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Oncology telepractice orientation program

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ABSTRACT

Telepractice in oncology is an evolving practice for nurses and cancer patients. Understanding the needs of our patients led the nursing leaders of a large academic teaching centre to undertake the challenge of creating a measurable and sustainable Telephone Readiness Assessment and Orientation Program. The experiences of patients and families regarding telephone interactions triggered the launch of Live Voice Answer, a centre-wide telepractice change. To support the transition from clinic practice to telepractice with the introduction of Live Voice Answer, an orientation program was created to lay the foundation for nurses to provide excellent standardized telepractice care.

A Practice Training Process map was designed to depict three stages required to successfully complete the orientation: Telephone Readiness Assessment, Telephone Practice Training session, and Practical Application. The frameworks used to support the Practice Training Process includes COSTaRS, College of Nurses of Ontario Practice Guideline: Telepractice, Cancer Care Ontario: Oncology Nursing Telepractice Standard, Cancer Care Ontario – Symptom Management Guides as well as our organizational policies. Benner's Novice to Expert Theory is also embedded to guide the skill/competency development. The purpose of this manuscript is to describe the telephone practice orientation program and share lessons learned that have contributed to its current evolution.

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INTRODUCTION

The Odette Cancer Program is a comprehensive program within a large academic teaching hospital. It consists of several inpatient acute care units and an ambulatory outpatient care centre that has 260,000 patient visits annually (Sunnybrook, 2021). In the outpatient setting, telepractice is an evolving practice for oncology nurses and patients and has demanded the establishment of an organized system that is safe, feasible, measurable, and sustainable.

The redesigned telepractice approach, entitled 'Live Voice Answer' (LVA), is specific to nursing practice in the ambulatory oncology program. The new approach is a symptom management and distress telephone line that ensures patients and families are connected to a nurse or clerical staff in real time to have health and appointment concerns addressed (Elmi et al., 2022). The redesign of telepractice at Odette prompted the need for a new orientation program for staff members.

The evolution of telepractice has directly impacted the delivery of telephone orientation at the ambulatory clinics at the Odette Centre. Given the purpose of Live Voice Answer is to create a seamless, person-centred, telephone experience that provides clear points of contact, navigation and support for patients, families and caregivers living through a cancer experience, the goals of our orientation program for telephone practice are to facilitate learning and optimize the nurses' assessment and communication skills, so they can provide the desired safe and effective telephone encounter. We wanted to have nurses utilize critical judgment, evidence-based tools, practice standards and organizational policies to facilitate a seamless transition from clinic practice to telephone practice. The objective of this article is to review the design and evolution of a telepractice training program at a regional cancer centre.

BACKGROUND

Telephone triage is a dynamic field that requires continual evaluation and re-evaluation (Koehne & Stein, 2020, p. 11). Telephone practice is an essential skill for Specialized Oncology Nurses (SON) in the Odette Cancer Centre ambulatory clinics. Nurses are expected to engage in telephone practice conducting focused assessments, creating a care plan, and providing appropriate interventions to support the psychosocial, practical and symptomology needs of the patient and family.

Prior to 2017, the SON required five years of oncology experience as a prerequisite to work in ambulatory oncology. Historically, newly hired ambulatory nurses received a specific-disease site assignment and their orientation would be tailored to their assigned disease site. For example, nurses assigned to the hematology site would receive training from the hematology site nurses and care for hematological patients only. Orientation was a few weeks long and encompassed both clinic and telephone practice.

Anecdotal review from SONs with several years of experience recall peer-to-peer telephone training at that time. Telephone training included caring for patients in clinic, listening to voice messages left by patients and families, and prioritizing which patients would be called based on level of urgency for action. The nurses used practice guides and telephone algorithms to guide their nursing care and were responsible for documenting the encounter in the patients' health record and in the Telephone Log (i.e., a tool used for coverage and handover). The assumption at that time was that the needs of the patient and family extended well beyond the clinic visit and, therefore, call resolution was critical.

