Assessing the acute oncology patient
Who, why, where and how!

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Aim of this session

• Provide insight into the AOS needs of patients within the NT cancer network
  – How many patients seek AOS support
  – Which patients seek advice
  – Why do they need help
  – What type of support do they need
  – How do we currently provided AOS support
  – What tools do we have to help
Triage assessment

- Triage = the process of determining the priority of patients' treatments based on the severity of their condition
- UKONS standards for triage - what do we have in place?
  - The triage practitioner has the right of admission ✓
  - There should be an identified assessment area ✓
  - There should be a clearly identified triage practitioner for each span of duty ✓
  - There should be a process for each step of the triage pathway ✓
  - Each step provides insights into the AOS service
Triage pathway

Attend for assessment
WPH or A&E

Follow assessment guidelines - advice on appropriate care location/service. e.g. pharmacy, GP, self monitor

Advice/reassurance

Triage and log Sheet

Triage Practitioner
Who is using the service?
How many calls do we receive – from early days (Oct 2010 to June 2014)
## Number of calls

<table>
<thead>
<tr>
<th>Month</th>
<th>Calls</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2017</td>
<td>791</td>
</tr>
<tr>
<td>February 2017</td>
<td>723</td>
</tr>
<tr>
<td>March 2017</td>
<td>709</td>
</tr>
<tr>
<td>April 2017</td>
<td>789</td>
</tr>
<tr>
<td>May 2017</td>
<td>735</td>
</tr>
<tr>
<td>June 2017</td>
<td>771</td>
</tr>
<tr>
<td>July 2017</td>
<td>667</td>
</tr>
<tr>
<td>August 2017</td>
<td>667</td>
</tr>
<tr>
<td>September 2017</td>
<td>650</td>
</tr>
<tr>
<td>October 2017</td>
<td>694</td>
</tr>
<tr>
<td>November 2017</td>
<td>660</td>
</tr>
<tr>
<td>December 2017</td>
<td>711</td>
</tr>
<tr>
<td>January 2018</td>
<td>713</td>
</tr>
</tbody>
</table>
Number of calls per day, Jan and Feb 2015
Time of day calls were received January 2015
Challenge of unpredictable demands

- There is a wide variation in volume of telephone calls each month and each day
  - We did not find a pattern
- The service need to meet a highly unpredictable workload
- This presents a challenge faced when trying to plan and deliver oncology telephone triage services
Which patients use the phone service
Primary diagnosis of patients

Breast
Lung
Colorectal
Gynaecological
Prostate
Upper GI
Lymphoma
Brain
Kidney
Head and neck
Melanoma
Recent treatment

- 537, 77% not recorded
- 34, 5% chemotherapy
- 12, 2% radiotherapy
- 45, 7% chemo-radio
- 60, 9% not on treatment

Legend:
- chemotherapy
- radiotherapy
- chemo-radio
- not on treatment
- not recorded
Reasons for contacting the service
Other common reasons for ringing
(all patients)

• Major illness
  – E.G. chest pain, deranged U&E, bowel obstruction, spinal cord compression, sudden confusion
• Medicines advice
• Minor ailments
  – E.G. Small bleed, infected toe, constipation, sore eye
• General query
  – E.G. DN fax, appointment query, dental advice
• What happens when a patient or relative rings for advice?
Attend for assessment
Cancer centre, A&E

Follow assessment guidelines - advice on appropriate care location/service. e.g. pharmacy, GP, self monitor

Advice/reassurance
How to decide assessment outcomes?

• Tools for triage
  – Telephone triage – based on UKONS triage guidelines
  – AOS guidelines

• Based on assessment of symptom severity and clinical signs
  – With elements of experience, intuition and hunches

• Colour coded grading of
  – Minor (green)
  – Moderate (amber)
  – Severe (red)
Action following assessment

