The Children & Young People's Cancer Association

Triage Toolkit for Children's Cancer Services

3rd Edition 2026

The Toolkit Manual

This manual and competency document belongs to:

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Expertise.
Progress.
Community.

The Triage Toolkit has been developed for use by all members of staff who may be required to man 24-hour telephone advice lines or conduct face-to-face triage for children who:

- Have received or are receiving systemic anticancer therapy in children's cancer services UK
- Have received any other type of anticancer treatment, including immunotherapy, radiotherapy and haematopoietic stem cell transplant
- May be suffering from treatment related immunosuppression (i.e. corticosteroids)

N.B. Adolescent patients treated within children's cancer services ARE included in this pathway. Adolescent patients treated in adult or TYA (teenage & young adult) units are included in the **Adult UKONS 24-Hr Triage Tool.**

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

This publication contains information, advice and guidance, it is intended for use within the United Kingdom (UK). Some countries have obtained permission to adapt the toolkit for local use. Countries who wish to do this should contact **info@cclg.org.uk.**

The information in this manual has been compiled from professional sources. It provides a guideline for practice and is dependent on the clinical expertise and professional judgement of the registered practitioner who uses it. Whilst every effort has been made to ensure the provision of accurate and expert information and guidance, it is impossible to predict all the circumstances in which it may be used. Accordingly, the authors shall not be liable to any person or entity with respect to any loss or damage caused or alleged to be caused directly or indirectly by what is contained in or left out of this information and guidance.

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1.0 Introduction and background

Changes in this version 3

This is Version 3 (2026) and follows review of the toolkit and current paediatric cancer care, alongside alignment with 3rd edition of the UKONS 24-Hr tool. The toolkit was also updated in 2020 (version 2), following a multi-disciplinary review. These reviews have taken place to ensure the tool remains fit for purpose as treatments advance. We would advise all organisations to ensure that you are using the most up-to-date version.

The triage assessment process remains unchanged in V3. Updates include alignment of the toolkit to changes in the UKONS V3 review (2024) and now follows the Resuscitation Council UK ABCDE assessment approach (2024). The working party took the opportunity to add additional questions and prompts to the tool to improve clarity. For example – in the **Shortness of breath/ difficulty breathing** section there are clear questions to ask and considerations

"Is it a new symptom? How long for? Is it getting worse? Change in respiratory rate/effort of breathing? Is there any respiratory noises (Wheeze/Stridor)? Is there a cough? Is it affecting activity level? Is there accompanying paleness, or mottling? Consider: choking, asthma or VIW exacerbation, anaemia, infection."

To note - The abbreviation VIW is used, standing for Viral Induced Wheeze, a condition that can affect any age group but is most commonly seen in children under five.

History

The Oncology/Haematology Triage Toolkit for Children and Young People (CYP) was developed as a guideline for the provision of triage assessment and advice for staff answering telephone advice line calls or undertaking face-to-face triage.

The toolkit is for use for all staff trained in the use of the toolkit who receive and manage telephone calls or undertake triage for CYP who:

- Have received or are receiving systemic anti-cancer therapy (SACT)
- Have received any other type of anti-cancer treatment, including radiotherapy and haemopoietic stem cell transplant or bone marrow cancer patients that have undergone transplant treatment
- Have a cancer or serious blood disorder diagnosis
- May be suffering from disease or treatment related immunosuppression

The toolkit provides recommendations for best practice for the appropriate assessment of patients. It should be used in conjunction with the triage practitioners' judgment. Patients with non-malignant haematological conditions are not covered under the governance of this tool.

The original CYP working group supported by the Royal College of Nursing (RCN) and the United Kingdom Oncology Nursing Society (UKONS) adapted the UKONS adult triage tool for use in CYP services. The adapted tool was subject to a pilot in 5 PTCs and 2 POSCUs, which resulted in a positive evaluation. The pilot was funded by the RCN.

The original version of the toolkit for children's services launched in 2016. It is now widely used across the UK for the telephone assessment and triage of patients who may be suffering from side effects associated with SACT, radiotherapy and immunosuppression.

The original working group recognised that there was a lack of relevant guidelines and training to support members of the clinical team who were undertaking telephone assessment of patients and providing clinical advice. In more recent years it has been acknowledged as also providing a systematic triage approach for face-to-face encounters, such as walk-in patients, or when community nurses visit patients in the home who present with symptoms of concern.

Prior to the introduction of the Triage Toolkit, telephone advice was reliant on the variable individual experience and knowledge of the nurse or doctor answering the call, rather than a systematic approach. There were local models of good practice, but they had not been validated. There were no tested assessment or decision-making tools in use prior to 2016. Furthermore, documentation and record keeping differed from trust to trust, and documentation of calls was noted to be generally poor.

The toolkit manual includes:

Rationale for use.

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

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

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

1.1 Quality of assessment and advice

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

Telephone triage incorporates taking an accurate history and identifying if there are any signs and symptoms of concern. The call may lead to promotion of self-care, a further telephone call or a face-to-face review (Armitage 2024).

The function of telephone triage is to determine the severity of the symptoms or problem described by the caller and direct them, if appropriate, to an emergency assessment or initiate a planned clinical follow up (Courson 2005).

Telephone triage is an important and growing component of current oncology practice; we must ensure that patients receive timely and appropriate responses to their calls (Towle 2009). This is now considered standard practice in paediatric and adult oncology services by 2026.