A limited pool of applicants to the Cancer Centre who were experienced ambulatory oncology nurses (>5 years) resulted in the hiring prerequisite shifting towards hiring experienced nurses, but who are novice ambulatory oncology nurses. This change emphasized the need to divide the clinic and telephone practice orientation. We now required a sequential orientation from clinic orientation and clinic practice followed by the introduction to telephone orientation. Our belief was that new staff nurses needed to have a solid foundation in ambulatory oncology practice prior to adding in the complexity of providing care over the telephone.

THE REDESIGN

The launch of Live Voice Answer Initiative in 2016 and its phased implementation approach permitted time for the Advanced Practice Nurse – Clinical Educator (APNCE) leadership team to create a standardized, measurable, and sustainable telepractice orientation program. This program is now called the Telephone Readiness and Orientation program.

The new orientation program for ambulatory oncology telephone practice was originally enhanced and standardized by the APNCE team. Then, between 2017 and 2020, improvements were made to the program. The improvements included incorporating elements from the Oncology Nursing Telepractice Standards Guideline from Cancer Care Ontario (CCO) and feedback from participants who completed the telepractice surveys we conducted. Other frameworks used to support and guide nursing telephone orientation and practice included: *Telepractice* (College of Nurses of Ontario, 2020), *Oncology Nursing Telepractice Standards* (Cancer Care Ontario, 2019) and *The Pan-Canadian Oncology Symptom Triage and Remote Support (COSTaRS)* (Stacey & Carley, 2017). The telepractice orientation program, its evolution, and lessons learned will be described in detail in this paper.

The new orientation program is a three-step approach with specific goals and objectives for each step. The first step is entitled Telephone Readiness and is initiated three months after completion of the disease site-specific orientation for clinic practice. The second step is Telephone Practice Training, a three-hour classroom session where the staff gain foundational knowledge and skills to manage patient calls. The last step is called Practical Application. The goal for this last step is for the new staff member to "buddy" with a mentor and practice the skills learned in a safe and positive environment.

Prior to engaging in the Telephone Readiness and Orientation, each nurse starting to practice at the Odette Cancer Centre Ambulatory Centre is assigned to a specific disease site at the point of hire. All staff receive a five-week unit-specific orientation that consists of an introduction to ambulatory oncology; overviews of radiation, surgical, and medical treatments; and a period of consolidation. Each week is tailored to the new staff member's designated disease site-specific team.

After practicing for three to six months in the ambulatory clinic, the new nurse is guided by the APNCE to take the next step in preparing for Telephone Readiness. Recognizing each nurse brings with them variability in their oncology, ambulatory, and telephone experience, the APNCE leadership team established a process to ensure staff are ready to move ahead with telephone practice orientation.

DESIGN OF THE TELEPHONE PRACTICE ORIENTATION PROGRAM

The APNCE team created the Telephone Readiness and Orientation Program that consists of three components (Appendix A) to guide each step of the orientation for the staff nurse. The telephone practice training process serves two purposes: 1) it is a standard method for assessing the readiness of nursing staff for telepractice, and 2) it is an organized guide supporting transformation from knowledge acquisition to knowledge application for telepractice nurses.

Step 1: Telephone Readiness Assessment

The first step towards independently practicing via telephone is the Telephone Readiness Assessment. The assessment process is initiated between three and six months after completing the initial orientation for ambulatory oncology practice. The process begins by coordinating dates with the Operation/Management Team so that the APNCE can have protected time to meet with the new nurse. During that meeting, resources are reviewed together including organizational policies related to telephone practice, oncology nursing resources, and self-assessment tools (Table 1). Staff are given the resources and have two weeks to read this Telephone Readiness package and complete the self-assessment tools. Upon completion of the self-assessment tools, the nurse is given a telephone readiness quiz. The quiz has three categories for testing: general oncology, policy procedures and standards of practice, and disease site-specific questions. The passing grade is 80%.

