Alder Hey Children's
NHS Foundation Trust

Standard Operating Procedure

24 Hour Telephone Advice Service Oncology / Haematology Unit

Version:	3
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Version Control, Review and Amendment Logs

Version Control Table				
Version	**Date**	**Author**	**Status**	**Comment**
3	April 2021	Kirsty Blackburn	Current	To incorporate updated CCLG guidelines
2	November 2015	C Wardell	Archived	Revised version to temperature guidelines
1	February 2010	K Birchall	Archived	New procedure created

Review & Amendment Log Record of changes made to document since last approved version			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
Various	Various	Incorporated updated CCLG guidelines	Updated guidance

1. Introduction

The Manual for Cancer Services, Children's Cancer measures (2014) states that a 24 – hour advice service should be provided for children and young adults with malignancy and their carer's.

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 201/14).

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

2. Purpose

This Standard Operating Procedure (SOP) has been written to:

- Improve patient safety and care by ensuring that patients, carers or health professionals receive a robust, reliable assessment every time they contact the advice line.
- Ensure assessments are of a consistent quality and that advice is determined based on the use of an evidence based assessment tool.
- Provide management and advice appropriate to the patient's level of risk.
- Form the basis of triage training and competency assessment.
- Help to maintain accurate records of the assessment and decision making process in order to monitor quality, safety and activity

3. Scope

This SOP

- Relates to all clinical staff involved in providing telephone advice on Ward 3b to patients, their carer's and health professionals. This includes:
    - Registered nurses,
    - Clinicians
- Applies to patients under the care of a Consultant Oncologist / Haematologist only.
- Is applicable to emergency admissions that will be identified and managed via this route.

4. Abbreviations

SOP	Standard Operating Procedure
CCLG	Children's Cancer and Leukaemia Group.

5. Responsibilities

5.1 The Cancer Lead Matron / Ward Manager is responsible for ensuring all staff are competent to provide telephone advice having received the appropriate training and experience.

5.2 Registered nursing staff and clinicians are responsible for ensuring that they:

- Have accurate and up to date knowledge of oncological specific clinical issues by maintaining professional portfolio
- Have completed the required training
- Have the necessary skills to undertake this role
- Complete the annual update as requested
- Maintain accurate and contemporaneous records regarding all advice given.

6. Procedure

6.1 Advice line

Telephone advice will be available 24 hours a day.

During Monday – Friday between the hours of 7am and 7pm (excluding Bank holidays) advice will be provided by day care staff.

Outside of these hours advice will be provided by in patient ward staff.

Consultant advice is available 24/7 from the on call Consultant.

Only staffs that have completed the training outlined in section 6 can take calls and give advice.

6.2 Triage Pathway

When a family or carer contacts the advice line the following process (adapted from the CCLG Telephone Triage Tool Kit v2) should be followed: (see Appendix 3)

- The call is directed to a trained triage nurse.

- A rapid initial assessment is undertaken. If not urgent, assessment continues. If urgent, stop assessment and ask caller to dial 999 and record action.

- The findings should be recorded on the triage log sheet (see Appendix 1)

- All problems / toxicities are assessed and graded according to the assessment tool guidelines (see Appendix 2)

- The toxicity scoring the highest grading takes priority

- The advice and action taken should be recorded on the triage log sheet.

- The appropriate health professional i.e. ANP / medical team should be informed of the patient's telephone query / admission.

- All 24 hours triage log sheets are to be reviewed at the 9am daily huddle by the Consultant on call and any further action required is undertaken. This is the responsibility of the nurse in charge to oversee.

- Completed triage log sheets should be sent to scanning to be inserted into the patients' medical electronic records.

6.3 Training

No member of nursing staff should give advice unless they have completed the following:

- Reviewed training slides on CCLG website.

- Successfully complete the 24-hour triage training and competency assessment

- 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's Cancer Service Specifications

Each nurse will need to undergo an update every 12 months. This will be assessed as part of their annual SACT assessment.

Medical staff will only give advice appropriate to their level of training. All grades below Consultant Oncologist will be encouraged (as part of the induction process) to seek assistance from either triage trained nurses, or more senior doctors on the unit if there is any doubt as to the advice given.