Successful triage will consistently recognise emergencies and potential emergencies, ensuring that immediate assessment and required interventions are arranged. Sujan (2013) found that the most frequent recommendation for improving communication was standardisation through procedures 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 CCLG Triage Toolkit is the only validated paediatric national guideline, specific to children's cancer services, in place to support training, standardisation and consistency of oncology triage. Implementation of the toolkit meets widely recognised national recommendations regarding the provision of a telephone triage service (NHSE 2017).

Although some of the original guiding documents have been superseded, or statement removed now that that triage practice is considered 'business as usual', many of the original drivers remain relevant. The Manual for Cancer Services, Children's Cancer Measures (NHS England 2014) stated that a 24-hour telephone advice service should be provided for children and young adults with malignancy and their carer givers. The measures also recommend that there should be agreed levels of training and qualification for those staff expected to manage advice line calls (NHS England 2013/14).

Furthermore, in the current NHS Service **Specification - Children's cancer services: Paediatric oncology shared care unit service specification** it is states that all children with cancer should have access to 24/7 expert oncology medical advice over the telephone either through PTC or POSCU, which must include a robust process for access to oncology team advice/reviews at weekends (NHS England 2021).

The World Health Organisation (WHO 2007) recommends that organisations use a standardised approach to handover and implement the use of a Situation, Background, Assessment and Recommendation process (SBAR).

This recommendation stresses 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 (Sujan et al. 2013).

The National Chemotherapy Clinical Reference Group (NHSE 2017) 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 a properly approved or registered organisation that meets required levels of safety and quality (The NHS Constitution for England 2023)

The toolkit V3 maintains good communication recommendations, ensuring that contact assessment and action taken is recorded in a standard format, using an agreed process with a common language. The developed pathway ensures that the treating team are made aware of the parent/carer contact and can see clearly what occurred, thereby meeting all elements of the SBAR protocol.

2.0 Purpose and scope

The CCLG Triage Toolkit provides i.e. 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 practitioner and the caller
- High quality communication and record keeping
- Competency-based training and assessment for practitioners
- Standards that can be used for auditing purposes
- The CCLG Triage Toolkit is an educational tool and includes a competency assessment framework that all disciplines of staff need to complete prior to undertaking triage calls.

The CCLG 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 recommendations for acute assessment by the practitioner who has carried out the triage.

The level of oncology/SACT knowledge and training required to manage a 24-hour advice line was variable nationally, and many practitioners felt unsure and ill equipped to make advanced care decisions prior to implementing the toolkit. The toolkit offers a systematic guide to assist those who will now be trained for the role. Triage training should be integrated into developing cancer careers, such at the **CCLG Career and Education Framework** and **Training Pathway**, or local equivalents.

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 (Males 2007).

Key factors to consider when developing such services are:

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

The CCLG 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 the triage records is recommended for assessment of quality and competency.

Standardised **eLearning training modules** have been created by UKONS for the adult 24-Hr Triage Tool. Two of the four units have been assessed as applicable across all age groups. We recommend that the following are incorporated into local Triage Toolkit Training programmes for children's services. CCLG intends to develop further eLearning in 2026 to offer equivalent paediatric specific training mapping against UKONS modules 2 and 4.

UKONS telephone triage training

1. Principles of telephone assessment and triage – applicable to children's cancer triage also and recommended.
2. The UKONS tool, its use and application in practice – Not paediatric specific
3. Governance and implementation of the service- applicable to children's cancer triage also and recommended.
4. UKONS tool: scenarios – Not paediatric specific

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

- Capacity and demand.
- Common concerns and problems that CYP with cancer present with.
- Data on emergency admissions

The Toolkit was subject to a multi-centre pilot, which resulted in an extremely positive evaluation. Version 3 (2026) includes learning from practice after 10 years of implementation across the UK.

Good practice tips

- The toolkit is being used by some Children's Community Nursing teams as an assessment tool during home visits. This practice is supported by the CCLG review group to ensure a systematic and thorough assessment of a patient before care is given at home and to aide SBAR reporting to other healthcare professionals if there are concerns following the assessment.

3.0 The CCLG Toolkit – content, application and implementation

The triage process can be broken down into three steps:

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

The Toolkit supports and guides the practitioner through each of the three steps leading to the early recognition of potential emergencies, identification of side effects of treatment or disease related symptoms, and provision of appropriate and consistent advice.

- Alert Card recommendations
- The Triage Pathway Algorithm and Clinical Governance recommendations

The Toolkit consists of:

- The Triage Tool (poster) based on **the NCRI-CTCAE common toxicity criteria** with individual guidelines
- Triage Log Sheet
- The Toolkit manual with competency assessment
- Links to the UKONS eLearning modules
- Training Presentation, teaching notes and training scenarios

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 Tool and the Log Sheet, which should be used to carry out the assessment, and to document the outcome of that assessment.

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

1. Initial contact and data collection
2. Triage assessment and decision making
3. Giving interim clinical advice and information to patients or others who might be with them regarding further action, treatment and care
4. Referring a patient for further assessment

3.2 The Alert Card

The National Institute for Health and Care Excellence (NICE) Neutropenic sepsis clinical guideline (2020), the National Chemotherapy Advisory Group (2009) and the Children's Chemotherapy Peer Review Measures (2014) recommend that each CYP and/or carer should be provided with a 24-hour contact number for specialist advice along with information about how and when to use the contact number. CCLG supports these recommendations and would also recommend a card containing key information about the treatment they are receiving alongside contact information should be provided for each patient/carer.

