## 1. Introduction and Who Guideline applies to

To ensure patients who are under the care of an Oncologist or Haematologist and receiving or have recently received anti cancer treatments gain prompt, safe and clinically effective advice 24/7 in the event they present with treatment-related toxicities and/or cancer related complications.

This guideline also applies to Haematology patients who are **not** currently receiving SACT. These include patients with bone marrow failure who are receiving supporting care only or patients with HbSS – Sickle Cell Disease.

This guideline applies to all staff responsible for giving clinical advice via the 24- hour Advice Line.

## 2. Guideline Standards and Procedures

This SOP is based on a document originally developed by Taunton & Somerset NHS Foundation Trust and has been amended in accordance with University Hospitals of Leicester policies and procedures.

The United Kingdom Oncology Nursing Society (UKONS) Oncology/Haematology 24 Hour Triage tool and Acute Oncology Initial Management Guidelines are utilised by University Hospitals of Leicester. These tools meet the national recommendations, NCEPOD, NCAG and Acute Oncology Measures and is supported by the UK National Patient Safety Agency (UKONS, 2019). If used correctly, this tool provides safe guidelines and advice for both staff and patients.

### Introduction & Service Overview

**2.1.** Patients actively known to an Oncologist/Haematologist being treated with anti cancer treatment including systemic anti-cancer therapies (SACT) (see 2.2) & radiotherapy should have access to prompt and timely clinical advice if they experience treatment or disease related symptoms/ complications.

**2.2.** SACT is an umbrella term for all systemic anti-cancer therapies and covers a wide range of drugs and multiple routes of administration, whilst not limited to but would include: oral, intravenous, subcutaneous, intramuscular and intrathecal.

**2.3.** For patients receiving cytotoxic chemotherapy and biotherapies the occurrence of treatment related side effects is expected to end at 6-8 weeks following completion or discontinuation of active treatment, but for patients who have completed immunotherapy it is important that advice is available beyond the completion of treatment owing to the delayed adverse effects that patients may experience. Immunotherapy patients have been known to experience acute adverse effects for up to 12 months post completion / discontinuation of treatment, although this could be longer. Patients who contact the 24-hour advice line with clinical concerns should always be triaged fully regardless of treatment completion date.

**2.4.** This standard operating procedure refers to the University Hospitals of Leicester arrangements set out for the Trust's 24-hour advice line, established to triage patients presenting with cancer related symptoms and/or treatment-related toxicities.

**2.5.** All Trusts delivering anti-cancer treatments within their organisation should provide a 24-hour advice line telephone service for patients to access when needed or have a contract with a secondary provider who offers a service meeting the specified criteria detailed within this document.

**2.6.** Usual working hours and out of hours/weekends cover may be delivered by different clinical services however standards of practice by each service must be consistent meeting the specified criteria detailed within this document in relation to University Hospitals of Leicester.

**2.7.** All patients receiving anti-cancer treatment/s will be given one telephone number to access for advice as well as given clear instructions of how and when to contact it. It is preferred that patients are given an alert card or patient information leaflet.

**2.8.** Trusts are required to have a documented strategy of alternate practice where patients are unable to communicate effectively using the telephone helpline. If a patient has additional requirements such as hearing impairment, this needs to be raised with the clinician or nurse at the new patient clinic review. The patient will be advised of the alternative process of being provided the direct triage number and using a texting service for the initial triage. For patients who's first language is not English, it is imperative that at their initial consultaion and/or their new patient case talk, that a family member or significant other/s are identified and provided with the emergency help line information. It will be agreed that these individuals can contact the help line on behalf of the patient , to seek appropriate nursing/medical advice.

**2.9.** There should be a designated triage nurse/s on each shift who is responsible for answering advice line calls from patients/relatives concerning treatment–related and/or disease-related symptoms.

**2.10.** There should be a recognised and seamless handover process between shifts to ensure patients requiring follow up by different shifts are processed safely and effectively in an unbroken continuum cycle of activity.

**2.11.** Where prior calls require "follow up" or when patients are referred to the service for telephone monitoring i.e. as a result of hospital avoidance strategies, these calls should usually be done within working hours, primarily between 09:00 – 17:00 hrs. However, service providers should be mindful that the unpredictability of unplanned care means some calls may be needed outside working hours/weekends and service provision should acknowledge this.

**2.12.** It is recognised that calls may be received from other health care professionals seeking advice e.g. GPs/District Nurses/Community Palliative Care Services/East Midlands Ambulance Service who are concerned about patients. All advice given and actions taken should be recorded using the triage log-sheet and assessment process as required.