All staff will have sufficient specialist oncology / haematology clinical knowledge / skill to advice on the following:

- Pyrexia / Neutropenia
- Sepsis
- Nausea / vomiting

- Diarrhoea
- Mucositis
- Rash
- Central line Care
- Chemotherapy
- Immunisations
- Schooling
- Socialising
- Infection Contacts
- Miscellaneous (tanning / tattoos etc)
- Long term effects of immunotherapy

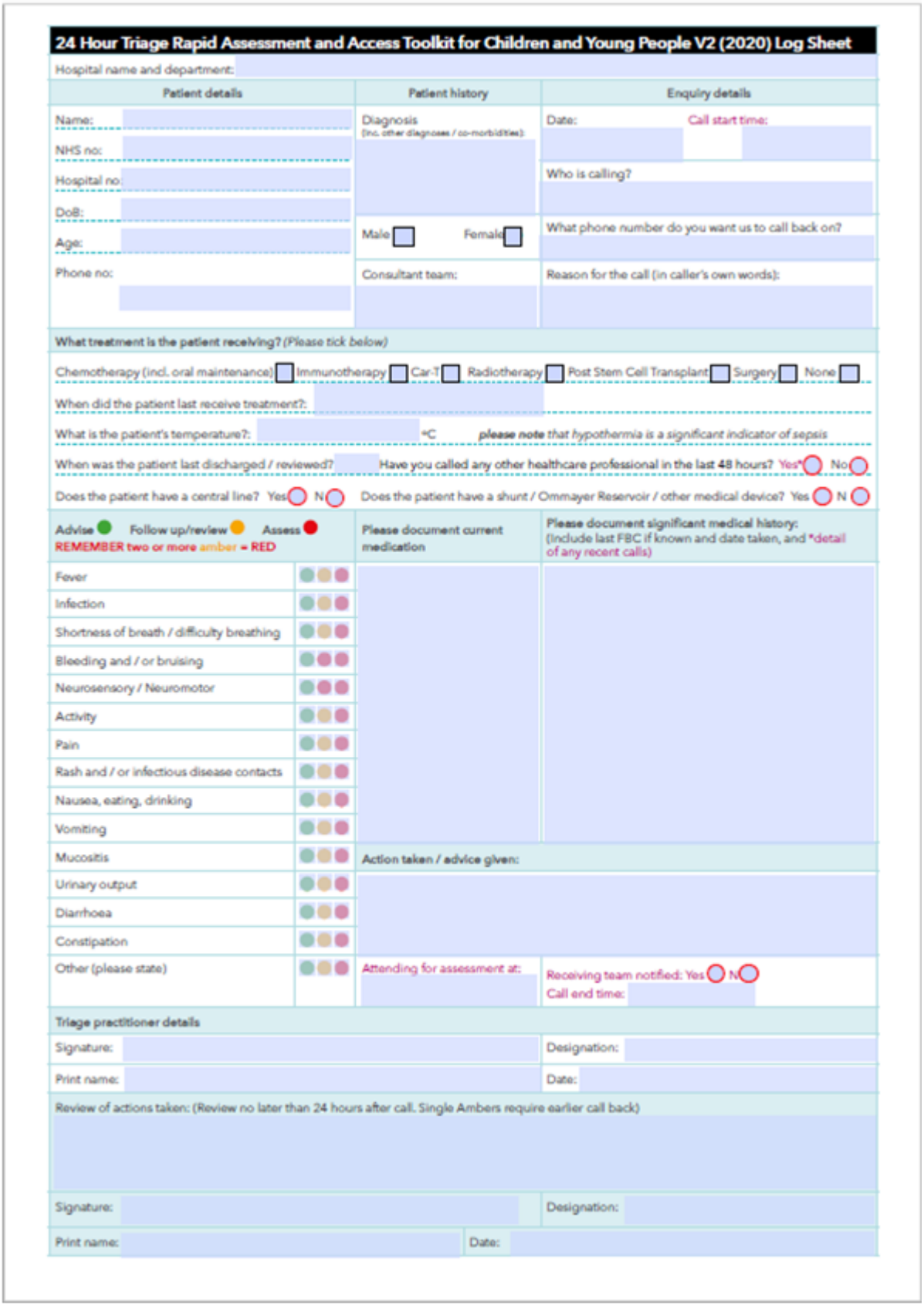
7 References

The manual for Cancer Services, children's cancer measures (2014)

CCLG Telephone Triage Tool Kit 2nd edition 2020.

8. Appendices

Appendix 1



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:	Diagnosis (Inc. other diagnoses / co-morbidities):	Date: Call start time:
NHS no:		Who is calling?
Hospital no:		
DoB:	Male ☐ Female ☐	What phone number do you want us to call back on?
Age:		
Phone no:	Consultant team:	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:

Appendix 2

Children and Young People Oncology / Haematology Triage Tool V2 (2020)

Review date: August 2023

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 / inflammation, 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, agitation, 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, paraesthesia (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? Pattern, 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 activities? 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, weakness, 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 24hr 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? Abdominal pain / discomfort? Any medication to relieve? Consider post haematopoietic stem cell transplantation (HSCT) N.B. Patients receiving immunotherapy 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.	