Self-Assessment Tools: The self-assessment tools include the Specialized Oncology Nursing Role Description, the nursing site-based knowledge guide or

Table 1:

Readiness Assessment Policies and Resources

Readiness assessment policies and resources
- Odette Nursing Email/Telephone/Verbal Orders policy
- Odette Nursing Site Email Accounts
- Odette Nursing Telephone Practice
- Specialized Oncology Nursing Role Description
- Electronic Media Device Policy
- Web link to CNO Telepractice Practice Guideline
- Web link to COSTaRS

disease site-specific competency checklist, and a Practice Review Rubric for Clinic Documentation self-evaluation. We incorporated self-reflection as a requirement for telephone readiness. This method of self-directed learning provides insight into one's knowledge strengths and gaps, while ensuring ongoing development and improved competence (Brixey & Mahon, 2010). The tools allow staff to critically inquire into their practice using purposive thinking and reflective reasoning (CNO, 2014). The Nursing Theory Framework proposes that expert nurses develop skills and understanding of patient care over time through a proper educational background as well as through a multitude of experiences (Nursing Theory, 2016).

Our Specialized Oncology Nursing Role Description is based on the CANO Standards of Care (Canadian Association of Nurses in Oncology, 2001). The role description provides clear practice standards and competencies for the practicing oncology nurse, outlining the nurse's scope of practice. The site-based knowledge guide (disease site-specific competency checklist for nurses) is a comprehensive list focused on specific disease site information and includes the following categories: pathophysiology, anatomy, surgical, medical and radiation treatment. The new nurses use this as a point of reference to identify strengths and gaps in their knowledge when providing disease site-specific nursing care.

Lastly, the new nurses are asked to review and reflect on their own documentation using a Practice Review Rubric for Clinic documentation created by the APNCE team (Appendix B). The self-reflection documentation rubric meets the practice standards for documentation as per the College of Nurses of Ontario (CNO) and allows the nurse to assess if their documentation meets CNO standards, principles of person-centred care, and evidence-based practice. The rubric was designed to improve staff documentation and is a strategy to improve how nurses capture the client's perspective and communicate the plan of care to all health care providers (CNO, 2008). The APNCE randomly selects five documented clinic encounters recorded by the new staff member, and patient identifiers are removed. The records are printed and given to the nurse to compare their notes against the documentation rubric. Using the documentation rubric as a guide, the nurse reviews and scores each documentation record and provides a rationale for their score. Written and verbal instructions are provided to explain how to use the clinic documentation rubric.

Following completion of the activities outlined in the Telephone Readiness package the APNCE meets with the nurse and reviews the self-assessment tool. The nurse is now ready to complete the Telephone Readiness Assessment Quiz.

The Telephone Readiness Assessment Quiz is a knowledge-based quiz aligned with the nurse's clinic assignment to a disease site-specific nursing site team. For example, a nurse assigned to the GI nursing team will receive a GI Telephone Readiness Assessment Quiz. Each disease site-specific quiz consists of 20 multiple choice questions and uses the following question categories: general oncology (four questions), organizational policies (11 questions), disease site-specific (five questions). The nurse must obtain 80% on this quiz to be considered ready for the next step of Telephone Training and Orientation. If the score is not 80% or higher, the quiz is reviewed with the nurse and the APNCE facilitates an opportunity to re-write the quiz. The objective in meeting with the new nurse at this time is to ascertain if the quiz score is indicative of the nurse not having read the material or to identify gaps in knowledge pertaining to general oncology knowledge, policies, or nursing disease site-specific knowledge.