- **Green** – follow advice on guidelines.
- **1 amber** – follow advice in guidelines.
- Ask patient to ring back if symptoms do not improve or worsen
- **2 or more amber** – organise appropriate medical review
  - WAU, GP, local A&E, next OPA
- **Red** – medical review at WPH unless alternative appropriate
  - e.g. A&E for cardiac chest pain, conditions that might require surgical intervention
| Temperature 37.5°C or more, OR symptoms of infection OR feels generally unwell | **Assessment questions**  
1. What is the patients’ temperature?  
2. How long have they had a temperature?  
3. Have they had any shivers or shaking?  
4. Do they have any other symptoms?  
5. Have they taken paracetamol or NSAID that could mask a pyrexia? |
|---|---|
| | **Arrange urgent medical review as risk of neutropaenic sepsis – follow neutropaenic sepsis pathway.**  
If no bed available at WPH send to local A&E. **Phone A&E to inform staff of patients arrival and need to follow the neutropaenic sepsis protocol** including urgent bloods and IV antibiotics within 1 hour if neutropenic sepsis suspected  
ALERT patients on steroids/analgesics or dehydrated may not present with pyrexia but may still have an infection |
<table>
<thead>
<tr>
<th>Nausea</th>
<th>Able to eat and drink, managing a reasonable oral intake</th>
<th>Can eat/drink but intake reduced, no signs of dehydration</th>
<th>Patient symptomatic of dehydration /haemodynamic instability or patient unable to take adequate oral fluids</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How long have they had nausea?</td>
<td>Give advice on prescribed anti-emetics including regular use and compliance with prescription. Advise to take frequent sips of fluid and eat small amounts often. Teach patient to monitor for signs of dehydration.</td>
<td>Arrange medical review of anti-emetics. <strong>May</strong> not need to attend WPH if appropriate to contact GP for new prescription of anti-emetics or S/C or IM anti-emetics.</td>
<td>Arrange urgent medical review at WPH. If no bed available at WPH send to local A&amp;E. Phone A&amp;E to inform staff of chemotherapy related antiemetic protocol. <strong>If on capecitabine or 5FU infusor discuss discontinuing with on call registrar/patients medical team.</strong></td>
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<tr>
<td>2. Are they taking anti-emetics as prescribed?</td>
<td></td>
<td></td>
<td><strong>If on capecitabine discuss dose reduction/discontinuing with on call registrar/patients medical team.</strong></td>
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<td>3. What is their oral intake?</td>
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<td>4. Are there any signs of dehydration e.g. decreased urine output, thirst, dry mucous membranes, weakness, dizziness, confusion?</td>
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<tr>
<td>5. Do they have any other symptoms e.g. stomach pain, abdominal distension, diarrhoea? (If yes, refer to appropriate guidelines)</td>
<td></td>
<td></td>
<td><strong>If on capecitabine or 5FU infusor discuss discontinuing with on call registrar/patients medical team.</strong></td>
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<tr>
<td>Palmar-plantar (hand-foot) syndrome (PPE)</td>
<td>Numbness, tingling, painless erythema, swelling, not disrupting normal activity</td>
<td>Painful erythema and swelling, discomfort that affects normal activity but still able to perform them</td>
<td>Moist desquamation, ulceration, blistering, severe pain, unable to perform normal activities</td>
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<tr>
<td>----------------------------------------</td>
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<td>-------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1. How many days?</td>
<td>Advise use of emollient cream.</td>
<td>Advise use of emollient cream. If on capecitabine or other oral cancer treatment that can cause PPE discuss dose reduction/ discontinuing with registrar/patients medical team.</td>
<td>Organise admission and medical review If on capecitabine or other medication that can cause PPE discontinue and discuss with registrar/patients medical team.</td>
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<tr>
<td>2. What areas are affected?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3. Is there any pain?</td>
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<td></td>
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<tr>
<td>4. Is the skin broken?</td>
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<td></td>
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<tr>
<td>5. Does it interfere with mobility/normal activity?</td>
<td></td>
<td></td>
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<tr>
<td>6. Is the patient on oral medication likely to be causing this – i.e. capecitabine, Sunitinib, Sorafenib</td>
<td>Numbness, tingling, painless erythema, swelling, not disrupting normal activity</td>
<td>Painful erythema and swelling, discomfort that affects normal activity but still able to perform them</td>
<td>Moist desquamation, ulceration, blistering, severe pain, unable to perform normal activities</td>
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AOS assessment and treatment guidelines

- Local guidelines have been developed
- Cancer services guidelines are accessible on the intranet
CHEMOTHERAPY INDUCED NAUSEA AND VOMITING

Nausea and vomiting are common side-effects of chemotherapy agents. Almost all regimens include prophyllactic anti-emetics and patients usually have oral anti-emetics given to take at home with their treatment regimens including 72-hours of dexamethasone. Patients presenting with nausea and vomiting should be promptly assessed as in cases of severe and prolonged vomiting life-threatening complication such as renal failure can develop. Nausea and vomiting related to chemotherapy can be acute (within 24 hours) or delayed (after 24 hours). Be mindful that these symptoms can also have other causes, especially > 5 days post-chemotherapy, such as the cancer itself and importantly infective causes.

Initial Assessment

Identify: All patients within 6/12 of chemotherapy or disease related immune suppression. These patients are often also myelosuppressed and are at risk of neutropenic fever and sepsis. If present, manage according to local guidelines.