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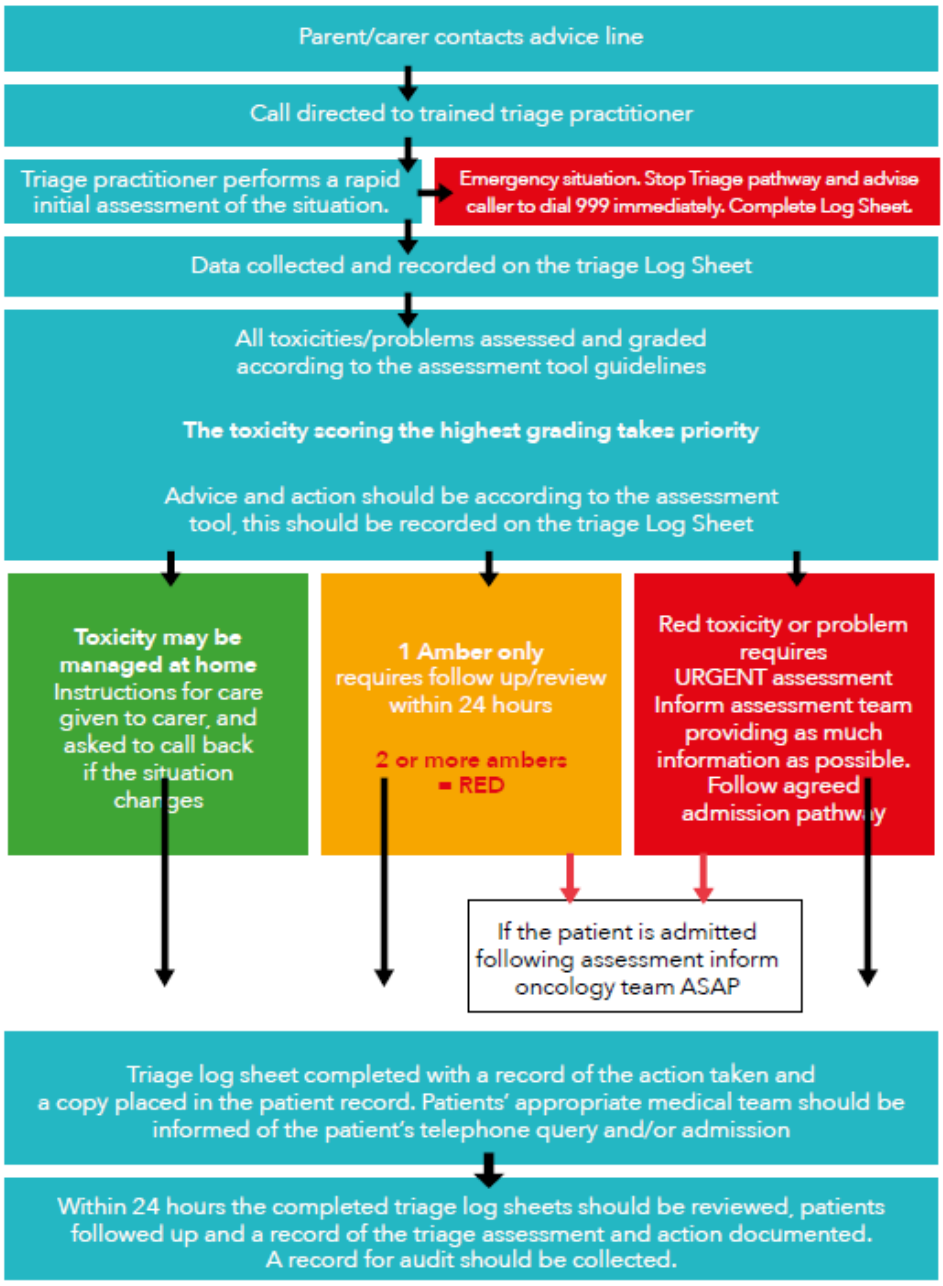
YOUNG LIVES vs CANCER

Appendix 3


Triage Pathway
Parent/carer contacts advice line
Call directed to trained triage practitioner
Triage practitioner performs a rapid initial assessment of the situation.
Emergency situation. Stop Triage pathway and advise caller to dial 999 immediately. Complete Log Sheet.
Data collected and recorded on the triage Log Sheet
All toxicities/problems assessed and graded according to the assessment tool guidelines
The toxicity scoring the highest grading takes priority
Advice and action should be according to the assessment tool, this should be recorded on the triage Log Sheet
Toxicity may be managed at home
Instructions for care given to carer, and asked to call back if the situation changes
1 Amber only
requires follow up/review within 24 hours
2 or more ambers = RED
Red toxicity or problem requires URGENT assessment
Inform assessment team providing as much information as possible.
Follow agreed admission pathway
If the patient is admitted following assessment inform oncology team ASAP
Triage log sheet completed with a record of the action taken and a copy placed in the patient record. Patients' appropriate medical team should be informed of the patient's telephone query and/or admission
Within 24 hours the completed triage log sheets should be reviewed, patients followed up and a record of the triage assessment and action documented. A record for audit should be collected.
Telephone Triage Tool Kit for Children's Cancer Services
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