If the nurse is assessed as 'not ready' for telephone training, meaning the nurse has not met one or more of the requirements of the Telephone Practice Readiness Assessment, the APNCE notifies the Operation/Management Team as to why the nurse is not ready to move forward with telephone training. The nurse may not be ready because the quiz score was below 80% or because practice concerns were identified from their documentation rubric self-reflection. According to the CNO Standards of Practice, documentation "is used to monitor a client's progress and communicate with other care providers. It also reflects the nursing care that is provided to a client" (p. 3). If significant concerns are identified such as consistently missing components of documentation or the nurse's rating of themselves is in the categories of unsatisfactory or needs improvement, then the APNCE works to understand how best to support the nurse and bridge the knowledge gap. The APNCE will create a learning plan together with the nurse to support learning activities using SMART learning goals. The College of Nurses of Ontario states, "reflecting on your practice, identifying your learning needs, developing SMART learning goals to meet those needs, completing learning activities and evaluating the resulting changes your learning has made to your practice activities" (SMART Learning Goals, p. 2) is an important set of skills for the professional nurse. Nurses who are 'not ready' to continue to telephone practice will continue to practice in clinic for an additional 4–6 weeks, after which the telephone readiness assessment will be repeated.

Step 2: Telephone Practice Session

Registered Nurses assessed as 'ready', attend the Telephone Practice Training session. The training session has evolved in length since its inception in 2017 from 2 hours to 3.5 hours. The contents of the Nursing Telephone Practice Training session, since October 2019, include topics identified in Table 2.

Step 3: Practical Application

The last component of the Telephone Readiness and Orientation Program is the integration of theory with practical application during actual telephone practice. In this part of the program, nurses have three half-days of observation and three half-days of supervised practice within two weeks of completing the Telephone Practice Training session to consolidate the learning gained from the training session. The Operation/Management Team works closely with the APNCE to identify and schedule the observational and supervised shifts.

Table 2:

Telephone Practice Training Presentation

Telephone Practice Training Topics	
Telepractice at the Centre	– Telephone practice defined – background and future state of telepractice – Overview of telepractice at the centre
Policy and standards that guide telepractice	– CNO – CCO – Hospital policies – Cancer Centre policies
Discussion and application of policies in practice	– Voicemail messages – Handover – Documentation – Email as a tool to support care
Review types of telephone work	– Overview of Live Voice Answer (LVA) – Site line voicemail – Email generated request – Proactive telephone practice – Patient education supporting patient needs
Review of person-centred-care and customer service principles	– best practice person centred care actions – customer service principles – voice quality – body language – enhancing the patient and family experience
Mock call	– Participants are provided with a copy of COSTaRS and with a scenario and script. – Participants are buddied; one nurse, one patient and one observer (if required) – Role play Nurse will document the encounter. The patient will provide feedback. – Mock calls are debriefed with the entire group. specify that this is with other members of the healthcare team (to avoid misconception that nursing emails patients)

During the three half-days of observation, the nurse is buddied with a colleague and learns how calls are received in real-time and are assessed and managed on the Live Voice Answer line. In addition, the trainee begins to retrieve and return voicemail messages from patients and families, conduct the disease site-specific proactive calls (anticipatory symptom care call), and address and navigate email generated requests from members of the healthcare team only.

In this part of the training, the nurse is provided with a telephone headset to connect into their buddies' telephone; buddies are assigned on a day-to-day basis. As per our program policy, the nurse and their buddy notify the caller that there is a new staff on the telephone call. A personal copy of the pan-Canadian Oncology Symptom Triage and Remote Support (COSTaRS) practice guide is provided to the new nurse. The purpose of the COSTaR guide is "to improve the quality training and consistency of cancer symptom management by nurses" (Stacey, Carley, 2017, p. 92). The tool is foundational in telephone practice as it guides nurse's assessment and management of cancer related symptoms due to treatment.

The three half-days of supervised practice involve the nurse being assigned the same buddy or a new buddy, and actively providing telepractice care for patients using evidence-based tools. The trainee is buddied, provided with a headset, and is able to respond to live telephone calls from the Live Voice Answer line but is supervised by the experienced staff member. In addition to practicing on Live Voice Answer, the trainees are expected to continue retrieving, prioritizing, and returning voicemail calls from patients and families, address email generated questions and concerns from members of the health care team, and practice conducting proactive calls.