These cards act as an aide memoir for the CYP and carer and as an alert for other healthcare teams that may be involved in the patient's care. Such cards or digital equivalents are now widely used in the UK.

The card should contain:

- Patient identification details
- Treatment protocol name or individual treatment pathway
- Information about symptom recognition/warning signs
- Emergency contact numbers
- Information about treatment delivery area

3.3 The Triage Pathway Algorithm and Clinical Governance

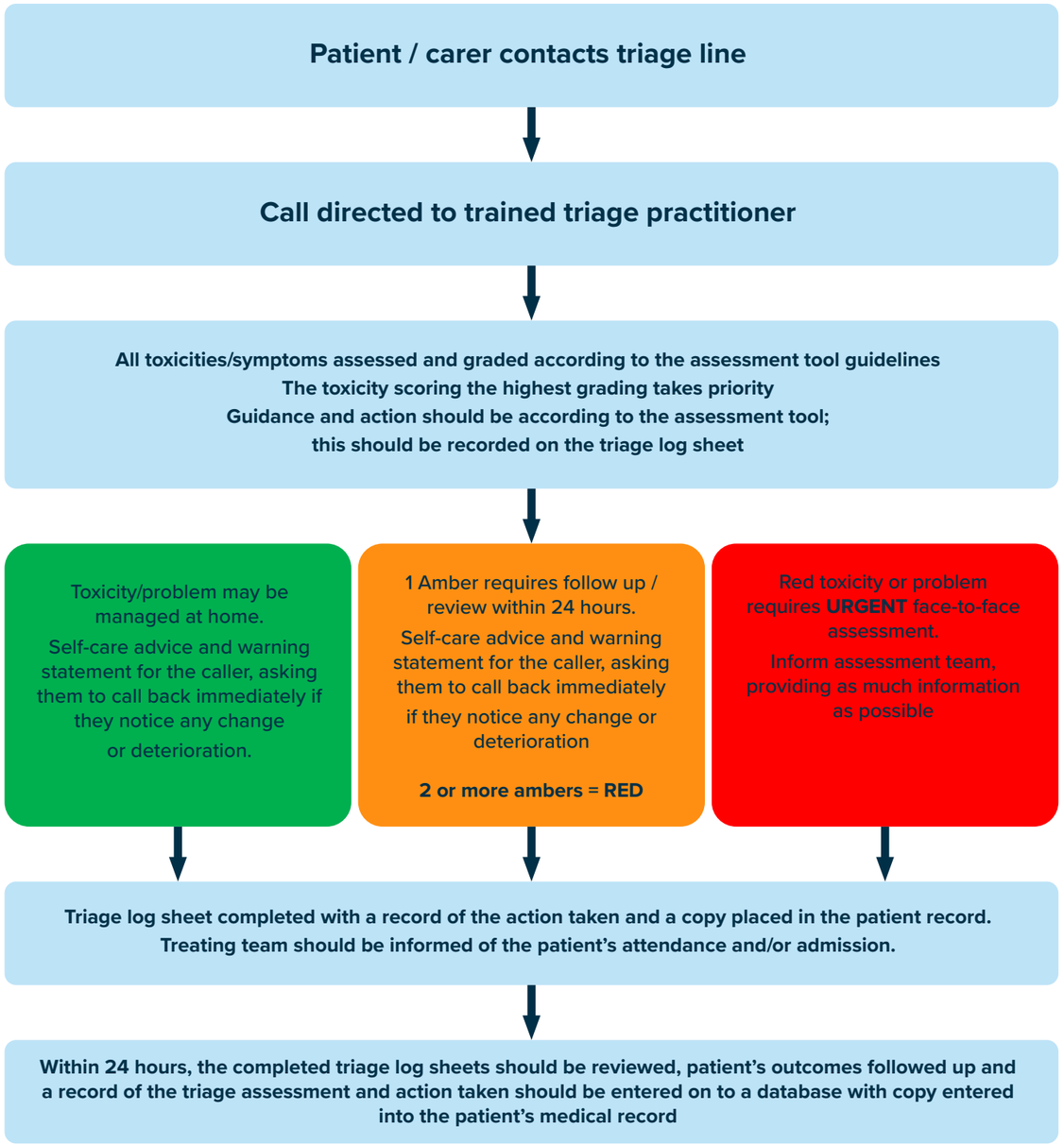
Written protocols and agreed standards can be useful to describe and standardise the process of data collection, planning, intervention and evaluation. They can also help reduce risk of liability (Males 2007).

The algorithm below details each step of the pathway and describes the roles and responsibilities of the triage practitioner. This must be agreed and approved locally. Advice line providers should have agreed assessment, communication and admission pathways. Assessment areas and routes of entry should be clearly defined.

There should be a clearly identified triage practitioner for each span of duty. The process should allow for allocation of responsibility to a nominated triage nurse/doctor for a period of duty. On completion of this period the responsibility for advice line/triage management and follow up of patients is clearly passed to the next member of suitably qualified staff. This should provide a consistent, high-quality service.

