The UKONS Toolkit has been developed for use by all members of staff who may be required to man 24-hour advice lines for patients who:

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

N.B.

Adolescent patients treated within adult units ARE included in this pathway

Systemic anticancer therapy is an overarching term encompassing all systemic anti cancer therapies including chemotherapy, immunotherapy and supportive therapies

V1.0 2018 - adapted from UKONS -UK V.2.0 with permission
1.0 Introduction

This version of the toolkit for Australia was agreed through a national collaborative working group of both medical and senior nursing representation across Australia. The UK Oncology Nurses Society (UKONS) 24-Hour Triage Tool 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 24-hour advice lines for assessment and advice. It is a tool for use by all members of staff who may be required to man a 24-hour advice lines for patients who:

- Have received or are receiving systemic anticancer therapy
- Have received any other type of anticancer treatment, including radiotherapy and bone marrow graft
- May be suffering from disease/treatment related immunosuppression (e.g. acute leukaemia, corticosteroids)

This guideline provides recommendations for best practice for the appropriate treatment and management of patients who contact the 24-hour advice line; it should be used in conjunction with the triage practitioner’s clinical judgment.

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

The triage and assessment process remains fit for purpose in light of these recent advances in treatment.

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.
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.

1.1 Quality of assessment and advice

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

The function of telephone triage is to determine the severity of the caller’s symptoms and direct the caller if appropriate to an emergency assessment or initiate clinical follow up. Telephone triage is an important and growing component of current oncology practice; we must ensure that patients receive timely and appropriate responses to their calls.

Successful triage will consistently recognise emergencies and potential emergencies, ensuring that immediate assessment and required interventions are arranged. Sujan found that the most frequent recommendation for improving communication was standardisation through procedure checklists and appropriate training in their use. All of the above are used within the UKONS Toolkit.

1.2 National guidelines, recommendations and reports

There are no national guidelines in place to support training, standardisation and consistency of oncology/haematology triage. However, there are national recommendations regarding the provision of telephone triage service: The Manual for Cancer Services recommends that all cancer patients receiving systemic anticancer therapy should have access to a 24-hour telephone advice service. The World Health Organisation (WHO) recommends that organisations use a standardised approach to handover and implement the use of the Identify, Situation, Background, Assessment and Recommendation process (ISBAR). 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. The Cancer Reform Strategy 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 Toolkit uses the ISBAR principles, which offer a structured method for communicating critical information that requires immediate attention and action contributing to effective escalation and increased patient safety.

2.0 Aims and objectives

The aim of the UKONS Toolkit is to provide guidelines that can be adopted as a standard; 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 advice for the practitioner and the caller
- High quality communication and record keeping
- Competency-based training
- An audit tool

The UKONS tool has been developed for use by all members of staff who may be required to take 24-hour advice line calls from patients who:

- Have received or are receiving systemic anticancer therapy
- Have received any other type of anticancer treatment, including radiotherapy and bone marrow graft
- May be suffering from disease/treatment-related immunosuppression (e.g. acute leukaemia, corticosteroids)

Adolescents and Young Adults (AYA) with cancer should be cared for within a dedicated AYA unit, which may be associated with a either service for children, or for adults. If they are treated in a AYA 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.

The UKONS 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.

Males’ 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 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.

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
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 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 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 V4.03 with individual guidelines

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 document the outcome following assessment.

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

It is applicable to support communication with individuals in a variety of settings.

3.2 The Alert Card

The group supports the recommendations of the National Institute for Health and Care Excellence (NICE) neutropenic sepsis clinical guideline, the National Chemotherapy Advisory Group (NCAG) report and the NHS England Chemotherapy Peer Review Measures. All patients and/or carers who are receiving or have received systemic anticancer 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 group suggests that a card containing key information about the treatment they are receiving and the advice line contact details should be provided for each 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. Such cards are now widely used in the adult setting in the UK.

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

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 advice 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 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 advice line service and the use of the UKONS Toolkit triage guidelines rests wholly with the service provider.

