

Oncology Telephone Triage Workshop

Improving Nurse Knowledge, Skill, and Confidence

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Introduction

Telephone triage in oncology is an essential practice as more cancer care has transitioned to the ambulatory setting in the last few decades.

The nurse (RN) is often the first point of contact through telephone triage and is responsible for proper symptom assessment and subsequent communication with a licensed independent practitioner.

There is no standardized training offered for this skill during orientation. It is imperative that oncology RNs have robust training embedded within nursing orientation as well as annual competency evaluation to ensure knowledge, confidence, and skill are maintained at an optimal level throughout employment.

Background

Standardized training → ↑RN preparedness, confidence, skill and knowledge (+) patient outcomes

Literature demonstrates effective training including interventions such as:

- Two day orientation
- Role playing
- Recording of potential calls
- Case scenarios
- Identification of personal competency

Telemedicine has been adopted in the healthcare community
Telemedicine has been supported by various professional organizations
Example telephone triage model recognized by AACN and ONS “nursing process”
Nursing process = interactive problem-solving process to provide individualized care.

Purpose & Aims

Purpose

To change office practice oncology RN knowledge, skill, and confidence in telephone triage using telephone triage models.

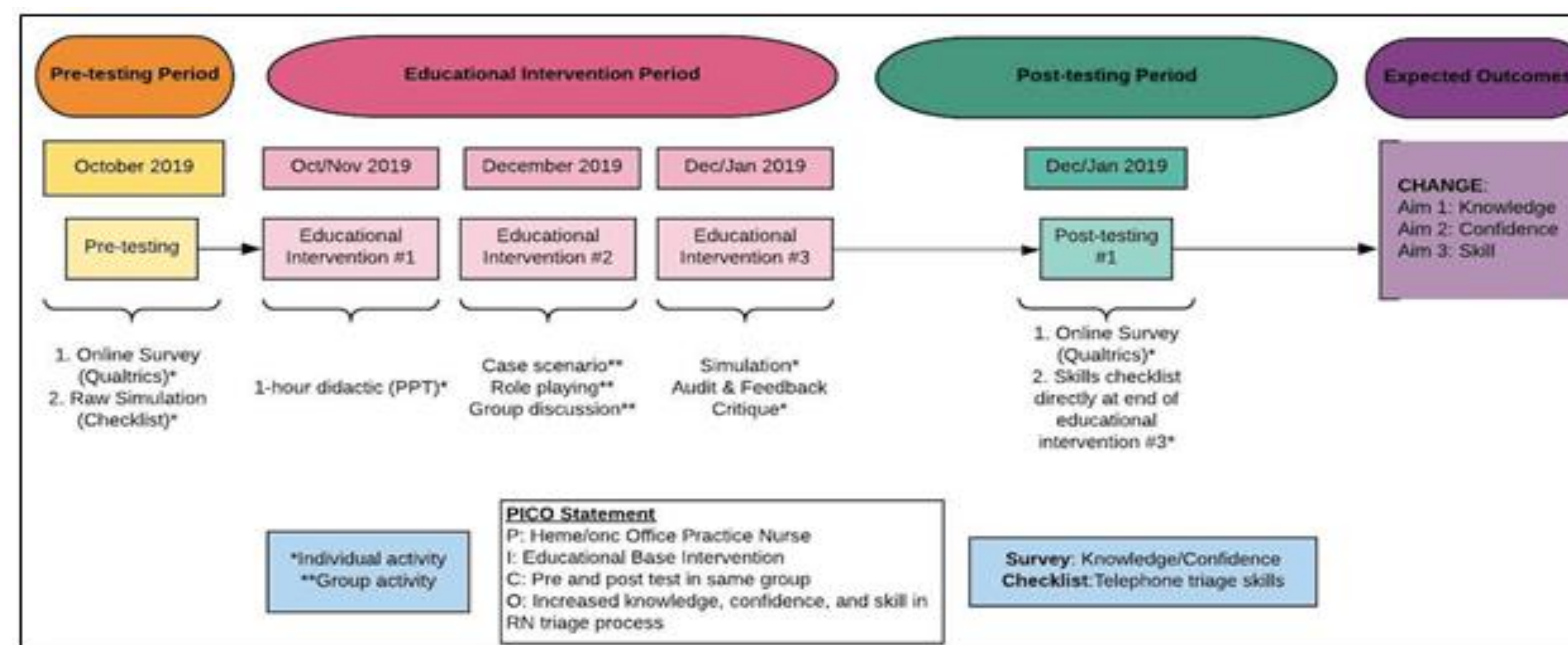
Project Aims

To determine if a telephone triage educational based intervention, specific to phone triage symptom management models, would change oncology RN’s (1) knowledge, (2) confidence, and (3) skill as measured by a prospective pre/post test by 10% over a 12 week period.