Nurses participating in telephone orientation are required to complete telephone logs during their buddied shifts. The purpose of this activity is to allow time for the participants to capture pertinent information such as the patient's most important concern, appropriately categorizing the type of call, assessment, and next steps. This information is reviewed with their buddy nurse (see telephone log appendix E). Should the telephone encounter generate a communication email to other members of the health care team (e.g., physician, social worker etc.), the nurses are required to use a communication tool called SBAR. SBAR (situation, background, assessment, recommendation), as stated by Muller et al. (2018), is a communication technique used to deliver comprehensive information efficiently, encourage interprofessional collaboration, and limit the probability of error (p.2).

Assessing nurse learning/performance

The success of telephone orientation is gauged by using Benner's Novice to Expert Theory to assess how the new nurse is progressing. The new nurse is considered Advanced Beginner when they are able to retrieve calls and voicemail messages and return calls. They are considered Level 2 Competent when they can respond to calls 'live' within a familiar disease site. To be assessed at a Proficient skill level, the nurse must be able to respond to 'live' calls from multiple disease sites.

In addition, the Practice Telephone Log (Appendix C) is also reviewed with the APNCE and serves as a means to initiate discussions around learning outcomes. The telephone log captures the patients main concern, whether COSTaRS was used, if SBAR was used for email generated encounters, if the issue was resolved, (and if yes, how it was resolved) and learnings from the day. Capturing this information contributes to the learning on the part of the new nurse and reinforces telephone practices. The information collected from the log is significant and foundational in telephone practice.

When all components; Telephone Readiness, Telephone Training, and Practical Application are successfully achieved, completion of the training program is confirmed. The nurse can then be assigned independently to telephone practice in addition to their clinic practice.

TRAINING EVALUATION

As part of the evaluation process, each new nurse is asked to complete a survey at the end of the Telephone Readiness and Orientation Program. Based on their feedback, revisions were made to the Telephone Readiness map and practical application step.

The training evaluation was created to determine if the orientation process was effective in meeting the overall orientation goal of providing new staff with a seamless and well-supported orientation as they transition into telephone practice. The team tailored evaluative questions to determine satisfaction with training, knowledge acquisition, and application of learning into practice. We asked the participants to rate their experience with Telephone Practice Readiness Assessment, the learning package, classroom content (telephone practice training), their preceptors/buddies experience, if the orientation program met their learning style, if the self-assessment facilitated identification of learning needs, and encouraged additional comments. The evaluation survey consisted of 8 questions formatted using a combination of Likert Scales and the option of free-text comments.

In total, 9 out of 21 staff who had been oriented using the new program completed the evaluation survey. Overall, the staff evaluation in Table 3 tells us that nursing staff are satisfied with the telephone training and found the orientation to be helpful in preparing them for independent telephone practice. Frequent comments on the evaluation form indicated the following aspects were helpful: Mock Call activity, the framework outlined to meet the standards and polices of telephone practice, and the opportunity for supervised practice.