The CCLG Triage Toolkit is a guideline and should be approved for use for each service provider by the appropriate organisational governance group prior to implementation. T**he governance responsibility for the provision of the service and the use of the guidelines rests wholly with the service provider.**

The Triage pathway algorithm



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

The service environment.

Organisations should consider the location and provision of triage services and aim to provide dedicated time in a suitable area for telephone consultation to take place. This will enable the practitioner to pay appropriate attention to the caller without being interrupted and facilitates real time recording 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.

Managing Emergency symptoms

The triage practitioner should consider the level of concern of the caller, as well as the information collected using the assessment tool to decide on the appropriate action to initiate. If the patient's problem is an acute emergency, such as collapse/ unconsciousness; airway compromise or severe difficulty in breathing; severe bleeding or signs of sepsis, then the following action should be taken:

- The assessment process should be shortened.
- Advise the caller to hang up and call 999 immediately to initiate Emergency services care.
- Complete the Log sheet with the information you had and document that emergency services were advised.

Proxy or patient

In the majority of cases, the call will be received from the child or young person's parent or immediate care giver. Where it is considered appropriate to the triage process, the practitioner can talk directly to older children and young people; as it may enable a more accurate and complete assessment.

Caller communication capability

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. Consider language barriers, poor call connectivity, level of distress. If there is any doubt about the parent or carers ability to provide information accurately, be understood or understand questions and instructions, then a face-to-face consultation must be arranged.

Call handlers should ensure that the parent/carer understands the questions asked and that they feel free to ask questions, clarifying information as required.

Good practice tips

If, in the triage practitioner's clinical judgement, 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 expediate face-to-face assessment or conversely leave the patient at home despite recommendation in the Toolkit, then there must be clear documentation of the rationale for that decision.

There are calls and queries that will not be addressed by the assessment tool for example: a medication query; central line problems or nasogastric tube 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 triage tool is based on the **NCRI-CTCAE common toxicity criteria.** It should be covered in training and used as a reference point for practice. Grading symptoms facilitates more accurate assessment of the scale of the problem. There is also a link between good practice in symptom recording (within or outside of a triage process) in cancer care to ensure treatment toxicity is accurately reported through clinical trial monitoring.

A CTCAE approach highlights the questions to ask and leads 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. It 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 the practice of the practitioner.

The presenting symptoms have been red, amber, green **(RAG)** rated according to the grade and significance. The tool not only recognises high-grade symptoms but also recognises that a significant number of parents/carers, and CYPs who contact 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 original UKONs pilot with 69% of those asked to attend requiring either intervention or admission (Jones, 2010).

Action selection is based upon the triage practitioner's grading of the presenting symptoms / toxicity:

Red

Any toxicity graded here takes priority and action should follow immediately. Patient must be advised to attend for urgent face-to-face assessment. Assessment pathways should be agreed locally

Amber +

If a patient has two or more toxicities graded amber they must be escalated to red action and advised to attend for urgent face-to-face assessment

Amber

One toxicity in the amber area must be followed up within 24 hours and the caller should be instructed to call back if they continue to have concerns or their condition d eteriorates. Scheduling a less urgent face to face assessment may also be considered.

Green

Callers must be advised to call back if they continue to have concerns or the patient's condition deteriorates or symptoms worsen.

If the patient is required to attend for assessment and it is indicated that they require support for transport, either due to a deteriorating or potentially dangerous condition or lack of personal transport, then this should be arranged as per local policy. Emergency services may be required based on the assessment.

If the CYP is deemed safe to remain at home then the parent/carer should receive sufficient information to allow them to manage the situation and understand when further advice needs to be sought (Males, 2007).

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

Good practice tips

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.

Triage Assessment Tool for Children's Cancer Services 3rd Edition (2026)

Review date November 2030

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.

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.

✓ All green = self care advice	☎ 1 Amber = Telephone review within 24hrs	☎ 2 or more Amber = Escalate to red	Red = Attend for assessment as soon as possible / consider 999