References

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Methods



Design: Quality improvement with pre- post test design

Setting: Outpatient Cancer Center Department of Hematology/Oncology

Framework: Johns Hopkins University EBP Model

Sample: n=13, convenience sampling

Inclusion Criteria: 1. Currently employed office practice RNs, part-time or full time, 2. Office practice RNs working in oncology, 3. Must provide direct care to patients in the oncology setting, 4. Must provide telephone triage to patients in the oncology setting

Analysis Tools: Online survey: Confidence (n=2) & Knowledge (n=11). Skills checklist (n=56)

Intervention: Participants underwent a three-part evidence-based workshop over a 12 week period which included an online didactic lecture, an in-person group case scenario, and a virtual triage simulation with feedback. The intervention was developed based on evidence and led by the DNP student (K.C.)

Intervention: Workshop

Intervention #1

History, MSH standards, clinical outcomes, triage models, legal implications, documentation

Intervention #2

Group case scenario with structured questions applying models taught

Intervention #3

Audit & feedback of pre-testing simulation triage skills

Models Taught

General

Greenberg Triage Nursing Process
Crisis Intervention

Symptom Assessment

OLDCARTS
OPQRST

Communication

Communication Model
SBAR

Results

This QI project enrolled 13 oncology RN (Appendix B1) primarily female (69.2%), most being over 31 years old (77%), with having received a bachelor's degree as highest level of education (100%). Out of 13 RNs, 69.3% had less than 10 years of RN experience, 53.8% had 0-4 years of oncology experience, and for both inpatient and outpatient, 69.2% had 0-4 years of experience. Lastly, 53.8% did not have telephone triage experience prior to this job, and 61.5% did not receive formalized training during orientation or any part of employment. A total of 13 RNs completed baseline data and 12 RNs completed the educational workshop.

Pre-test median knowledge score was 72.72% (IQR 18.18), post-test 72.72% (IQR 22.73). There was no difference in median knowledge scores from pre to post-test ($p=0.11$). Pre-test median confidence summary score was 3.00 (IQR 2.5), post-test 4.00 (IQR 0.75), summary difference score of 1.00 (IQR 2.75) reflecting an overall improvement from pre- to post-test ($p=0.01$). The median skill summary score pre-test was 49.12% (IQR 9.82), post-test 73.21% (IQR 12.05), summary difference score of 26.34% (IQR 15.18) reflecting an overall improvement ($p = 0.00$). Statistical significance was found with outcome measures of confidence and skill.

Comparison of Median Pre and Post-Test Knowledge Summary Scores (N=13)

Outcome Variable	Pre-Test (n=13)	Post-Test (n=12)	Difference (n=12)	P
Knowledge	72.72% (18.18)	72.72% (22.73)	18.18% (31.82)	0.108 (>0.05)

Note: Wilcoxon Signed Rank test was used due to low sample

Comparison of Median Pre and Post-Test Knowledge Summary Scores (N=13)

Outcome Variable	Pre-Test (n=13)	Post-Test (n=12)	Difference (n=12)	P
Confidence	3.00 (2.5)	4.00 (0.75)	1 (2.75)	0.008 (<0.05)

Note: Wilcoxon Signed Rank test was used due to low sample

Comparison of Median Pre and Post-Test Knowledge Summary Scores (N=13)

Outcome Variable	Pre-Test (n=13)	Post-Test (n=12)	Difference (n=12)	P
Skill	49.12% (9.82)	73.21% (12.05)	26.34% (15.18)	0.002 (<0.05)

Note: Wilcoxon Signed Rank test was used due to low sample

Conclusions

Oncology RNs are responsible for telephone triage and require standardized education and competency using telephone triage models. At present, there is no standardized training offered during employment. It is imperative that oncology RNs have a robust education embedded within orientation as well as annual competency evaluation to ensure knowledge, confidence, and skill are kept at an optimal level. This novel oncology telephone triage education model with e-learning and virtual simulation, translates evidence-based strategies into solutions, applies innovation and technology to advance nursing practice, supports Magnet® tenets and optimizes both nursing practice and patient outcomes.