### Triage Process Algorithm

1. Patient/carer contacts advice line
2. Call directed to trained triage practitioner
3. Data collected and recorded on the triage log sheet
4. All toxicities/problems assessed and graded according to the assessment tool guidelines.
5. The toxicity scoring the highest grading takes priority.
6. Advice and action should be according to the assessment tool; this should be recorded on the triage log sheet
7. Toxicty/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
8. 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
9. 2 or more ambers = RED
   - Inform assessment team, providing as much information as possible.
   - Follow agreed admission pathway
10. Triage log sheet completed with a record of the action taken and a copy placed in the patient record. Patient’s consultant should be informed of the patient’s attendance and/or admission.
11. 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 filed in patient’s notes.
3.4 The Triage Assessment Process and Tool

The triage practitioner’s assessment of the presenting symptoms is key to the process.

3.4.1 Key points

Dedicated time in a suitable area for the consultation will enable the clinician to pay appropriate attention to the caller, without being interrupted.

The triage practitioner should assess if telephone management is appropriate in the present situation. If the patient’s presenting problem is an acute emergency, such as collapse, airway compromise, haemorrhage or severe chest pain, then the following action should be taken:

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

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.

The practitioner should ensure that the patient/carer understands the questions asked and instructions provided, and that they should feel free to ask questions, clarifying information as required.

The triage practitioner should consider the data collected along with the patient/carer level of concern in order to perform a clinical assessment using the assessment tool and decide on the appropriate action to initiate.

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.

There are advice 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.

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

- **Red** - any toxicity graded red takes priority and action should follow immediately. Patient should be advised to attend for urgent assessment as soon as possible
- **Amber +** - if a patient has two or more toxicities graded amber they should be escalated to red action and advised to attend for urgent assessment
- **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

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

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 NCI-CTCAE common toxicity criteria V4.03 to assess the severity of the problem and/or seek further clinical advice regarding management.
ONCOLOGY/HAEMATOLOGY ADVICE LINE

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

If you consider the patient to be emergencies then refer to the 000 Emergency Number.

Patient management problems should be resolved by the patient's treating oncologist.

This triage tool is to be used in conjunction with the triage tool provided by your local area's children's hospital or PHN. It is not intended to replace the Children's Health System of Australia's (CHSA) triage tool.

Please contact your local oncologist if you have any questions or concerns about this tool.

Full guidance on the management of patients who present with problems related to newly diagnosed cancer therapy can be found in the 2018 Australasian oncology/haematology guidelines for the management of newly diagnosed cancer.

For further information regarding the 2018 Triage Tool, please contact oncoled@unisa.edu.au.