Toxicity / Symptom ↓ Grade →	0	1	2	3	4
Shortness of breath / difficulty breathing Is it a new symptom? How long for? Is it getting worse? Change in respiratory rate/effort of breathing? Is there any respiratory noises (Wheeze/Stridor)? Is there a cough? Is it affecting activity level? Is there accompanying paleness, or mottling? Consider: choking, asthma or VIW exacerbation, anaemia, 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 (change of colour, choking, grunting, noisy breathing, agitation) Advise 999
Bleeding and Bruising Is there active bleeding? How long? Site of active bleeding? Is there any injury/ trauma involved? Is the bleeding spraying, pouring or enough to make a puddle? Is the patient on anticoagulants? New bruises or petechiae? Are they localised (in one area) or multiple/widespread? Any blood in urine or stools? Any nose bleeds or gum bleeding? Is the latest platelet count known?	None	Mild, self limiting bleeding, controlled by conservative measures. New localised bruising. Monitor and arrange full blood count if on treatment.	Bleeding that is not self limiting or keeps restarting and/or multiple sites of petechiae/bruising Arrange for urgent full blood count and review.	Uncontrolled bleeding. Moderate to severe petechiae / purpura / bruising. Advise 999	
Consciousness & Cognitive/ Neurosensory / neuromotor Establish patients level of consciousness using AVPU (alert, responds to voice, responds to pain, unresponsive). This may indicate the need for urgent 999 action. When did the problem start? Is it continuous? Is it getting worse? Is it affecting mobility/function? Any constipation or faecal / urinary incontinence? Any vision changes? Paralysis (consider cord compression)	None	Any new or increased signs of sensory loss, paraesthesia (abnormal sensation, pins & needles), weakness or vision changes and / or loss of function, altered gait, aggitation, repetitive movements, loss of awareness, stiffening or level of consciousness.			
Activity Recent change in activity levels and ability to carry out activities of daily living? Appear or feel generally unwell or exhausted? Is this a new problem? Is it getting worse? How many days? Any other associated symptoms? 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.	Lying around much of the day. Minimal active play or normal activities. Sleepy, lethargic, floppy.	
Pain Is it a new problem? Where is it? How long has it been a problem? Has any analgesia been given & effect? How does child describe it? Can they score it? Is there pain around a device (shunt, Ommaya reservoir, feeding device, CVAD) If infusion running, consider extravasation.	None or no change from normal. Pain score 0	Mild pain. Not interfering with function or activity. Pain score 1-3 Arrange for review at next scheduled appt. Consider phone review	Moderate pain. Pain interfering with function but not activity. Pain score 4-5	Severe pain interfering with function and activity. Pain score 6-8	Severe disabling pain. Repeated headaches (often worse in the morning) which may or may not affect function. Pain score 8-10
Fever Receiving or has received Systemic Anti Cancer Therapies (SACT) within the last 8 weeks or immunocompromised? Recent Blood count known? On G-CSF? Has any antipyretic medication been given? 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 **Advise to take temperature and follow fever toxicity if pyrexial** Are there any specific symptoms, such as pain, burning/stinging or difficulty passing urine? Cough and/or sputum? Any shivering, chills or shaking episodes? Localised signs of infection e.g. redness, swelling, inflammation.	None	Localised signs of infection or inflammation otherwise generally well	Signs of infection [e.g. access device or line, abdominal pain,] and generally unwell.	Signs of severe symptomatic infection.	Potential life threatening sepsis (severe symptoms e.g. difficulty breathing, floppy, altered consciousness, clammy / sweaty skin, extreme discomfort) Advise 999
Skin and / or Infectious Disease Contacts Where is the problem? How much of body is affected? Use rule of 9's to assess localised vs widespread as % of BSA. How long has it been there? Is it getting worse? Is the area associated with recent infusion/injection? Are there any of following - rash, pain, feeling generally unwell, broken or cracked skin, problems with nails, dry or itchy skin, weeping, swelling, warm to touch? Is the rash non-blanching? Risk of GVHD? Close contact with infectious diseases (Chicken pox, shingles, measles, other) > 15 minutes?	No rash or no change from normal. No known infectious contacts or no direct close contact.	Localised rash/skin changes covering <10% BSA with or without itching, redness. No pain.	Rash/skin changes covering 10-30% BSA that is limiting normal activity with or without painful redness or swelling or itching. And/or close contact with infectious disease longer than 15 minutes, without symptoms	Rash/skin changes covering >30% with or without associated symptoms. Generally unwell or sudden onset non-blanching rash. GVHD flare up. And/or direct infectious disease contact with symptoms.	
Nausea, Eating & Drinking How many days? What is oral intake? Taking antiemetics as prescribed? Excessive thirst? Assess urinary output and colour? What is impact on wellbeing and activity level?	None/ no change from normal.	Able to eat/drink reasonable intake.	Able to eat/drink but intake is significantly decreased and impact on wellbeing and/or activity level	Oral intake significantly decreased, with or without debilitating nausea. Excessive thirst. Prolonged nausea with other concerns from parents e.g. behaviour change, weaknesses, headache.	
Vomiting Caution in the case of infants. How many days? How many episodes? What is oral intake? Is there any constipation or diarrhoea (see specific toxicity) Any particular triggers or patterns, e.g. every morning on waking? Possible infectious causes? Assess patient's urinary output and colour.	None	1 episode in 24hs	2-5 episodes in 24hrs.	Over 6 episodes in 24 hrs. Repeated early morning vomiting (may only be one episode a day).	
Mucositis Is the patient able to eat or drink? Are there any mouth ulcers, white patches on mucosa or pain on swallowing? If yes, for how many days? Is there any evidence of infection? Consider mixed symptoms and potential for systemic fungal infections, especially post transplant and high dose therapies. Consider personal history of post-treatment mucositis.	None	Painless ulcers, mild redness, mild soreness. Patient able to eat, drink and talk as normal. Personal history of severe post-treatment mucositis - escalate to amber →	Painful ulcers and/or redness. Mild soreness but able to maintain some fluids and soft diet.	Painful ulcers and redness, difficulty eating and drinking.	Significant pain, significant decrease in fluids and diet, and/or reduced urinary output, and / or difficulty talking and swallowing.
Urinary output Passing urine / nappies wet? Colour of urine? Are they drinking normally? Discomfort/Pain? 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.	Poor or absent urine output / dry nappies. Dark urine. Sunken fontanelle in babies. Few or no tears when crying. Dry mouth. Drowsy. Pain.	
Diarrhoea How many days?> How many times in 24 hours? Abdominal pain/ discomfort? Any blood or mucus in stool? Any regimen specific antidiarrhoeal medication given? Eating and drinking normally? Recent contact with anyone who has diarrhoea? Consider infectious causes; post transplant; constipation/overflow. Caution in the case of infants.	None or no change from normal	Increase of up to 3 bowel movements a day above pre treatment normal.	Increase of up to 4-6 episodes a day above pre treatment normal or nocturnal bowel movements and / or moderate cramping. If diarrhoea persists after taking regimen specific antidiarrhoeal escalate to red → If patient is or has been on immunotherapy escalate to red →	Increase of up to 7-9 episodes a day OR incontinence/severe cramping/mucus/bloody diarrhoea	Increase >10 episodes a day or grossly bloody diarrhoea
Constipation How long since bowels opened? What is normal? Is there any pain and/ or nausea or vomiting? Is the patient on laxatives - have they been given? Is the patient eating/drinking normally? Recent antidiarrhoeal medication been given? Is wind being passed? Note: The Bristol stool chart can be used to assess bowel movement	None	Mild - no bowel movement for 24hrs over pre-treatment normal	Moderate - no bowel movement for 48-72 hrs above normal pattern despite active intervention (Medication). If associated with pain / vomiting escalate to red →	Severe- 72 hours or more of no bowel movement and/or pain, nausea, vomiting	No bowel movement for > 96 hours - consider paralytic ileus
Other: Parental or healthcare professional concerns **NOTE: patients who have previously received immunotherapies** may have immediate or delayed (>8 weeks after treatment), subtle or severe, and / or life threatening inflammatory or autoimmune responses affecting any part of the body.	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.	

