performance status					
Ocular/Eye problems					
Mucositis/Oral					
Anorexia					
Nausea					
Vomiting					
Diarrhoea					
Constipation					
Urinary					
Skin					
Pain					
Neurosensory/Motor					
Other please state:					

Medical history/ Co-morbidities:

Do you carry any other alert cards?

Yes O No O .....

Current medication:

Details related to call including any other symptoms not listed and action taken:

Attending for assessment, receiving team contacted? Yes O No O

Follow up required? Yes O No O

Consultants team contacted? Yes O No O Date: ..... Clinical trials team informed? Yes O Not on a trial O

Triage practitioner Signature: ..... Print: ..... Designation: ..... Date: .....

Follow up outcome:

Signature:..... Print: ..... Designation: ..... Date: ..... Time: .....

5.0 Training and competency

It is vital when introducing any defined process such as this that the user involved receives training and support and is assessed as competent prior to participating.[9]

The training covers 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

The UKONS Toolkit Manual should be read in detail at the start of training, and the four telephone triage online modules completed. This should be followed by a local process of scenario practice, observed clinical practice and competency assessment. This approach was used in the pilot process https://www.e-lfh.org.uk/programmes/ukons-telephone-triage-training/.

The competency assessment has been developed according to national guidance.[10] It is recommended that this assessment be repeated annually to ensure that competency is maintained.

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 triaging calls to the triage line.

All advice line practitioners should successfully complete;

- **24-Hour training modules**
- **Scenario practice**
- **Observed clinical practice**
- **Competency assessment/ agreement**

5.1. The competency assessment

This competency framework is clinically focused and covers:

- Referring a patient for further assessment
- Giving clinical guidance to patients/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 triage 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

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

Conduct and responsibility

This workforce competence has indicative links with the following dimensions within the NHS Knowledge and Skills Framework.[14]

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

and

- Nursing and Midwifery Council Code of Conduct[15]
- Health and Care Professions Council (HCPC) Standards Of Conduct, Performance And Ethics[16]
- Further detail can be found at appendix 2 p.30

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

Scope of the competency assessment

This framework covers the following guidance:

- Giving clinical advice, which will include:
  - Managing emergency situations
  - Monitoring for and reporting changes in the patient's condition
- Calming and reassuring the patient/carer
- The importance of identifying the capacity of the patient/carer to take forward advice, treatment or care
- The importance of ensuring the caller contacts the advice line 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 that falls outside of this guideline, and of recording the rationale for the advice given and action taken

5.2 Competency assessment record

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

This is to deem that ..... has been assessed as competent in the use and application of the "24-Hour Triage Toolkit"

Practitioner name.....

Practitioner Signature.....

Assessor name.....

Assessor Signature.....

Date.....

Organisation.....

1. Knowledge and Understanding You need to be able to explain your understanding of the following to your assessor: Date		To be signed and dated by the practitioner and assessor to confirm competency	
		Date	Signature
1a.	Your own role and its scope, responsibilities and accountability in relation to the provision of triage assessment and 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 toolkit in practice, its use as a risk assessment tool when presented with symptoms/ toxicities and decision making		
1f.	The process to be followed in directing requests for onward action to different care pathways and related organisations.		
1g.	Why it is important that you advise the individual making the call of the course of action you will take and what will happen next.		
1h.	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:			
2a.	Explain to the individual what your role is and the process you will go through in order to provide the correct advice/instruction.		
2b.	Select and apply the Toolkit triage process appropriate to the individual, and the context and circumstances in which the assessment 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 Toolkit 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 • should be according to scope of pratice or local guidelines /pathways • 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		
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 carer 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 process.		

Disclaimer

Care has been taken in the preparation of the information contained in this document and tool.

Nevertheless, any person seeking to consult the document, apply its recommendations or use its content is expected to use independent, personal medical and/or clinical judgment in the context of the individual clinical circumstances, or to seek out the supervision of a qualified clinician. Neither UKONS nor Macmillan Cancer Support make any representation or guarantee of any kind whatsoever regarding the triage toolkit content or its use or application and disclaim any responsibility for its use or application in any way.

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Glossary

CRS – Cytokine Release Syndrome

CYP – Children and Young People

CVAD – Central Venous Access Device

HCPC – Health and Care Professions Council

ICANS – Immune effector cell-associated neurotoxicity syndrome

ICI – Immune Checkpoint Inhibitor

MSCC – Metastatic Spinal Cord Compression

NICE – National Institute for Health and Care Excellence

NCAG – National Chemotherapy Advisory Group

NCI-CTCAE – National Cancer Institute- Common Terminology Criteria for Adverse Events

NMC – Nursing and Midwifery Council

NPSA – National Patient Safety Agency

RAG – Red, Amber, Green

RT – Radiotherapy

SACT – Systemic Anti-Cancer Treatment

SOR – Society of Radiographers

SVCO – Superior Vena Cava Obstruction

TYA – Teenage and Young Adults

UKAOS – United Kingdom Acute Oncology Society

UKONS – United Kingdom Oncology Nursing Society

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Acknowledgements

The development group would like to acknowledge the following individuals and organisations for their help and support in the development of the tool kit and subsequent updates.

- The Royal Wolverhampton Hospital Trust
- Macmillan Cancer Support
- Pauline Boyle, Research Delivery Manager & Professional Clinical Lead NIHR Clinical Research Network: West Midlands
- Abbie Pound, Medical Writer
- NIHR Clinical Research Network: West Midlands
- Telford Reprographics
- Department of Clinical Illustration, New Cross Hospital
- Keri Wolfe, Media 1 Productions
- United Kingdom Acute Oncology Society (UKAOS)

Appendix – Skills for Health information

Please see below indicative links with the following dimensions within the NHS Knowledge and Skills Framework:[13]

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

and

- Nursing and Midwifery Council Code of Conduct[15]
- Health and Care Professions Council (HCPC) Standards Of Conduct, Performance And Ethics[16]

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.

The Nursing and Midwifery Council (NMC) Code of Conduct

The practitioner is reminded that they are accountable for practice as detailed in the NMC code of conduct15 and HCPC Standards Of Conduct, Performance And Ethics.[16]

The codes detail standards for practice 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 practice 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) overthe-counter medicines

UKONS
Oncology Nursing Society

Oncology/Haemato-oncology

24-Hour Triage

TOOLKIT

'Inspiring Cancer Nursing'

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Mi 2355814 01.12.16 v1.2