TO BE OBTAINED FROM: ONCOLOGY/HAEMATOLOGY ADVICE LINE

Table of symptoms and conditions

<table>
<thead>
<tr>
<th>Symptom</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever - escalating has received Systemic Anti-Cancer Treatment (SACT) within the last 4 weeks or within 1 week of the last dose, or it is a new problem.</td>
<td>None</td>
<td>None</td>
<td>Increase of up to 4-6 episodes a day or moderate increase in ostomy output or nocturnal movement or moderate cramping.</td>
<td>None or no change from normal.</td>
<td>None</td>
</tr>
<tr>
<td>Pain or nausea - arising from localisation of disease.</td>
<td>None</td>
<td>None</td>
<td>None or no change from normal.</td>
<td>None or no change from normal.</td>
<td>None</td>
</tr>
<tr>
<td>Confusion or disorientation</td>
<td>None</td>
<td>None</td>
<td>None or no change from normal.</td>
<td>None or no change from normal.</td>
<td>None</td>
</tr>
<tr>
<td>Urinary disturbance</td>
<td>None</td>
<td>None</td>
<td>None or no change from normal.</td>
<td>None or no change from normal.</td>
<td>None</td>
</tr>
<tr>
<td>Tiredness - not related to treatment</td>
<td>None</td>
<td>None</td>
<td>None or no change from normal.</td>
<td>None or no change from normal.</td>
<td>None</td>
</tr>
<tr>
<td>Vomiting</td>
<td>None</td>
<td>None</td>
<td>None or no change from normal.</td>
<td>None or no change from normal.</td>
<td>None</td>
</tr>
<tr>
<td>Diarrhoea</td>
<td>None</td>
<td>None</td>
<td>None or no change from normal.</td>
<td>None or no change from normal.</td>
<td>None</td>
</tr>
<tr>
<td>Anaemia</td>
<td>None</td>
<td>None</td>
<td>None or no change from normal.</td>
<td>None or no change from normal.</td>
<td>None</td>
</tr>
<tr>
<td>Neutropenia or infection</td>
<td>None</td>
<td>None</td>
<td>None or no change from normal.</td>
<td>None or no change from normal.</td>
<td>None</td>
</tr>
<tr>
<td>Neurosensory/motor disturbance</td>
<td>None</td>
<td>None</td>
<td>None or no change from normal.</td>
<td>None or no change from normal.</td>
<td>None</td>
</tr>
<tr>
<td>Fatigue</td>
<td>None</td>
<td>None</td>
<td>None or no change from normal.</td>
<td>None or no change from normal.</td>
<td>None</td>
</tr>
<tr>
<td>Dizziness</td>
<td>None</td>
<td>None</td>
<td>None or no change from normal.</td>
<td>None or no change from normal.</td>
<td>None</td>
</tr>
<tr>
<td>Dizziness</td>
<td>None</td>
<td>None</td>
<td>None or no change from normal.</td>
<td>None or no change from normal.</td>
<td>None</td>
</tr>
<tr>
<td>Constipation</td>
<td>None</td>
<td>None</td>
<td>None or no change from normal.</td>
<td>None or no change from normal.</td>
<td>None</td>
</tr>
<tr>
<td>Bowel disturbance</td>
<td>None</td>
<td>None</td>
<td>None or no change from normal.</td>
<td>None or no change from normal.</td>
<td>None</td>
</tr>
<tr>
<td>Other issues</td>
<td>None</td>
<td>None</td>
<td>None or no change from normal.</td>
<td>None or no change from normal.</td>
<td>None</td>
</tr>
</tbody>
</table>

For further information regarding the 2018 Triage Tool, please contact oncoled@unisa.edu.au.
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 consultation should be arranged.

Record name and current contact details in case the call is interrupted and you need to get back to the caller.

Step 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 Log Sheet

It is vitally important that the data collection process is methodical and thorough in order for it to be useful and provide an accurate record of the triage assessment. A standardised format for recording telephone consultations will support the triage process in the following ways:

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

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 interview, and an accurate record of what the practitioner was told and what they asked is vital.

A log sheet should be completed for all calls and 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:

- Complete
- Accurate
- Legible
- Concise
- Useful
- Traceable
- Auditable

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 filed in the patient record.

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

- Assess quality of advice and record keeping
- Monitor activity level
- Identify actual or potential problems
- Support service improvement and innovation
- Analyse certain disease or treatment specific groups
- Support research
- Contribute to national data collection and analysis
### Patient Details

<table>
<thead>
<tr>
<th>HOSPITAL NAME / DEPT:</th>
<th>UKONS/AUS 24 HOUR TRIAGE LOG SHEET</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Hospital no.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>DOB:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Tel no.:</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Patient History

<table>
<thead>
<tr>
<th>Reason for call</th>
<th>(In patient’s own words)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Is the patient on active treatment?</strong></td>
<td>YES ☐ │ NO ☐</td>
</tr>
<tr>
<td><strong>SACT ☐ Immunotherapy ☐ Radiotherapy ☐ Other ☐ Supportive ☐</strong></td>
<td></td>
</tr>
<tr>
<td><strong>State regimen:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Are they part of a clinical trial?</strong></td>
<td>YES ☐ │ NO ☐</td>
</tr>
<tr>
<td><strong>When did the patient last receive treatment?</strong></td>
<td>1-7 days ☐ 8-14 days ☐ 15-28 days ☐ Over 4 weeks ☐</td>
</tr>
<tr>
<td><strong>What is the patient’s temperature?</strong></td>
<td>°C</td>
</tr>
<tr>
<td><strong>(Note that hypothermia is a significant indicator of sepsis)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Has the patient taken any anti-pyretic medication in the previous 4-6 hours?</strong></td>
<td>YES ☐ │ NO ☐</td>
</tr>
<tr>
<td><strong>Does the patient have a central line?</strong></td>
<td>YES ☐ │ NO ☐</td>
</tr>
<tr>
<td><strong>Has the patient taken any immunotherapy?</strong></td>
<td>YES ☐ │ NO ☐</td>
</tr>
<tr>
<td><strong>Infusional pump in situ?</strong></td>
<td>YES ☐ │ NO ☐</td>
</tr>
</tbody>
</table>