**2.13.** Systems and practices should be in place to ensure that calls are not delayed or go unanswered. Patients need to be advised to leave a clear message on the telephone answer phone, detailing their name; S Number; consultant, presenting problem and telephone contact number. Calls should be returned within 1 hour. Patients should be advised that if calls not returned within this timeframe, that they call the advice line again.

## 3. Triage Practice and Documentation

**3.1.** In Leicester we use the validated UKONs triage log sheet and grading tool. All patient calls will be triaged using a validated triage tool, (UKONS, 2016) telephone triage log sheet and grading tool.

**3.2.** Triage documentation must be completed in real time.

**3.3.** Local systems and processes will be clearly documented to ensure staff direct patients appropriately who require urgent clinical assessment and review. If beds/chairs are available, patients will be advised to attend the Osborne Assessment Unit within the Osborne Building for assessment/admission.

**3.4.** Clear processes must be documented where concerns arise regarding the stability/acuity of the patient's condition arise e.g. significant shortness of breath, chest pain, or symptoms when assessed may represent haemodynamic compromise will be advised to attend the Emergency Department. All other patients including those with suspected metastatic spinal cord compression; thrombocytopenic nose-bleeds or febrile neutropenia will be directed to the Osborne Assessment Unit for urgent assessment. However, if beds are not available, it maybe necessary to direct them to the Emergency Department. It is necessary that should a patient be directed to the Emergency Department, that the triage nurse contactsthe Emergency Department DART (Deteriorating Adult Respinse Team) to alert them of their impending arrival.

**3.5.** Where patients are unable to travel independently due to lack of transport, the triage nurse should request an ambulance crew to attend the patient. A request of 1 hour or less, depending on the circumstances, is recommended.

**3.6** If a patient is considered too unwell, c/o signifciacnt chest pain or experiencing breathing difficulties, the nusrse must advise the patient to immediately call for an emergency ambulance

**3.7.** Patients advised to attend the Osborne Assessment Unit or ED should be referred as follows:

• Telephone or face to face handover to designated assessment area or ED providing patient details using the UKONs 24hr triage sheet, providing clear details of patient identifiers; Consultant and presenting problems.

• If the patient is transferring to Osborne Assessment Unit – if they have not arrived within 2hrs of the initial call, it is the responsibility of nursing staff within Osborne Assessment Unit to contact the patient for an update, and if necessary to contact ambulance control for update regarding estimated time of arrival.

**3.8.** Triage nurses should refer to agreed policies and procedures to guide their triage practice and to ensure that any clinical advice is current and evidence based

**3.9.** The outcomes of all calls should be recorded on the UKONS triage sheet detailing the reason for call, toxicity grading score i.e. UKONS RAG score, advice given, and level of follow-up required, this includes attendance to clinical area for review or if episode is closed following advice provided.

**3.10.** On completion of the call all completed log sheets Monday – Friday will be collected by the Acute Oncology nurses. They will review all log sheets to ascertain as to whether follow up calls are required – this will be done by the Acute Oncology nurses within 24 hrs of original call. On weekends, these log sheets will be collected by the registered nurse identified on the telephone triage rota to complete the call backs. The completed forms will again be collected by the Acute Oncology team on the following Monday.

**3.11.** The Acute Oncology Nursing service will collate this telephone activity and will upload all log sheets to the CITO system

## 4 Education and Training

**4.1.** Only registered nurses who have undergone training can take triage calls.
All nurses performing triage calls will have: completed the UKONS SACT Competency Passport and deemed competent in the administration of SACT. They will have received training in the use of the UKONS Triage Tool and have been considered competent in accordance with the UKONS triage training and assessment.

All nurses new to triage must be supervised by a trained SACT Nurse until deemed competent by a registered SACT assessor. Training and competency assessment for new members of staff will be provided by the Acute Oncology Nurses and appropriately trained staff within the clinical areas, and will be conducted in line with the process laid out in the Triage Toolkit (UKONS 2019). Annual re-assessment of competency will be performed.

**4.2.** The level of experience and clinical role of a telephone triage nurse is not stipulated within this document. It is left to each in dividual service provider to agree this at local level. The East Midlands Cancer Alliance acknowledges that triage practitioner competency is documented within the UKONS competency document and advocates this as a minimum requirement. At University Hospitals of Leicester, it has been agreed that staff need to have completed both the theory and practical SACT competencies at least 3 months prior to commencement of the approved triage training. Ward leaders/matrons can use an element of discretion dependent upon prior experience. This does need to be supported with valid evidence of previous expertise.