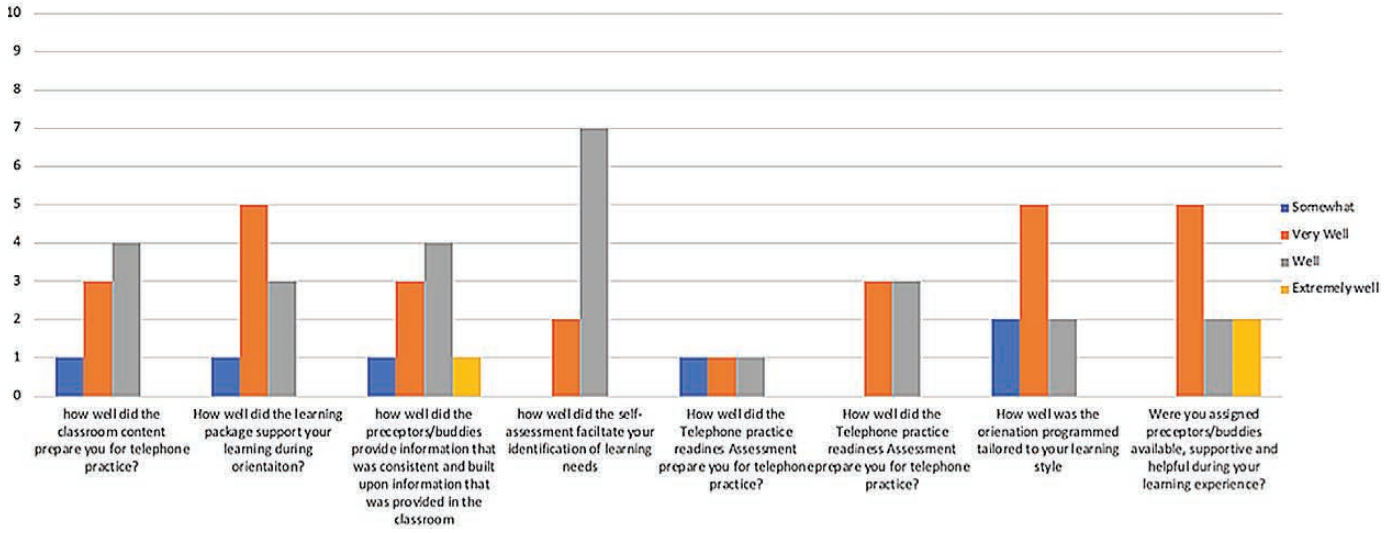
Revisions and updates to the program

The original telephone Practice Training Process flow chart (Appendix B) created in 2017 was revised in 2018 and 2019. The flow chart provided the APNCE team with a visual standardized orientation flow with each major component of the orientation pathway sequenced into a decision flow process. The latest version of the flow chart (Appendix A) shows modifications made to address staff who are assessed to be 'not ready' for telephone training and provides the APNCE with a means of addressing nursing practice concerns (i.e., requiring a professional learning plan with competency goal towards telephone practice). Details of the Telephone Practice Training were added to provide clarity for leadership staff and a follow-up sequence to complete the telephone practice orientation.

Telephone Readiness Assessment: The telephone readiness assessment did not significantly change since it was designed in 2017. The only modification made is the timeline between completion of

Table 3

Evaluation responses concerning satisfaction with telephone practice orientation program



the unit orientation and the readiness assessment. Originally, it was decided staff will be assessed for telephone practice readiness three months after the unit orientation. This was changed in 2019 to 3-6 months out of the need to be flexible with the algorithm so staffing requirements in the Ambulatory Centre could be met and staff could have more time in the clinic before advancing into telephone practice. We have observed, as stated in the Cancer Care Ontario (2019) recommendation, "an RN with Canadian Nursing Association (CNA) certification in oncology CON(C) and >2 years of experience in oncology is recommended" to provide oncology telepractice care (Oncology Nursing Telepractice Standards, p. 7). Fortunately, we have not experienced critical telephone practice issues with staff who have been prepared under our Telephone Readiness and Orientation model.

Telephone Practice Training presentation: The Training session presentation has gone through several revisions since the original presentation in 2017. The original was two hours in length and reviewed policies, customer service principles, and COSTaRS clinical scenarios. The Telephone Practice Training presentation was revised in 2019 and the session was extended to 3.5-hours (Table 2). The APNCE team reviewed the CCO Oncology Nursing Telepractice Standard skills for telepractice and incorporated those skills to the Telephone Practice presentation. These skills included interview strategies, the 5-A Model, managing challenging situations, health literacy, and evidence-based Practice (CCO, 2019). The Mock Call was also revised to include different nurse/client telephone scenarios (i.e., two COSTaRS symptoms and 1 non-COSTaRS scenario). Having a variety of scenarios allowed for fulsome and rich debriefing after the role-playing during the mock calls.