### Enquiry Details

<table>
<thead>
<tr>
<th><strong>Follow Up Action Taken:</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Signature:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Print:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Designation:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Date:</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Significant Medical History

- **Fever - Im SACT**
- **Chills and sweats**
- **Oliguria**
- **Decreased urinary output**
- **DI**
- **Hypotension**
- **Hypovolaemia**
- **Compromised organ function**
- **Receiving chemotherapy**
- **Symptoms of sepsis**
- **Palliative**
- **Hypertension**
- **Nausea**
- **Vomiting**
- **Constipation**

### Triage Practitioner

| **Attending for assessment, receiving team contacted?** | YES ☐ │ NO ☐ |

### 24 Hour Follow Up

<table>
<thead>
<tr>
<th><strong>Action Taken:</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Signature:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Print:</strong></td>
<td></td>
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<tr>
<td><strong>Designation:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Date:</strong></td>
<td></td>
</tr>
</tbody>
</table>

### 5.0 Training and competency

It is vital when introducing any defined process such as this that the team involved receives training and support and is assessed as proficient prior to participating.

The UKONS Toolkit Information and Instruction Manual should be read in detail at the start of training, followed by a process of formal classroom based training with scenario practice, and then observed clinical practice and competency assessment. This approach was used in the pilot process.

The manual contains a competency assessment document linked to the national key skill framework that should be completed for all those who undertake UKONS triage and assessment. It is recommended that this assessment be repeated annually to ensure that competency is maintained; assessment could be linked to the chemotherapy annual competency assessment.

The training slides are available at [http://www.ukons.org](http://www.ukons.org) and can be adapted to include local detail, such as advice line numbers and service leads.

### 5.1 The competency assessment

This competency framework is clinically focused and covers:

- Referring a patient for further assessment
- Giving interim clinical advice and information 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.

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 advice line.

All staff managing oncology advice lines should successfully complete the 24-hour triage training and competency assessment.
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

- Australian Health Practitioner Regulation Agency guidance.
- UK Nursing and Midwifery Council Code of Conduct15
- UK Health and Care Professions Council (HCPC) Standards Of Conduct, Performance and Ethics16

Further detail can be found at appendix 2 p.26

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 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 Rapid Assessment and Access 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:

<table>
<thead>
<tr>
<th>Date</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>Your own role and its scope, responsibilities and accountability in relation to the provision of clinical advice.</td>
</tr>
<tr>
<td>1b</td>
<td>The types of information that need to be gathered and passed on and why each is necessary.</td>
</tr>
<tr>
<td>1c</td>
<td>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.</td>
</tr>
<tr>
<td>1d</td>
<td>Barriers to communication and responses needed to manage them in a constructive manner.</td>
</tr>
<tr>
<td>1e</td>
<td>The application of the triage Toolkit guidelines available for use as tools for decision making in relation to different types of request and symptoms, illnesses, conditions and injuries.</td>
</tr>
<tr>
<td>1f</td>
<td>The importance of recording all information obtained in relation to requests for assistance, treatment, care or other services on the Toolkit log sheet.</td>
</tr>
<tr>
<td>1g</td>
<td>The process to be followed in directing requests for onward action to different care pathways and related organisations.</td>
</tr>
<tr>
<td>1h</td>
<td>Why it is important that you advise the individual making the request of the course of action you will take and what will happen next.</td>
</tr>
<tr>
<td>1i</td>
<td>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.</td>
</tr>
</tbody>
</table>
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 request is being made.

2c. Adhere to the sequence of questions within the protocols and guidelines. Phrase questions in line with the requirements of the protocols and guidelines, adjusting your phrasing within permitted limits to enable the individual to understand and answer you better.

2d. Demonstrate competent use of the assessment tool and completion of the 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
   - 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 pathway.
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 report content or its use or application and disclaim any responsibility for its use or application in any way.

References

7. Australian Commission on Safety and Quality in Health care 2011: Implimentation Toolkit for Clinical Handover Improvement and resource portal
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<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Project/Manager</th>
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</tr>
</thead>
<tbody>
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<tr>
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</table>

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</table>
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This version of the toolkit for Australia was agreed through a national collaborative working group of both medical and senior nursing representation.