Observations: Temperature, Pulse, BP, Respiration rate, Oxygen saturations

Investigations: Full Blood Count, U & E, LFTs, Calcium, PO4

Questions:
- What cancer treatment is the patient receiving? When was the last treatment/tablet taken? Primary cancer diagnosis
- History of onset, duration, frequency, volume. Review use of anti-emetics?
- Review other medications. Could these be the cause of symptoms?
- Any abdominal pain? Signs of dehydration? Review dietary intake over last few days

If the patient is on oral anticancer therapy that is associated with nausea and vomiting and the patient has moderate or severe symptoms, the anticancer therapy must not be continued until it has been discussed with the treating oncology medical team or the on-call oncologist at Weston Park Hospital.

Mild: Grade 1
1-2 episodes/24hrs

Moderate: Grade 2
3-5 episodes/24hrs

Severe: Grade 3
>6 episodes/24hrs
Can be life-threatening – requires urgent intervention

Severe: Grade 4
>10 episodes/24hrs

Mild to moderate:
If significant reduction in oral intake: check U+E’s for dehydration. Encourage oral fluids. IV fluids may be needed.

Review current use of anti-emetic and encourage patient to take regularly if not already doing so. Consider change of and/or addition of further anti-emetics

Review other medications – could these be cause of symptoms? Enquire about constipation (SHT, antagonists such as ondansetron or granisetron can cause this)

Moderate (grade 2): If taking oral anti-cancer therapy, withhold and discuss with oncology/haematology treating team or on-call oncologist/haematologist

Review for potential infective sources and treat appropriately. Encourage patient to phone Weston Park Hospital if symptoms do not improve or worsen

Antiemetic management
1st line: Domperidone 20mg QDS PO (or metoclopramide 10mg TDS PO or IV)
2nd line: Ondansetron 4-8mg PO (or granisetron 3mg BID IV) (for acute and delayed emesis)

If refractory to above, consider use of Haloperidol 1.5mg route PO and/or use of syringe drivers – e.g. metoclopramide 30-60mg s/c over 24 hours. Early referral to palliative care team once 2 or more anti-emetics are required is recommended.
What are the outcomes of the calls?
Outcomes of calls

- 271, 40% Advice over phone
- 205, 30% Attend WAU
- 144, 21% GP referral
- 48, 7% other hospital (A&E)
- 12, 2% D/W reg/cons

Legend:
- Advice over phone
- Attend WAU
- GP referral
- other hospital (A&E)
- D/W reg/cons
• Which patients attend the cancer centre for review?
  – WAU Monday to Friday – 8am to 8pm
    • 8 chairs and 4 beds
  – Wards out of hours and weekends
Where do patients live
Emergency admissions to WPH by patients nearest hospital 2017
total = 764 admissions

- Barnsley: 94
- Chesterfield: 106
- Doncaster: 87
- Rotherham: 192
- Sheffield: 285
Who referred them?

- 46% Doctors
- 20% Nurses
- 17% Registrar
- 8% Self
- 6% Other
- 3% MD
July 2017
red = Saturday, green = Sunday

Number Of Admissions Each Day
Number each day of the week for 4 weeks (July 2017)
Time of day of admissions
Top 6 reasons for treatment related admissions

• Suspected neutropenic sepsis
• Nausea and vomiting
• Infection, not neutropenic
• Diarrhoea
• Electrolyte imbalance
• Head and neck radiotherapy symptom management
Top 4 non-treatment related reasons

• Pain and symptom management
• Oncology emergency (SCC, collapse)
• Disease related symptoms (e.g. jaundice, hypercalcaemia)
• Pulmonary embolus, DVT
Where do patients go (July 2017)

- Home: 82
- Wards: 212
- Transfer: 2
- Missing data: 13
Feb 2017 review

How would you rate the service

<table>
<thead>
<tr>
<th></th>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
<th>Not documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone triage</td>
<td>32</td>
<td>15</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Assessment unit</td>
<td>34</td>
<td>11</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Acute oncology service</td>
<td>11</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>77 (68.75%)</td>
<td>31 (27.6%)</td>
<td>3 (2.7%)</td>
<td>1 (0.9%)</td>
<td>7 (NA)</td>
</tr>
</tbody>
</table>
Challenges of AOS and triage

• Workload is variable and unpredictable

• Patient triage and assessment isn’t easy!
  – requires skill and experience

• Recording missing patients – who doesn’t get through, who we send to local DGH
  – Work in progress to identify this and develop evidence based plans
Is it worth it?

• It IS proving to be a valuable resource for patients
  – Provides timely access to specialist advice and treatment
  – Prevents inappropriate admissions
  – Allays unnecessary patient anxiety
  – Valuable safety net

• But it is a Challenging service to provide
  – Recognised it has outgrown its resources
• New model has been developed for dedicated phone triage
  – To be implemented this year