Practical Application: The Practical Application has not been revised. There are three phases including: observation shifts with a buddy, supervised practice shifts with other staff nurses, and independent practice. In addition to interactions on live calls, the practical application shifts include the retrieval and returning voicemail messages and email generated calls as well as proactive calls.

NEW LESSONS / FUTURE CONSIDERATIONS

One of the lessons we have learned is that the staff prefer the practical application of telepractice training to be scheduled as close as possible following the Telephone Practice Training Session. In addition, based on staff evaluation comments, it would be helpful to include case scenarios about challenging situations that arise on the telephone (e.g., an oncologic emergency). Future considerations include, providing examples of common urgent calls, providing a list of frequent types of calls from each disease-site, as well as a list of internal telephone numbers/extensions and emails to be distributed during orientation.

CONCLUSION

The Telephone Readiness Program is required to support the Live Voice Answer Program where patients are receiving telephone support in real-time from their respective nursing disease-site team. The Telephone Practice Training evaluation revealed staff satisfaction with preparedness for independent telephone practice. We believe the trilogy of Telephone Readiness Assessment, Telephone Practice Training Session, and Practical Application provides a robust, seamless and sustainable telephone orientation program. Nurses new to telephone practice are now equipped with the tools, practice standards and organizational policies required to provide a safe and effective telephone encounter for patients and their families.

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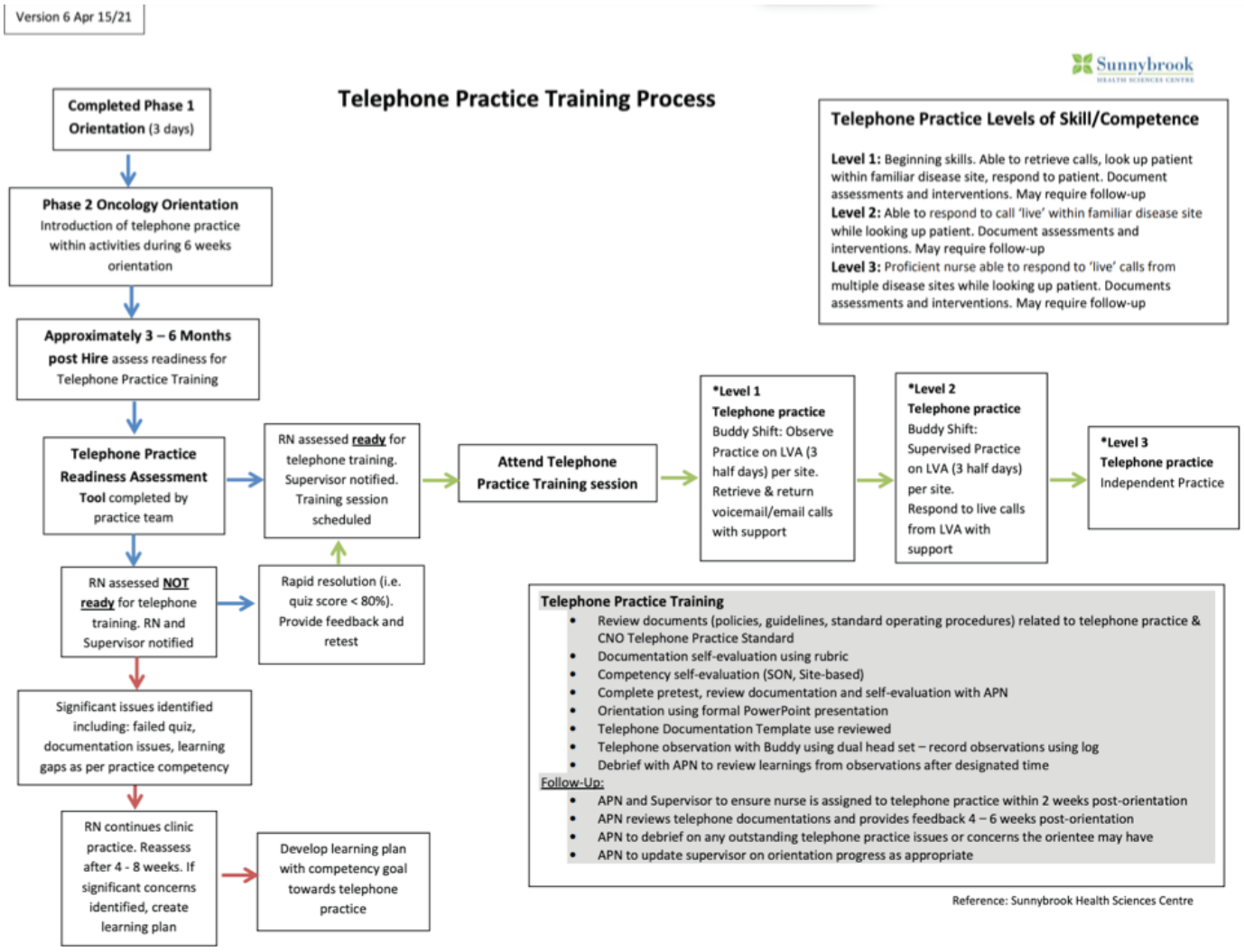
Appendix A