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<thead>
<tr>
<th>Name</th>
<th>Title</th>
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<th>Organisation</th>
<th>Email</th>
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</tbody>
</table>
Acknowledgements

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Peninsula Health, Frankston, Victoria, Australia.
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, Wolverhampton.

Appendix 1 - Table of changes

Table of amendments/changes approved for Version 2.

<table>
<thead>
<tr>
<th>No.</th>
<th>Amendments/changes to the assessment tool/poster</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Addition of immunotherapy caution statement</td>
</tr>
<tr>
<td>2.</td>
<td>All indicators and grading updated to reflect NCI-CTCAE common toxicity criteria V4.03</td>
</tr>
<tr>
<td>3.</td>
<td>Clarity provided regarding the assessment of patients who have pre-existing symptoms prior to commencing treatment. The question will now be no symptoms or no change from normal</td>
</tr>
<tr>
<td>4.</td>
<td>Addition of the following symptom indicators with appropriate grading and RAG rating:</td>
</tr>
<tr>
<td></td>
<td>• Urinary disorder</td>
</tr>
<tr>
<td></td>
<td>• Confusion/cognitive disturbance</td>
</tr>
<tr>
<td></td>
<td>• Ocular/eye problems</td>
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<tr>
<td>5.</td>
<td>Greater detail added to the following indicators:</td>
</tr>
<tr>
<td></td>
<td>• Diarrhoea - caution note added for immunotherapy patients. Escalation details added for grade 2 symptoms when failed on antidiarrhoeal or receiving/received immunotherapy</td>
</tr>
<tr>
<td></td>
<td>• Infection - more detail regarding the signs of infection added to the white indicator box</td>
</tr>
<tr>
<td></td>
<td>• Neurosensory/motor - more detail regarding significant signs and symptoms with additional red flags for Metastatic Spinal Cord Compression, cerebral metastases and cerebral events</td>
</tr>
<tr>
<td></td>
<td>• Rash - addition of body surface area guidance to indicator and grading boxes</td>
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</table>

<table>
<thead>
<tr>
<th>No.</th>
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<tbody>
<tr>
<td>1.</td>
<td>Addition of immunotherapy treatment box</td>
</tr>
<tr>
<td>2.</td>
<td>Addition of anti-pyretic question</td>
</tr>
<tr>
<td>3.</td>
<td>Addition of infusional pump question</td>
</tr>
<tr>
<td>4.</td>
<td>Addition of immunotherapy caution statement</td>
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<td>5.</td>
<td>Addition of the following symptom indicators with appropriate RAG rating:</td>
</tr>
<tr>
<td></td>
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<tr>
<td></td>
<td>• Ocular/eye problems</td>
</tr>
<tr>
<td>6.</td>
<td>Attending for assessment, record requested.</td>
</tr>
<tr>
<td>7.</td>
<td>Previous contact history</td>
</tr>
</tbody>
</table>
Appendix 2 – 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
- Nursing and Midwifery Council Code of Conduct15
- Health and Care Professions Council (HCPC) Standards Of Conduct, Performance And Ethics16

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

Ensure that you make sure that patient and public safety is protected.

You work within the limits of your competence, exercising your professional ‘duty of candour’ and raising concerns immediately whenever you come across situations that put patients or public safety at risk. You take necessary action to deal with any concerns where appropriate.

Recognise and work within the limits of your competence

- Accurately assess signs of normal or worsening physical and mental health in the person receiving care
- Make a timely and appropriate referral to another practitioner when it is in the best interests of the individual needing any action, care or treatment
- Ask for help from a suitably qualified and experienced healthcare professional to carry out any action or procedure that is beyond the limits of your competence
- Complete the necessary training before carrying out a new role

Always offer help if an emergency arises in your practice setting or anywhere else

Arrange, wherever possible, for emergency care to be accessed and provided promptly

Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

- Prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person’s health and are satisfied that the medicines or treatment serve that person’s health needs
- Make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines
Oncology/Haematology

24 Hour Triage

RAPID ASSESSMENT AND ACCESS TOOLKIT