Hospital logo

CCLG The Children & Young People's Cancer Association

YOUNG LIVES vs CANCER

UKONS Oncology Nursing Society

The Assessment process step by step

Step 1. Perform a rapid initial assessment of the situation: Is this an emergency? Do you need to recommend contacting the emergency services?

Do you have any doubt about the parent/carers ability to provide information accurately or understand questions or instructions provided? If so, then a face-to-face consultation should be arranged.

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

Step 2. What is the callers initial concern? Why are they calling?

You should do an initial assessment, using an ABC approach to ascertain if there is any threat to life or an emergency situation that requires the caller to hang up and initiate a 999 call. Record on the log sheet.

If there is no indication of immediate threat to life, continue to assess and grade the callers initial concern, ensuring that you record this on the log sheet, and continue to complete the assessment process. If at any point in the call threat to life is identified, stop the call and advise 999.

If the patient is stable, you should complete the assessment process in order to gather further information for the face-to face assessment.

Step 3. If the callers initial concern scores AMBER, record this on the log sheet and proceed with further assessment.

Move methodically down the triage assessment tool, asking appropriate questions, e.g. does the child have any difficulty breathing? If NO tick the green box on the log sheet and move on. If YES use the questions provided to help you grade the problem and note either amber or red and initiate action (tick the log sheet).

If the CYPs symptoms score red or another amber at any time they should be asked to attend for assessment.

Step 4 – look back at your log sheet.

- Have you fully completed the assessment?
- Have you arranged assessment for all patients who have scored RED?
- Have you arranged assessment for all patients who have scored more than one AMBER?
- Have you fully assessed all the patients who have one AMBER, is there a tick in all the other green boxes of the log sheet?
- Have you fully assessed all the patients who have one GREEN, is there a tick in all the other green boxes of the log sheet?
- Have you recorded the action taken and advice given?
- Have you documented any decision you have taken or advice you have given that falls outside this guideline, and recorded the rationale for your actions?

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 (Situation, Background, Assessment, Recommendation) process. 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.

The SBAR Log Sheet 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 advice line practitioners record verbatim what the parent/carer calls for (Males, 2007). This information may be important if the call should require review at any time. Assessment and advice can only be based on the information provided at the time of interview and an accurate record of what the practitioner was told and what they asked is vital.

A Log Sheet should be completed for all calls and may be used for unscheduled patient visits or assessing symptoms during home visits. This provides an accurate record of triage and decision-making and will support audit of the helpline service.

The data collected should be:

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

There should be a robust local system of record keeping, with log sheets available for audit purposes.

This may be in 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 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

The 2026 revised version of the Log Sheet includes asking if there has been any previous calls in the past 5 days (including to any other healthcare providers) and prompts to look for other related Log Sheets – this is to help you assess if this is an ongoing problem and to consider if the problem is worsening. The Log Sheet asks you to consider any current or previous immunotherapy, recognising that side effects to these patients may start months or years after treatment.

Good practice audit tips

- Log sheets discussed in weekly team meetings
  - To see what actions were suggested & that they have been followed
  - To ensure all relevant teams involved have been informed (e.g. Research teams for those on clinical trial)
- If paper copies – keep available where Triage Calls occur (e.g. ward or office) for 7 days so easy to locate & then file in notes/load to electronic patient record.

Triage Toolkit for Children's Cancer Services 3rd Edition (2026) Log Sheet

Hospital name and department:[Form Fill text Box]

Patient details	Patient history	Enquiry details
Name:	Diagnosis (Inc. other diagnoses / co-morbidities):	Date: Call start time:
NHS No:	Consultant team:	Who is calling?
Hospital No:	Has the patient had any concerns or issues that have required a call to any healthcare professionals in the last 5 days?	What phone number do you want us to call back on?
DoB:		Reason for the call (in caller's own words):
Age:	Yes ◯ (Look for other TT related log sheets.) No ◯	

Is the patient on active treatment?
Systemic therapy (Chemo / Targeted / Immunotherapy) ◯ CAR-T / Cellular therapy ◯ Post stem cell transplant ◯ Radiotherapy ◯ Surgery ◯ None ◯

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

Has the patient received previous immunotherapy? Yes ◯ No ◯ Don't know ◯

CAUTION: Immunotherapy / targeted therapy toxicities may present during or months-years after treatment.