Telephone Practice Training Process



Appendix B

Practice Review Rubric for Clinic Documentation

Practice Review – Documentation Rubric

Total Score: Documentation Telephone Practice	**Formula to achieve Section Score: (Add each element score together to total out of 30). Divide by total number of elements (6): (n+n+n+n+n+n) ÷ 6**				**/5**	
Documentation – Clinic Practice	• The documentation does not reflect the nursing process*	• The documentation rarely reflects the nursing process*	• The documentation usually reflects the nursing process*	• The documentation consistently reflects the nursing process*	• The documentation always thoroughly reflects the nursing process*	
	• The voice of the patient and their concerns are not reflected	• The voice of the patient and their concerns are rarely reflected	• The voice of the patient and their concerns are usually reflected and informing care	• The voice of the patient and their concerns are consistently reflected in the charting and guiding care	• The voice of the patient and their concerns are always reflected and guide action	
	• Interprofessional collaboration is not reflected.	• Interprofessional collaboration is rarely reflected.	• Interprofessional collaboration is usually reflected, when appropriate	• Interprofessional collaboration is consistently reflected when appropriate	• Interprofessional collaboration is always reflected when appropriate	
	• Notes never reflect the nursing care provided and frequently reflect other team member's interactions	• Notes inconsistently reflect the nursing care provided and occasionally reflect other team member's interactions	• Notes usually reflect the nursing care provided and not the other team member's interactions	• Notes consistently reflect the nursing care provided and not the other team member's interactions	• Notes always reflective of the nursing care provided, and not the other team member's interactions and plans of care	
	• An appropriate evidence based response to symptom/distress screening scores is not present	• An appropriate evidence based response to symptom/distress screening scores is rarely present	• An appropriate evidence based response to symptom/distress screening scores is usually present	• An appropriate evidence based response to symptom/distress screening scores is consistently present	• An appropriate evidence based response to symptom/distress screening scores is always present	
	• Documentation is not timely	• Documentation is rarely timely	• Documentation is usually timely	• Documentation is consistently timely	• Documentation is always timely	
Total Score: Documentation Clinic Practice	Formula to achieve Section Score: (Add each element score together to total out of 30). Divide by total number of elements (6): (n+n+n+n+n+n) ÷ 6				**/5**	

1

* Nursing Process reflects assessment, planning, implementation and evaluation/follow-up (APIE/F)

Reference: Sunnybrook Health Science Centre

Appendix C

Practice Telephone Log

Practice Training – Telephone

MRN #

Patient's main concern If symptom related, which costars was used to assess:

Did not use Costars__

If email was generated to a team member, was SBAR used? Yes_____ No_____

How was issue resolved?

Reflections What were your 'learnings' from today?