**4.3.** Therefore, only staff that have successfully completed formal training in telephone triage and are recognised as competent as per the agreed standards will have the responsibility of undertaking telephone triage.

**4.4.** The recommended training programme and competency base framework is described within the UKONS 24-hour Triage Information and Instruction Manual (UKONS, 2016). All training must be recorded and linked to a staff record.

**4.5.** Staff are required to complete the Guy's Cancer Academy on line training module.

**4.6.** There is an expectation that staff undertaking the triage training, that they are allocated a minimum of 2 supernumary days whereby they shadow a trained assessor, and in turn take supervised calls as per the triage process.

**4.7.** Clinical staff answering telephone calls who do not meet the above criteria should not provide clinical advice and call handling should be directed to those who have.

**4.8.** Training in telephone triage should only be provided by nominated trainers who have successfully completed training and competency assessment themselves. This will involve a consultation, completion of the triage tool learning package and observation of practice to confirm / agree competency.

**4.9.** Competence should be measured annually as part of a triage practitioner's annual appraisal.

**4.10.** Where triage practitioners have had a gap in practice of 12 months or more, they must successfully complete the training competency programme before being deemed fit the practice.

## 5. Patient Education

**5.1.** The majority of patients receiving SACT will receive a Pre-Chemotherapy Assessment and education. There some patients who require urgent see and treat, for example, those with melanoma and for these instances, information will be provided by the treating clinician. During these consultations, patients will be provided with the following information, which is not exclusive:

- the 24hr emergency contact number
- information on the key signs and symptoms to report (see below)

**5.2.** To ensure that any signs of infection are detected and treated promptly it is important that.patients are aware of the need to monitor their temperature at home and should be advised to purchase a thermometer. If they are unable to do so, they can make contact with the Macmillan Information Centre who can provide this.

**5.3.** Patients must be educated on the key symptoms identified on the National Chemotherapy Alert card.

**5.4.** Patients must also be educated about contacting the 24-hour triage line:

- if your temperature is below 36°C
- If your temperature is above 37.5°C
- if you have any unusual bleeding or bruising
- If you have vomited more than once in 24 hours
- If you have had 4 or more bowel movements above normal, or 4 episodes of diarrhoea in 24 hours
- If you have mouth ulcers or soreness that prevents you from eating or drinking
- If you are admitted to another hospital for any reason
- If you are experiencing emergency symptoms (e.g. chest pain) then call for an emergency ambulance immediately and not the emergency advice line

**5.5.** Patient education must be seen as a continual process, not a one-off event and staff should take every opportunity to remind patients and their relatives of the importance of reporting significant symptoms.

**5.6.** A vital part of patient education is to validate patients understanding of the information given. This can be done by reiterating scenario's with the patient what they would do if they developed one of the key symptoms.

## 6. Monitoring Compliance/Clinical Effectiveness

| What will be measured to monitor compliance | How will compliance be monitored | Monitoring Lead | Frequency | Reporting arrangements |
|---|---|---|---|---|
| Patient Experience | Patient questionnaires | AOS | 6 monthly | To matrons. Clinical leads |
| Staff training | Training records on HELM | Lead SACT Nurse/Clinical leads | Yearly | |
| Service Audit | Quality of telephone triage | AOS | 6 monthly | |

## 7. Supporting References


United Kingdom Oncology Nursing Society (UKONS) Acute Oncology Initial Management Guidelines, 2019.

United Kingdom Oncology Nursing Society (UKONS) (2016) Oncology Haematology 24-Hour Triage, Rapid Assessment and Access Toolkit. https://www.ukons.org/site/assets/files/1134/oncology_haematology_24_hour_ triage.pdf (accessed 22/02/23)

NHSE (2018) Quality Surveillance Programme. The Cancer Peer Review Acute Oncology Measures - https://www.qst.england.nhs.uk/users/sign_up NHSE (2017)


## 8. Key Words

Haematology and Oncology Emergencies; 24hr help line; triage; patient education

| CONTACT AND REVIEW DETAILS | |
|---|---|
| **Guideline Lead: Clair Burroughs – Macmillan Lead SACT Nurse and Teena Eddison – Acute Oncology Specialist Nurse** | **Executive Lead** |
| **Details of Changes made during review: Version 1 – due for review in 2025** | |