What is the patient's temperature? °C Note that hypothermia is a significant indicator of sepsis

Has the patient received any anti-pyretic medication in the last 4-6 hours? Yes ◯ No ◯

Does the patient monitor their blood glucose? Yes ◯ No ◯ If Yes: Current Blood Glucose level:

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

Does the patient have a central line? Yes ◯ No ◯ Does the patient have a shunt / Ommaya reservoir / lumbar port/ other medical device? Yes ◯ No ◯

Does the patient have an infusion pump running? Yes ◯ No ◯

Advise | Follow up | Assess

Remember: 2 or more AMBER = RED

Symptom	0	1	2	3	4
Breathing					
Bleeding & / or bruising					
Consciousness & neuro					
Activity					
Pain					
Fever					
Infection					
Skin &/or infection contact					
Nausea, eating and drinking					
Vomiting					
Mucositis					
Urinary output					
Diarrhoea					
Constipation					
Other					

Please document current medication	Please document significant medical history: (Include last FBC if known and date taken, and detail of any recent calls)

Action taken / advice given:

Call end time:

Attending for assessment at (Location): | Receiving team notified: Yes ◯ No ◯ Name:

Triage practitioner's details

Signature:	Designation:
Print Name:	Date:

Review no later than 24 hours after call. Single Ambers require earlier call back. Start a new Log sheet if there are new symptoms.
Notes, review of actions taken

Signature:	Designation:
Print Name:	Date:

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YOUNG LIVES vs CANCER

UKONS Oncology Nursing Society

5.0 Training and competency

5.1 The competency assessment

It is vital when introducing any defined process such as this that the team involved receives training and support and is assessed as proficient prior to participating (Males, 2007).

The 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 Toolkit Manual should be read in detail at the start of training, and the relevant online modules (see page 7) completed. This should be followed by a local process of scenario practice, observed clinical practice and competency assessment. This process was trialled in the pilot phase.

The competency assessment has been developed according to national guidance (Males 2007). It is recommended that it is repeated annually to ensure that competency is maintained.

The set of supporting training slides used during the pilot are available at **www.cclg.org.uk/triagetool** and can be adapted to include local detail, such as advice line numbers and service leads.

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 and should refer these calls to a trained member of staff.

Good practice audit tips

Re-assessment could be linked to the SACT annual reassessment.

This competency framework is clinically focused and covers:

- Referring a patient for further assessment
- Giving interim clinical guidance to CYP, parents/ carers or others who might be with them regarding further action, treatment and care.
- It may involve talking via the telephone to an individual in a variety of locations or talking face to face in a healthcare environment.

The aim of the 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

Advice and information will usually be given to a parent or carer, unless the caller is an older teenager, in which case it may be given directly to the patient if they are of sufficient age to both understand, and to act on it.

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

All staff working within CYP oncology services and who are expected to manage advice lines should be appropriately trained as follows: Successfully complete

- The two relevant UKONS eLearning Modules (see page 7)
- Local Triage training including scenario practice, observed clinical practice and competency assessment.
- In children's services it is recommended that nurses should have achieved a minimum of foundation competencies as recommended within the Improving Outcomes Guidance for Children and Young People with Cancer (NICE 2014) and current Children's Cancer Service Specifications for each country in the UK.

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

6.1 Conduct and responsibility

Nursing and Midwifery Council (2018) The Code: Professional standards of practice and behaviour for nurses and midwives.

The practitioner is reminded that they are accountable for practice as detailed on the NMC (2018).
The code details the following guidelines for practise that are relevant to the advice.

- Always practise in line with the best available evidence
- Communicate clearly
- Work cooperatively
- Keep clear and accurate records relevant to your practice
- Recognise and work within the limits of your competence
- Always offer help if an emergency arises in your practice setting or anywhere else

Please see below indicative links with the following dimensions within the NHS Knowledge and Skills Framework (November 2010)

- 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: Develop own skills and knowledge and provide information to others to help their development
- HWB6 - Assessment and treatment planning
- HWB7 - Interventions and treatments

Note: The KSF was originally introduced with the Agenda for Change pay structure. It is no longer widely in use in the NHS but core principles remain. There are other generic Frameworks being developed in 2025, such as the Leadership and Management Development Framework for managers, and other multiprofessional frameworks

CCLG Career and Education Framework for children and young people cancer nursing V3.0 (2022 and any subsequent updated versions)

Training in the triage tool supports nurses with some competencies within the following sections of the framework.

- 1.0 Communication: underpinning principles and skills across all CYP cancer care:
- 4.0 Supporting CYP, family and carers living with, through and beyond cancer
- 7.0 Early and Intermediate consequences of SACT, radiotherapy and surgery

6.2. 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.

6.2.4 Scope of the competency assessment

This framework covers the following guidance:

Giving clinical advice which will include:

  - Managing emergency situations
  - Monitoring for and reporting apparent changes in the individual's condition
- Calming and reassuring the CYP or their parent/carer
- The importance of identifying the capacity of the parent/carer, or young person (where applicable) to take forward advice, treatment or care
- The importance of ensuring the caller contacts the helpline again if condition worsens or persists
- The importance of completing the assessment pathway and ensuring that decisions are documented and reviewed.
- The importance of documenting any decisions taken or advice given which falls outside this guideline and recording the rational for the advice given and action taken.

6.2.5 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: _____

Knowledge and Understanding You need to be able to explain your understanding of the following to your assessor:		To be signed and dated by the **student and assessor** to confirm competency	
		Date	**Signature**
1a	Your own role and its scope, responsibilities and accountability in relation to the provision of clinical advice.		
1b	The types of information that need to be gathered and passed on and why each is necessary.		
1c	How communication styles may be modified to ensure it is appropriate to the individual and their level of understanding, culture and background, preferred ways of communicating and needs.		
1d	Barriers to communication and responses needed to manage them in a constructive manner.		
1e	The application of the triage toolkit guidelines available for use as tools for decision making in relation to different types of request and symptoms, illnesses, conditions and injuries.		
1f	The importance of recording all information on the toolkit log sheet.		
1g	The process to be followed in directing requests for onward action to different care pathways and related organisations.		
1h	Why it is important that you advise the individual making the request of the course of action you will take and what will happen next.		
1i	The circumstances in which a request for assistance, treatment, care or other services may be inappropriate/beyond your remit and the actions you should take to inform the person making the request of alternatives open to them.		

2. Performance Criteria: to confirm competency You need to demonstrate that you can:		To be signed and dated by the **student and assessor**	
		Date	**Signature**
2a	Explain to the individual what your role is and the process you will go through in order to direct their request.		
2b	Select and apply the 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 • Should be according to scope of practice 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		

2. Performance Criteria: to confirm competency You need to demonstrate that you can:		To be signed and dated by the **student and assessor**	
		Date	**Signature**
2j	Manage any obstacles to effective communication and check that your advice has been understood.		
2k	Provide reassurance and support to the individual or third party who will be implementing your advice, pending further assistance.		
2l	Ensure that you are kept up to date regarding the patient's condition so that you can modify the advice you give if required.		
2m	Ensure that full details of the situation and the actions already taken are provided to the person or team who take over the responsibility for the patient's care.		
2n	Recognise the boundary of your role and responsibility and the situations that are beyond your competence and authority.		
2o	Seek advice and support from an appropriate source when the needs of the patient and the complexity of the case are beyond your competence and capability.		
2p	Ensure you have sufficient time to complete the assessment.		
2q	Provide information on how to obtain help at any time.		
2r	Record any modifications, which are made to the agreed assessment process and documentation and the reasons for the variance.		
2s	Record and report your findings, recommendations, patient and/or carers response and issues to be addressed according to local guidelines.		
2t	Inform the patient's medical team on the outcome of the assessment as per the assessment pathway.		

Re-Assessment Certificate

Personal Development

☐ I have, within the previous 12 months, demonstrated continual professional development in relation to the Triage Toolkit for Children's Cancer Services, (e.g. attended workshops regarding the Triage Toolkit, reflective scenario-based session, conference presentations, re-read training materials)

2. Policies and Standards

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

☐ Cancer Service specifications

☐ Cancer services operational policy

☐ Out of hours management of an Oncology/haematology patient

3. Process

☐ I ensure the RAG system is followed when using the Triage Toolkit

☐ I ensure the 'log sheet' is appropriately completed and communication regarding patients is discussed with the relevant MDT

☐ I ensure when applicable 24 hour call backs occur through the agreed Hospital Designated Practitioner and / or myself

4.Communication Assessment Skills

☐ I conduct telephone consultations using the Triage Tool for Children's Cancer Services through application of good communication and information delivery skills

☐ I ensure patient/carers are aware of the Triage Tool and contact pathway pre discharge from Principal Treatment Centre or Paediatric Oncology Shared Care Unit.

☐ I have within the past year peer-reviewed log sheets within the service and participated in giving feedback to the wider team or Hospital trainer and / or engaged in learning from local audits.

5. Declarations

☐ I remain competent to use the Triage Toolkit

☐ I do/do not require any further training regarding the Triage Toolkit

Signed: _____ **Date:** _____

Name: _____ **Position:** _____

Assessor

I have observed _____ perform triage using the Oncology/haematology

Signed: _____ **Date:** _____

Name: _____ **Position:** _____

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Produced by a project review team withing CCLG: CYP-CANN The Children & Young People Cancer Association Nurses' Network
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We are CCLG: The Children & Young People's Cancer Association. We unite the children and young people's cancer community, driving collective action and progress. Powered by expertise, we work together to create a brighter future for children and young people with cancer.

Research is the key to better treatments, improved care, and potential cures. We fund and lead world-class research, fuelling groundbreaking work led by brilliant minds. Collaboration is at the heart of our approach - bringing together the right people and organisations to drive progress and deliver real impact.

We provide trusted information and guidance for children and young people with cancer, their families, and everyone supporting them. Our expertise helps them navigate the challenges of cancer and its impact, offering reassurance and clarity when it's needed most.

Through our professional membership, we bring together the brightest minds in childhood cancer, creating a national network that drives progress. Together, we shape better treatment and care - developing guidelines, sharing knowledge, offering expert advice, leading pioneering research, and creating essential resources and education for professionals. Our collective expertise sets the standard, advocating for excellence at every level - local, national, and global.